African Americans' Perceptions of Psychotherapy and Psychotherapists

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African Americans' Perceptions of Psychotherapy and Psychotherapists

Vetta L. Sanders Thompson and Anita Bazile
University of Missouri—St. Louis

Maysa Akbar
St. Louis University

Do you have a multicultural practice? Do you understand the attitudes and expectations African Americans hold about mental health services? The attitudes and beliefs of 201 African Americans regarding psychotherapists, psychotherapy, and barriers to treatment were explored by means of focus groups. Key barriers to service utilization included stigma, lack of knowledge, lack of affordability, lack of trust, impersonal service, and lack of cultural understanding. Participants reported that race should not matter in therapy, but they often believed that psychologists were insensitive to the African American experience. The implications of participants' reports for meeting African American mental health and therapy needs are considered.

Although psychologists are aware of the differential pattern of use and response to mental health services among ethnic clients, the in-depth understanding that would permit development of appropriate responses and programs is limited. Psychologists often struggle with whether, when, and how efforts to address issues of race, ethnicity, and culture will affect mental health attitudes and therapeutic response. The focus group is a qualitative research strategy that uses a semistructured discussion format to elicit a more in-depth understanding of the attitudes, values, and beliefs that affect behavior (Stewart & Shamdasani, 1990). Although this strategy sacrifices the rigor and precision of quantitative studies, it is a useful preliminary strategy that allows members of communities to share their insights on relevant issues and their opinions about how needs and concerns might be addressed. The current study represents a preliminary effort to understand what values and

concerns may affect African American mental health attitudes and service use, as well as what efforts by the psychological community may prove beneficial in promoting an image of multicultural sensitivity and competence.

African Americans have been identified as a group that uses mental health services inconsistently (Kessler et al., 1994; D. W. Sue & Sue, 1990). Research has documented the overuse of inpatient services and the over- and underuse of outpatient services depending on the setting and problem (Atkinson, Morten, & Sue, 1998). More recently, Snowden (1999) noted a mixed pattern of usage when sociodemographic differences and diagnoses were not controlled. However, controlled analyses indicated that African Americans in a community sample were consistently less likely than White Americans to seek mental health services.

The National Survey of Black Mental Health (Jackson, Neighbors, & Gurin, 1986) indicated that African Americans sought services as a result of referrals by physicians, family members, or friends and tended to contact physicians, ministers, and hospitals; only 9% of those surveyed used the services of psychologists, psychiatrists, or community mental health facilities. African Americans have been found to average fewer sessions and to terminate from outpatient mental health services earlier than White Americans (D. W. Sue & Sue, 1990). Diala et al. (2000) noted that African Americans were more likely than White Americans to report positive attitudes toward seeking professional help and to feel comfortable discussing personal problems with a professional, and they were less embarrassed about friends knowing that they were seeking therapy prior to service use. African Americans were also more likely to reference negative attitudes and less likely to use mental health services after professional contact. These findings suggest the importance of examining barriers to African Americans' treatment seeking.

A number of variables have been suggested to explain the inconsistent use of mental health services noted among African Americans. Economic issues may be relevant in this regard. Lack of access to health insurance would require African Americans interested in mental health services to use public programs (Muntaner & Parsons, 1996). Mutchler and Burr (1991) noted wealth as a factor in racial differences in the use of mental health services.

Because many African Americans are categorized as low income, economic issues cannot be ignored.

Therapists' race and/or ethnicity, style of therapy, facility policies, and client and therapist attitude similarity have been suggested as relevant factors (Asbury, Walker, Belgrave, Maholmes, & Green, 1994; Okonji, Ososkie, & Pulos, 1996; Thompson, Sanders, & West, 1993; Wilson & Stith, 1991). It is interesting to note that data from the National Survey of Black Mental Health indicated no therapist race or ethnicity preferences among the African Americans surveyed (Jackson et al., 1986). Fewer than 10% of African Americans saw an African American therapist. Of those participants who reported seeing an African American therapist, only 22% expressed a preference for an African American, and preference for an African American therapist did not have an impact on their willingness to see a mental health provider again.

Davis and Proctor (1989) noted that although evidence suggested that race/ethnicity affected the therapeutic process, there was no evidence that racial dissimilarity impeded treatment outcome. S. Sue, Fujino, Hu, Takeuchi, and Zane (1991) noted that whereas African Americans had lower rates of premature termination when there was an ethnic match, ethnic match did not affect treatment outcome. Asbury et al. (1994) conducted an empirical study of African American participation in rehabilitation services that may have relevance for attrition rates noted among African Americans in therapy. The results of discriminant analyses indicated that racial similarity, perceptions of provider competence, and perceptions of the service process determined ongoing participation. Helms and Cook (1999) suggested that willingness and ability to engage in therapeutic work with a racially or an ethnically different therapist may depend on client racial identity and consciousness.

Terrell and Terrell (1984) suggested that African Americans who rated high in mistrust were more likely to terminate therapy prematurely. Nickerson, Helms, and Terrell (1994) reported that African American students who rated high in cultural mistrust of White Americans were less likely to visit the campus counseling center. Thus, issues of trust may be relevant to African Americans' attitudes toward mental health and service usage.

An early study by Silva de Crane and Spielberger (1981) noted that African Americans reported more negative attitudes toward individuals with mental illness than did members of other ethnic groups. The presence of stigma has been cited as an influence on service utilization patterns (Link & Phelan, 1999; Markowitz, 1998; Sirey et al., 2001). If mental illness carries strong stigma in the African American community, it may adversely affect use of mental health services. Cooper-Patrick et al. (1997) noted that in focus group discussions, African American patients raised more concerns regarding stigma than did White patients.

Neighbors (1990) noted gender and problem type as issues affecting African Americans' use of mental health services. The death of a spouse or a loved one was an event likely to encourage African American men to seek services. Furthermore, women and individuals with economic problems were likely to seek the assistance of ministers (Neighbors, Musick, & Williams, 1998). If a minister was contacted first, individuals were less likely to seek assistance from other professionals.

Given the referral and service provider selection patterns of African Americans, it seems important to carefully examine the beliefs, attitudes, and expectations of the African American community regarding mental health service providers and use of mental health services. This study considers community attitudes toward psychotherapy and psychotherapists through the use of focus groups.

Focus Group Discussions of Mental Health

Twenty-four mixed-sex focus groups were conducted in an urban, Midwestern city. Groups ranged in size from 3 to 12 members. A total of 201 African Americans (134 women and 66 men) participated in discussions. One participant did not provide information on gender. Participants included consumers of mental health services, family members of consumers, as well as a large number of participants with no direct experience with mental health. Characteristics of the participants are summarized in Table 1.

All focus groups were conducted by an African American female psychologist with 8 years of experience conducting focus groups with African Americans. An African American counseling graduate student assisted. Focus groups were 1.5 hr long. The initial focus group probes (developed by Vetta Sanders Thompson) were reviewed by a graduate assistant and revised. The probes were then pretested in a mock focus group. The probes that were developed to address mental health knowledge, attitudes, and concerns are shown in Table 2.

Focus groups were conducted from May 2000 through November 2000. Participants were volunteers recruited via newspaper advertisements and posted announcements. Participants contacted the principal investigator and were screened by phone. Contact

Table 1
Summary of Participant Characteristics (N = 201)

Variable	Range	*M*	*SD*	%
Age (in years)	18–74	35.8	12.9	
Education (in years)	8–22	18.0	2.7	
Income ($)	0–150,000	19,322	20,211[a]	
Mental health experience				
None				46.0
1 or more therapy sessions				31.7
Family or friend therapy experience				17.1
Considered therapy, did not attend				5.2

[a] *Mdn* = $18,000.

Table 2
Focus Group Probes of African American Mental Health Knowledge, Attitudes, and Concerns

Category	Probes
Problem type	When should psychotherapy be considered? What types of problems require psychotherapy?
Therapist image	Describe your image of a psychologist. Describe your image of a therapist. Describe your image of a counselor. Who would you prefer to see?
Race/gender/ethnicity	Does race matter in the selection of a therapist? Does gender matter in the selection of a therapist? Does ethnicity matter in the selection of a therapist?
Service center characteristics	What characteristics would you look for in the mental health facility you attended? What characteristics would you look for in the mental health facility you recommended to a family member?
Therapist characteristics	What characteristics would you look for in a therapist you saw? What characteristics would you look for in a therapist you recommended to a family member?
Discussion of race/ethnicity	Should therapists of a different race or ethnicity discuss race or ethnicity during the initial phase of therapy?
Therapy goals	What goals would you set for therapy? What would you want to accomplish in therapy?

information was obtained that permitted reminder calls 1–2 days prior to the focus group. Following the group discussion, each participant was provided with a $20 stipend.

Although the group facilitator began the process and moved the discussion along with the aid of discussion probes, the specific content and order of the discussion were driven by participants' responses (Stewart & Shamdasani, 1990). All sessions were audiotaped, and each session's audiotape was transcribed verbatim. In addition, an assistant completed detailed field notes based on focus groups and the debriefing discussions that followed. Tapes, transcripts, and notes were independently read in their entirety (by Vetta Sanders Thompson and Anita Bazile, as well as by two African American student assistants). We consolidated our impressions into a list of themes and issues on the basis of our independent review of transcripts, field notes, and debriefing notes. We met to discuss discrepancies in themes, interpretation, and assignment of meaning, and we (Vetta Sanders Thompson and Anita Bazile) resolved differences through discussion until there was consensus. We organized the findings thematically, with references to level of consensus among participants and relevance for population subgroups noted throughout.

The interpretation of these focus group discussions must be approached with caution. This was a qualitative study, and the relative influence of the issues identified cannot be quantified. Although we made an effort to obtain a diverse sample, the participants were not representative of a national sample of African Americans. It is likely that there were regional differences in service use attitudes and preferences, as well as in knowledge about mental health. This sample was composed of volunteers, and it is impossible to know how individuals who chose to participate differ from those who did not. It is plausible that individuals who had concerns about mental health issues in the African American community were more likely to agree to participate in a study of this nature. In addition, the provision of a monetary incentive may have resulted in a larger proportion of low-income participants.

Seeking Psychotherapy

There was general agreement on the primary reasons to seek psychotherapy. Participants reported that schizophrenia, depression, and suicidal ideation suggested the need for psychological intervention. The identification of these disorders suggests that seeking therapy is associated with serious mental illness. There was no dissent noted on drug and alcohol abuse, rape, child sexual abuse, and domestic violence as major life events or traumas requiring therapeutic intervention. Finally, grief and attempts to cope with life stressors (i.e., relationships, finances, discrimination, etc.) were identified as appropriate reasons to seek the services of mental health professionals, although there were differences in reported willingness to do so.

Participants with no mental health background typically reported a preference for the term *counseling* over *psychotherapy.* Psychotherapy was seen as unfamiliar and was associated with the stigma of mental illness. Participants reported associating counseling with problem solving, help, and assistance. Individuals who reported prior treatment were more comfortable with the term *psychotherapy* but noted the stigma experienced as a result of its use:

> "Umm, well, I tend to think of counseling as more beneficial, because with counseling you get to get help with solving problems."

> When you say psychotherapy, you think psycho, you just think "crazy." You don't want to think you're crazy, you just think you have a problem and you need help.

> I think for me I just had a really bad perception of it because I had no idea what it was and I always just equate it to "you're crazy."

There were some participants who viewed *psychotherapy* and *counseling* as equivalent terms, and a smaller minority viewed psychotherapy as a more in-depth, long-term intervention.

Barriers to Seeking Psychotherapy

Cultural Barriers

There was surprising consensus on the barriers to seeking mental health services. The existence of cultural beliefs, such as the need to resolve family concerns within the family and the expectation that African Americans demonstrate strength, were not debated. The need to seek psychotherapy was associated with weakness and diminished pride:

> I think my family is more like, we can work it out within ourselves rather than going outside. . . . I don't know if it was so much knowing, but they just feel like we're a family and we're a strong enough family to handle it.

> Well I think that also goes with an African American dream to be considered a strong family. Mental illness is considered a weakness and we wouldn't even recognize it in the first place, because strong families just don't do that.

Males focused on diminished pride and weakness, whereas women noted the historical requirement that they be the anchor and source of strength in the family.

Participants also noted strong prohibitions on sharing information with those outside of a circle of family and trusted friends. One participant noted the following:

> Just the whole idea of like telling your problems to a total stranger, unless it's someone that you know. . . . It's like you don't know that person, but then they want to know everything about you.

Other comments reflected concerns regarding the necessity for disclosures about friends and family:

> Because unless you are like straight up schizophrenic or something, then it's really not the doctor's business what is going on in your life or in your family's life. But if you are in therapy talking about your problems, chances are your friends and family are going to have to come up.

Although participants agreed on the existence of these beliefs, they debated their wisdom. Older participants and men were more likely to suggest continued endorsement of these views. Some participants, although hesitant about the process, recognized the benefits of psychotherapy:

> It's sort of an invasion of privacy, but I also see it as being a help if you're able to get what's on your mind out and able to get some help from someone else.

Finally, a surprising majority of participants noted the historical expectation that life would be difficult and that African Americans as a cultural group could and would cope with all adversity. This expectation was believed to inhibit help-seeking behaviors:

> We as African Americans were always taught and always raised that you're not going to have it easy. You're going to be at a disadvantage. You're going to have to be tough. You're going to have deal with problems.

This attitude suggests that the weak ask for help; thus, seeking treatment is a sign of weakness. The tremendous burden of poor health and mental health that African Americans endure because of this belief resulted in very limited support for its continuation.

Stigma

Individuals who had received mental health services, as well as those with no prior experience with such services, noted that the stigma of mental illness, as well as the shame and embarrassment associated with it, was a significant barrier to seeking treatment. The only debate among participants was whether African Americans stigmatized mental illness more than other groups. Participants discussed a feeling that others reject those with mental illness. They noted that individuals with mental illness, as well as their families, hide their illness:

> The average person, when they find out a person is having mental problems, they turn their back on them.

> If they do [go to therapy], they try to keep it confidential and no one knows about it because you are labeled very quickly.

Financial Barriers

Cost was noted as a health care issue for most African Americans and as a significant barrier to seeking mental health treatment. Participants noted that African Americans frequently lack adequate insurance to cover mental health services. Individuals not in the field of mental health (the majority of the participants) suggested that hourly fees were excessive and that in the face of more pressing needs and financial challenges, psychotherapy was a luxury. Some participants questioned the value of services given the perception of high costs, whereas others questioned the ability to receive quality services without adequate income or insurance. Participants who used Medicaid benefits complained that medication was the most frequently recommended treatment and that psychotherapy and counseling were not offered as options.

Lack of Knowledge

Despite the sense that therapy was required to address certain issues, even educated participants reported that they lacked sufficient knowledge of the signs and symptoms of mental illness (i.e., depression, anxiety, etc.). Participants noted that it was particularly difficult to discern when a situation or condition had reached a stage requiring professional services. Lack of information led several participants to consult churches for resources and referrals. Likewise, emergency rooms were viewed as accurate sources of information and referral that also allowed individuals to avoid the stigma of seeking services and issues related to payment.

> Like that man said, he had bipolar disorder. Too often we dismiss them as crazy. That's just something that culturally we don't know about. It sounds kind of cliché to say that we need to educate our people, but that's the basic truth.

> People don't know about any of the different organizations around here that are willing to help them. They don't know what resources to go to get that help.

Participants were very interested in services that were located in the community; however, only approximately half of participants reported an interest in services that specifically focused on African American mental health. They suggested that they could not conceive of specific or specialized services that would satisfy the entire community given its diversity.

Alternative Resources

Older, more religious participants reported the use of prayer as a way of coping with mental health issues. This was not, however, a widely endorsed strategy. The church was often cited as a source of financial and social resources. Participants who reported strong religious convictions were most likely to see the church as a general resource. Indeed, some participants noted that confidentiality and understanding were sometimes unavailable through the church. Relationship concerns were perceived as problems that could be addressed by a minister or with assistance from family and friends.

Psychologists and Therapeutic Issues

Psychologists

Variations in views were encountered as discussions of psychology and psychologists ensued. Psychologists were described as older White males, who were unsympathetic, uncaring, and unavailable. A common characterization was that psychologists were "impersonal." Psychologists were described as elitist and too far removed from the community to be of assistance to most African Americans. Those participants with prior therapy experience gave the most realistic descriptions of psychologists; however, this did not always result in a positive image:

> It doesn't seem like they're truly concerned about you, what you could possibly be going through. You know it's just like "I'm about to get paid . . . your hour is up."

Approximately half of participants reported a belief that psychologists, unlike social workers and counselors, failed to participate in community education, prevention, and outreach, whereas others indicated too little information on the profession to comment. Participants noted a reluctance to trust professions not active in the African American community and activities directed toward community well-being. Participants who had sought therapy noted the difficulty in locating African American or ethnic minority therapists. In addition, many participants found the emphasis on education and degrees "intimidating." A small number of participants discussed how education limited the therapist's understanding of their life experiences:

> I would say there are more White psychotherapists out there than Blacks. You know if you made an appointment to see a therapist, more likely than not you are going to be sitting down talking to someone who can't relate to you.

Mistrust

The issue of trust generated the greatest debate among participants. Participants with no psychotherapy experience and little knowledge of the profession reported that although psychotherapy might be beneficial, most therapists lacked an adequate knowledge of African American life and struggles to accept or understand them. Participants discussed the stereotypes of African Americans in the larger society and challenged the ability of psychologists to remain unbiased. Also of interest were participants' fears, which included misdiagnosis, labeling, and brainwashing. Psychologists were perceived as predisposed to viewing African Americans as "crazy" and prone to labeling strong expressions of emotion as illness:

> You might not trust White people. You're not going to sit and talk to somebody if you don't trust them. You know what I'm saying.

Individuals with psychotherapy experience discussed the importance of the therapist's knowledge of the illness, appropriate treatment, and concern for the needs of the individual client in developing trust.

Participants described circumstances that facilitated overcoming mistrust. They reported increased comfort when the therapist did not appear overwhelmed by their problems and issues. The therapist's ability to demonstrate genuine concern, ask appropriate questions, and the sense that there was a personal connection were important to the development of trust.

Psychotherapy

The majority of focus group members described psychotherapy as an invasive, impersonal strategy to gain relief from distress. Regardless of the general view of psychotherapy, participants discussed the desire for competent care and believed that the cost of psychotherapy resulted in limited access for most African Americans. Participants who had participated in long-term psychotherapy were more positive. They reported empathy, compassion, time to develop trust, as well as a sense that a relationship had formed as significant to attitudes about therapy. Many participants reported experiencing and hearing about cold, condescending, arrogant interactions, and there were persistent complaints about the inability to make a connection. Confidentiality issues were raised as discussions focused on the variety of agencies (i.e. schools, courts, etc.) that referred African Americans for mental health treatment. Psychoeducation related to diagnosis, symptoms of the illness, and warning signs of mental illness was also expected, as well as what one participant termed "real prevention."

The lack of trust in providers made the use of psychotherapy intimidating. Participants with psychotherapy experience reported that they were disturbed by the inability of therapists to clearly explain the goals, the expected length of therapy, and how therapy would help, although they were able to overcome this concern. It is noteworthy that participants reported a preference for therapies that focused on the provision of tools and strategies that promoted successful coping rather than on insight or resolution of specific problems. Focus group participants were hesitant about any strategy perceived as permitting the therapist to give advice or tell them what to do. This issue seemed related to the participants' concern regarding a therapist's ability to understand their situation. Although participants agreed that few if any therapeutic modalities were developed with African American treatment in mind, a small minority noted that this was not necessary when treating serious, persistent mental illness.

Despite these concerns, participants emphasized the need for and benefit of psychotherapy in the African American community. They noted that if therapists made sincere efforts to understand African American clients, clients would participate in finding common ground. Participants discussed strategies for working with White American therapists:

From my personal experience, if a Black person is going to seek professional help, it's not really the color of their skin, it's the qualifications.

I found out that it really doesn't matter. A lot of them let you solve your own problems. Actually in therapy, you are solving your own problems.

Cultural Sensitivity

It should not matter, but it really does. . . . I guess that you are more comfortable with someone who is more similar to you than someone you consider in a totally different lifestyle.

Over half of the participants reported a preference that race not matter in the provision of mental health services but indicated a vague fear that it did. Men and lower income participants were more likely to assert that race mattered. Participants reporting this attitude noted that it was based on sensitivity to the historical issues and experiences of the African American community. Participants believed that therapists were influenced by frequently encountered stereotypes of African Americans. They noted that African American psychologists could be too far removed from the culture and as insensitive as therapists who were not African American. Participants were less likely to note, but did acknowledge, the extent to which differences in socioeconomic status played a role in their perceptions. Psychologists were perceived as middle- to upper-middle-class, with limited understanding of poor and working class life:

If it has something to do, say, with a relationship with your spouse or something, I don't think it would matter what ethnicity the person was. Even if they were the same ethnicity, it's not going to guarantee that they understand. They grow up in a middle-class neighborhood and they don't know anything about where I am.

Participants with psychotherapy experience noted that certain problems, such as experiences with racism, discrimination, the stress of "paying bills," balancing work and family life, and exposure to community trauma, were avoided because of fears that the therapist would not understand. Participants also noted that this fear led to a tendency to edit or limit what was discussed. Similarly, issues of rape, domestic violence, and child sexual abuse were almost unanimously seen as inappropriate or difficult to discuss in mixed-sex therapist–client dyads.

I think on some issues, like racism or something like that, a White person can't really relate to that. I want someone [who] could really understand what I'm talking about. Even just with Black people in general, we have diversity and we have internalized racism within us. We have the whole thing about shades, and I don't think a White person could really comprehend what I was talking about.

When queried about the advisability of addressing issues of racial differences early in the therapeutic relationship, participants had mixed reactions. Approximately one third of participants felt that discussions of race not initiated by the client were indicative of therapists' racism and discomfort. Another third indicated that they would be relieved and could speak honestly if a therapist initiated such a conversation. Still other participants were neutral and doubted that such a conversation would affect the course of therapy. Participants stated that if they were uncomfortable and felt

misunderstood in a mixed-race dyad, they would not return to therapy:

It would bother me [for the therapist to bring up race] because I would think that they are racist, that they're not going to be fair and give me the same treatment as they give the next person.

I wouldn't care if they brought it up. I want to talk about it.

Applications and Implications for Clinical Practice

Although focus group discussions are preliminary, they can provide important insights into the attitudes and beliefs that promote particular patterns of mental health service use by the African American community. Focus group responses indicated that depression, schizophrenia, and suicide were considered primary reasons to seek treatment. Participants also noted the need for treatment in cases of drug and alcohol abuse, rape and other acts of violence against women, child sexual abuse, as well as grief. Thus, serious mental illnesses, as opposed to daily stressors and problems in living, are most likely to precipitate treatment seeking.

There is a strong need to educate the community on the range of issues psychologists are prepared to address and how these promote well-being. An increase in outreach efforts in the African American community may result in positive and accurate images of psychology and psychologists. Accurate images can facilitate community willingness to view psychologists as sources of assistance for emotional and interpersonal crises and difficulties. Presentations of materials from the American Psychological Association's (APA) public education campaign to the African American community might improve awareness of the value of psychology.[1]

Consistent with data from the National Survey of Black Mental Health (Jackson et al., 1986), the present study reveals that African Americans participating in these focus groups were not generally negative toward seeking mental health services, but they held attitudes and beliefs that negatively affect actual treatment seeking. Participants reported greater comfort with the idea of obtaining counseling rather than psychotherapy, which was associated with the use of the label "crazy." Issues identified as barriers to treatment seeking have been noted previously in the literature. Despite acknowledgement of the need for services and perhaps consistent with the focus on serious and persistent mental illness, participants noted that stigma, costs, and knowledge of available services affected treatment seeking (Mutchler & Burr, 1991; Nickerson et al., 1994; Silva de Crane & Spielberger, 1981; Terrell & Terrell, 1984).

It is noteworthy that participants suggested that the use of emergency room services provided a method of addressing all three issues. Emergency rooms must assess patients regardless of their ability to pay and were perceived as a source of referral. In addition, it was suggested that stigma could be avoided through emergency room use because of others' inability to ascertain the nature of the services sought. This is an expensive and in many instances an inappropriate use of the emergency room, but it reflects an effort to address both the need for services and concerns related to seeking these services. This utilization strategy is also problematic because, as Snowden's (1999) analysis of African

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[1] See http://helping.apa.org/resilience/

American utilization data indicates, physicians often fail to recognize the need for referrals.

Clearly, mental health education should include information on the location and appropriate use of services. Community mental health centers might consider offering walk-in and urgent-care services in satellite offices located in hospitals or other community institutions. The availability of these services, whether located at community mental health centers or satellite locations, would require extensive advertising in the community to be effective. Psychologists could also advertise any intake hours routinely available during the week. Takeuchi and Uehara (1996) noted research support for the effectiveness of ethnic minority programs in reducing reliance on emergency services. This option should also be explored.

Focus group participants viewed the typical psychologist as an older, White male and discussed their concern that psychologists could not be sensitive to the social and economic realities of their lives. A sense of connection and the ability to establish a relationship were important concerns for these African American participants. The perception that the therapeutic relationship is difficult to establish suggests the need to examine the relationship boundaries maintained by the profession, which may be misunderstood and perceived as a lack of caring.

Current Health Insurance Portability and Accountability Act (HIPAA; 1996) regulations and implementation efforts require that psychologists provide information to patients about their privacy rights and how information will be used. This requirement also provides an opportunity for psychologists to educate patients about confidentiality, a concern that relates to the frequency of school, judicial, and social service involvement among African Americans in therapy (Wilson & Stith, 1998). The complexities of the HIPAA regulations will likely increase suspicion and concern if they are presented simply as additional documentation and forms to sign. However, African American clients may respond positively if they know that HIPAA guidelines require their authorization for release of information that is not relevant to their treatment, billing procedures, or the claims process to employers, schools, or other entities (APA Practice Organization, 2002). In addition, the requirement that psychologists inform clients of potential uses and disclosures of their protected health information and the right to limit these uses may increase African American clients' sense of control until trust in the therapist has developed. Therapists may want to take the time to discuss this information and create an opportunity to explore confidentiality concerns and requests. These discussions may generate a sense of genuine concern for the client's feelings and position and promote the sense that the therapist is open to the development of a collaborative relationship.

One of the most significant issues addressed by focus group participants was the complex way in which the issue of race affects attitudes about therapy and treatment seeking. Although many participants reported that race should not matter, they discussed their concern that ultimately it did. Participants were concerned that stereotypes affected therapists' attitudes toward and treatment of African American clients. The early discussion of race by therapists, although recommended in the literature, was not universally viewed as a positive strategy to deal with client concerns. Some participants reported that this strategy would increase their suspicions. Thus, the considerations outlined by La Roche and Maxie (2003) are important in decisions to discuss race. The clinician must strive to understand the racial identity, level of consciousness, meaning of racial differences, experience of discrimination, and level of client distress when deciding when and if race is to be discussed.

Participants indicated that they often looked for subtle cues to determine therapists' cultural attitudes and sensitivity. They reported that items easily overlooked, such as ethnic minority reading material in the waiting room, diversity of the art in therapy and waiting rooms, and ethnic minorities who work for and with the therapist, affected their perceptions. Therapists' reactions to financial, legal, employment, and discrimination issues were monitored. Focus group participants indicated that therapists who seemed overwhelmed or unwilling to address these issues might limit client disclosure and participation in the therapeutic process.

Focus group participants were clear that they used signs of anxiety and discomfort with racial issues as signals of racial attitudes and competence to work with African Americans. It is therefore important for psychologists to address any anxieties or concerns they might have regarding offending or alienating clients, and they must understand and respond appropriately to clients who react negatively to discussions of race in therapy. Cardemil and Battle (2003) addressed possible responses to clients who respond negatively to therapist-initiated discussions of race.

Increased cultural competency may facilitate the type of positive experiences necessary to improve psychologists' image in the African American community. Practical activities reflecting competency with African American clients might include careful attention to the need to orient clients to the therapeutic process. Therapists must be prepared to provide clear statements of therapeutic goals, benefits, and anticipated time frames for treatment when this can be specified, or to offer explanations for their inability to do so. The ability to provide "early motivators"—a sense that improvement will occur and that problems can be resolved—will encourage treatment persistence. Participants also reported a desire for a therapeutic approach that emphasized the development of a relationship consistent with the interpersonal orientation often noted in the African American community (S. Sue, Zane, & Young, 1994). Diagnoses and terms should be explained in direct and understandable language. The significance of the diagnosis and its relationship to treatment planning should also be addressed. African American willingness to seek psychotherapy will increase with positive exposure to psychologists.

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