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African American Men's Perception of Psychotherapy at a Mental Illness & Chemical Dependency (MICD) Program: What Factors do they Consider Therapeutic/Helpful

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African American Men’s Perception of Psychotherapy at A Mental Illness & Chemical Dependency (MICD) Program: What factors Do They Consider Therapeutic/helpful

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MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month period to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master’s thesis nor a dissertation.

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Abstract

There are limited empirical data that study the factors that enhance or prevent African American men from using psychotherapy. The purpose of this study was to explore the perception that African American men have of psychotherapy and factors that they consider helpful. Using a qualitative design, eight African American men volunteer to participate in the study to explore their perception of psychotherapy. These eight African American men came from a day treatment facility in the Twin Cities area and had a positive perception of psychotherapy as a tool to help them manage their drug and alcohol and mental health problems. The participants in this study contributed lack of knowledge, stigma of being labeled crazy, fear of being misunderstood, misdiagnose and medicated, fear of being considered weak, self-pride and defensiveness as some of the factors that discourage African American men from using psychotherapy.
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Introduction

African American men experience the same mental health issues as everyone else, but they are at a higher risk of experiencing mental health issues than the rest of the population due to racism and social and economic disparities they encounter daily (Thorn & Sarata, 1998). Many researchers and therapists wonder why African American men do not use psychotherapy as a means to solve their mental health issues. According to Sanders Thompson, Bazile, and Akbar (2004), African American men do not use psychotherapy as often as Caucasian men do, and if they do, they will attend fewer sessions and terminate services earlier than the Caucasian men. Sanders Thompson and his colleagues (2004) further went on to say that, African American men overuse inpatient services because it reduces the stigma that is associated with seeking mental health services in outpatient settings.

Several factors have been identified as barriers to African American men seeking psychotherapy. Some of these barriers are culture, accessibility, stigma, finance, and lack of knowledge of psychotherapy, race and mistrust of psychotherapists (Thompson et al., 2004). These barriers are briefly discussed later in the literature review. These barriers, as well as the African Americans’ perception of Caucasian psychotherapists in cross-cultural therapeutic settings, could affect the degree to which African Americans seek and remain in psychotherapy (Constantine, 2007; Thompson et al., 2004).

This study was stimulated by the researcher’s curiosity as to why the African American men at the African American Family Services (AAFS) were receiving psychotherapy when the literature indicates that African American men shy away
from using psychotherapy in dealing with their mental health issues. Many of these
men were involved in cross-cultural therapy. Some of them were involved in
therapy (group or individual) with both Caucasian and African American therapists
and therefore would give a good evaluation of their interaction with their therapists.
This further increased the researcher’s interest in knowing if any of these men have
experienced racial microaggressions from their therapists (Constantine, Smith,
Redington, & Owens, 2007).

Racial microaggressions as described by Sue et al., (2008) are brief everyday
behavior, verbal or non-verbal exchanges that send denigrating messages to people of
color because they belong to a particular racial minority group. Racial
microaggressions are unconsciously carried out against minority groups in the form
of subtle snubs or dismissive looks, gestures, and tones (Sue et al., 2008). These
exchanges are so automatic in daily conversations and interactions that they are often
overlooked as being innocent and harmless. Sue et al., (2008) identified three
categories of racial microaggressions, which include microassaults, microinsults and
microinvalidations. These categories are discussed in the literature review. However,
Muran (2007) gave a scenario that best describes microinvalidations in
psychotherapy. He talked about the African American men who like all men, have
been socialized to avoid expressing their feelings of weakness and vulnerability.
When the African American man is in therapy and the therapist fails to acknowledge
the racial issues he faces and equates his situation to all men, and misinterpret the
racial issues he faces, the African American man tend to feel invisible and unknown.
The next concept is cultural competence. Sue (1998), defined cultural competence as:

“the belief that people should not only appreciate and recognize other cultural groups but also be able to effectively work with them. One is culturally competent when one possesses the cultural knowledge and skills of a particular culture to deliver effective interventions to members of that cultural” (p. 440).

According to Sue and his colleagues (2008), to be culturally competent, the therapist needs to understand his/her own worldviews and those of the clients. The therapist must guard against stereotyping behaviors and misapplication of scientific knowledge in his/her interaction with the clients. Cultural competence is also getting cultural information and then applying that knowledge. This cultural awareness allows the therapist to see the entire picture and improve the quality of his/her therapeutic relationship with the client (Sue et al., 2008). To adapt to different cultural beliefs and practices requires a therapist to be flexible and have respect for others viewpoints (Sue, 1998). Cultural competence means to listen to the client and to find out and learn about the client's beliefs of health and illness. To provide culturally appropriate care, the therapists need to know and understand how the client’s culture has influenced their health behaviors (Sue, 1998).

The general purpose of this study was to explore the perception of psychotherapy held by African American men in a mental illness and chemical dependency (MICD) program and to identify those factors in psychotherapy that are beneficial to them. The research questions for this study are: (1) what is the African
American men’s perception of the psychotherapy they are receiving in the MICD program and (2) What factors do these men value as therapeutic or helpful?

However, for the purpose of this research, the researcher used the theory of racial microaggression and the concept of cultural competence to uncover barriers that the African American men face, their perception of the psychotherapy they are receiving at the African American Family Services (AAFS) agency and the factors they considered therapeutic or helpful. The significance of this study is that it will help therapists learn to address barriers identified by the participants and learn skills in building a healthy therapeutic relationship with African American men.

**Literature Review**

The literature review section will briefly discuss the following: Barriers to seeking psychotherapy, racial microaggressions in contemporary society and the impact of race in cross-cultural psychotherapy relationships. Under barriers to seeking psychotherapy, the researcher will discuss cultural barriers, accessibility, stigma, lack of knowledge, therapists and therapeutic issues, and cultural mistrust,

**Barriers to Seeking Psychotherapy**

**Cultural Barriers.** African American men have reported that seeking mental health services indicate a sign of weakness and it diminishes their pride (Sanders Thompson et al., 2004). The cultural beliefs of African Americans are that family problems should be handled by family members within the family and trusted friends, but not by strangers. This strong sense of commitment to the family and extended family poses a barrier about sharing information about mental health to a stranger
(Gary, 2010). It is also against the norm of the African American culture to disclose mental health issues about a family member or friend to someone outside the family. Once an individual is in therapy, chances are that mental health issues about a family member will surface. This cultural belief is especially strong among older African American men (Gary, 2010).

Another cultural barrier that was noted by Sanders Thompson and his colleagues (2004) is the historical expectation that African Americans as a group of people are able to withstand and cope with every hardship in life. It is expected that they will pull themselves up “by their boot straps” in the midst of difficulties in life. This expectation has hindered African American men from reaching out for help with mental health issues. They see psychotherapy as an invasion of an individual’s privacy (Sanders Thompson et al., 2004).

**Accessibility.** Research has indicated that accessing mental health care in the African American community depends on the type of problem and experience the individual is facing and the social support that the person is receiving from his peers, family and friends (Lindsey, Korr, Broitman, Bone, Green, & Leaf, 2006). These social networks provide care or make a referral to get formal help Lindsey et al., (2006). They may also coerce the individual to seek out help. The social networks might monitor the individual’s care and may provide assistance with transportations or appointment reminders. They may even perpetuate the stigma regarding formal service usage by telling others in the community about their mental health care (Lindsey et al., 2006).
According to Lindsey et al., (2006), earlier researchers ignored the social processes related to seeking care and advice by African Americans, however these processes are important in seeking mental health services. The majority of African American adults use informal help sources exclusively or in combination with professional help in response to mental illness. One of these professional help services is psychotherapy.

Psychotherapy is very expensive. The high cost associated with getting psychotherapy is a serious issue affecting the African American population. Many of them lack health insurance and those who do have health insurance, have limited coverage (Thompson et al., 2004). Many African American men are unemployed and therefore cannot afford the hourly cost of psychotherapy. Most African Americans feel that in the face of pressing needs, seeking psychotherapy is a luxury. Many of the mental health services are also outside of their community, and this makes it difficult to get to these centers due to lack of transportation.

Many African American adults also question the quality of care that is given to them in the absence of adequate income or insurance (Lindsey et al., 2006; Thompson et al., 2004). Those who used Medicaid benefits have complained that medication was the only option offered to them and counseling or psychotherapy was not an option offered to them (Thompson et al., 2004).

**Stigma.** The stigma, shame and embarrassment associated with mental illness are also serious barriers that hinder African American men from seeking mental health treatment (Lindsey et al., 2006; Thompson et al., 2004). Once it is discovered that a person has mental illness, peers and members of his community avoid him and
his family. Because of this attitude from community members, African American men would rather hide their mental illness than seek treatment (Gary, 2010). African American adolescent males and adults do not acknowledge the need for mental health services. They are also skeptical of using these services especially when they believe they might be stigmatized by their social networks (peers, families & friends) for using these services (Lindsey et al. 2006).

Lack of Knowledge. Many African American men claim they do not know the symptoms associated with of mental illness (Sanders Thompson et al., 2004). They reported that they did not know when a situation was serious enough to seek professional help so they sought help from their church leaders or went to the emergency room, if their situation got out of control. Going to the emergency room also helps them cover the cost for mental health services.

Lindsey et al., (2006) reported that African Americans have negative perceptions of mental health care. Their negative perception served as a hindrance to them seeking mental health services even when these services were available to them. Their peers and families play an important role in regards to seeking help and responding to mental illness. Their family members encouraged them to seek formal mental health services.

Another factor associated with the lack of knowledge was the fact that African American men do not know what resources to go to for help in their community. They did not know if services in their community would be culturally appropriate services that would satisfy the community, given its diversity (Thompson et al., 2004). These individuals are not aware of specific agencies like United State
Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) and National Alliance on Mental Illness (NAMI) (Sanders Thompson et al., 2004). Older and more religious African Americans turn to the church for prayer as a way of coping with their mental illness (Sanders Thompson et al., 2004).

**Therapists and the Therapeutic Issues.** According to Thompson et al., (2004), it should not matter who an individual therapist is because therapists are there to help people solve their own problems. However, African Americans feel more comfortable with someone who is more similar to them culturally than someone who is culturally different from them. Sanders Thompson et al., (2004) conducted a research study with 201 African Americans in a focus group, in an urban, Midwestern city. They had twenty-four mixed –sex focus groups between the ages of 18 to 74. Their research was a qualitative study that was conducted to get an in-depth understanding of the attitudes, values, and beliefs that affect African Americans mental health attitudes and use of services. Their research was also conducted to get a sense of what efforts are needed to be made by the psychological community to promote an image of multicultural sensitivity and competence therapy.

Similar research done by Snowden, (1999) showed a mixed pattern of usage when socio-demographic differences and diagnoses were not controlled. In another research where the sample was controlled, analyses showed that African Americans in a community sample were consistently less likely to seek mental health services than European-American (Thompson et al., 2004). Sanders Thompson et al., (2004)
found that African American men regarded race and ethnicity as important factors in seeking mental health services.

During the six months qualitative research (Thompson et al., 2004), the focus group participants expressed various views as it related to psychologists and therapeutic issues. Participants viewed psychologists as older white males, who were unsympathetic, uncaring and unavailable. Participants further described psychologists as impersonal, elitist and too far removed from the African American community to be of any help to them.

African Americans who had prior therapeutic experience with white therapists, felt like the therapists were not truly concerned about them and what they were going through but about being paid for the hour they spent in therapy with the client (Sanders Thompson et al., 2004). They talked about the difficulty in finding African American or ethnic minority therapists. Whatley et al., (2003) discovered in their research that African American male college students did not go to seek counseling on their college campus where the counselor was white.

According to Sanders Thompson and his colleagues (2004), African Americans are reluctant to trust professionals who are not actively involved in the African American community in activities towards the wellbeing of the community. Participants in their study conveyed that the education and degrees of the therapists are intimidating and that the therapists’ degrees limited their understanding of the participants’ life experiences.

**Cultural Mistrust.** Trust was the issue that drew the most attention based on Sanders Thompson et al., (2004) research study. The participants (all African
Americans) who never had psychotherapy treatment and little or no knowledge of the profession, reported that even if psychotherapy is beneficial, most therapists do not have adequate knowledge of the African American lifestyle and struggles to accept them or understand them. Thompson et al., further stated that participants believed that psychologists were predisposed to viewing African Americans as “crazy”, thereby labeling their strong expressions of emotion as illness.

Participants in the study who had experience with therapy talked about the therapist’s having adequate knowledge of the illness, appropriate treatment and the ability of the individual client to develop trust in the therapist (Sanders Thompson et al., 2004). Many researchers suggest that cultural mistrust negatively affects the therapeutic relationships between an African American client and the therapist and if he perceives white therapist as helpful (Nickerson, Helms, & Terrell, 1994).

According to Sue et al., (2007), negative race-related experiences or the cumulative effects of racial micro-aggressions could be one of the possible factors affecting cultural mistrust.

**Racial Microaggressions in Contemporary Society**

This next section will discuss the theory of racial microaggressions and the three forms of racial microaggressions. Historically in the United States, African American experienced racism that involved direct aggression towards them as a group in the forms of, for example, segregated schools, segregated place of worship and segregated buses (Smith, Constantine, Graham, &Dize, 2008). This form of racism was characterized by the belief that one group is superior to another. This form of racism is referred to as overt (smith et al., 2008). In the past, racism was
overt and explicit, but in today’s contemporary society, it is more subtle and operates more on a covert and unconscious level (Dovidio, Gaertner, Kawakami, & Hudson, 2002).

Some researchers refer to contemporary racism as aversive racism (Dovidio, 2001), neoracism (Tougas et al., 2004) or subtle racism (Sue et al., 2008). People of the dominant population who engage in covert racism may verbalize beliefs of racial equality but in their unconscious mind, hold negative beliefs that influence their behaviors toward people of the minority group (Dovidio et al., 2002; Smith et al., 2008). They may also engage in subtle acts of racism consciously or unconsciously (Quillian, 2008).

Research done by Dovidio et al., (2002) supported the existence of contemporary racism. Their research indicated that people’s attitudes, both explicit and implicit, could shape behaviors, especially during interracial interactions. For example, some of the participants in their study self-reported positive attitudes toward a particular group of people but implicit and negative prejudices influenced nonverbal behaviors. Dovidio et al., (2002) measured the attitudes toward blacks of 40 white participants. These participants then engaged in 3-minute interracial interactions with confederates who were blind to the hypotheses and level of implicit and explicit prejudices. Confederates and observers all rated the level of friendliness in the interracial interactions. The results showed that explicit attitudes towards blacks predicted observers’ ratings of verbal friendliness in the interracial interactions. The implicit prejudices predicted negative nonverbal behaviors. Dovidio (2002), suggested that when whites people display such incongruent behaviors,
(verbally friendly but nonverbally negative behaviors), blacks become distrustful of whites. This suggests that although people are aware of their prejudices and show verbally friendly behaviors, they tend to be unaware of their implicit biases that are visible in their behaviors that are more difficult to control, such as facial expressions (Quillian, 2008). Earlier researchers such as Inman and Baron (1996) demonstrated that people who have a history of oppression are particularly sensitive to subtle, covert racism, which may be more harmful than overt racism (Salvatore & Shelton, 2007).

**The Impact of Race in Cross-Cultural Psychotherapy Relationships**

Sue et al., (2007), identified what they called color-blind attitudes as a type of racial microaggression that may occur in clinical practice. They referred to color-blindness as the view that the color of a person does not matter, and that race is an invisible and irrelevant factor that does not need to be addressed (Neville, Lilly, Duran, Lee, & Browne, 2000). Sue and his colleagues (2007) further indicated that such color-blind statements invalidate racially related experiences that people have had and imply that race does not influence people’s lives. Therapists who hold this view misinterpret, deny, or even wrongly conceptualize client problems and symptoms, which can lead to ineffective treatment (Neville, et al., 2006). It is important to recognize the invisible quality of racial microaggressions that convey messages of color-blindness, especially as they may serve as barriers in the therapeutic relationship (Constantine, 2007). Racial microaggressions may influence case conceptualization, impact perceptions of symptoms presented by African American clients (Neville et al., 2006; Gushue, 2004), or affect empathy towards
them (Burkard & Knox, 2004). Thus, color-blind racial attitudes may influence various aspects of a therapist’s abilities and skills in therapy with multicultural clients (Sue et al., 2007).

There have been few studies that have examined ethnic minorities’ perceptions of microaggressions as they occur in cross-cultural counseling, and the occurrence of microaggressions conveying color-blind messages. In a study that was both qualitative and quantitative, Constantine (2007) examined the experiences of 40 African Americans in counseling with Caucasian therapists. Constantine evaluated the impact of racial microaggressions on the clients’ perceptions of the working relationship and their overall satisfaction with counseling. Constantine created a scale specifically for this study to measure African Americans’ experiences of racial microaggressions in counseling. Results showed that African Americans who experienced racial microaggressions in the counseling relationship were less satisfied with counseling and reported weaker therapeutic relationships. The African American clients in this study identified color-blind statements as the common type of microaggressions used by the White counselors.

Constantine (2007) demonstrated the importance of the concept of microaggressions to cross-cultural therapy in her study. First, she demonstrated that Caucasian therapists could commit racial microaggressions with African American clients. Second, she showed that racial microaggressions affected satisfaction in counseling and the therapeutic relationship. Third, she found that one type of racial microaggression that occurred in clinical practice was expression of color-blind racial attitudes. Given that African American clients are not always trustful of
Caucasian therapists (Poston, Craine, & Atkinson, 1991; Sue et al., 2007) and that, they utilize mental health services infrequently and terminate early (Constantine, 2007). It is important to recognize those factors that affect the therapeutic process in such cross-cultural dyads.

Addressing the issues of race, color, and ethnicity in the therapeutic context has shown to be an important feature when working with diverse clients (Sue et al., 2007). One reason African American clients avoid disclosure of race-related incidents is that they feel their experiences will be invalidated or minimized. In their qualitative study, Sanders Thompson et al., (2004), found that one theme generated by the groups was a sense of mistrust toward psychologists. Participants discussed fears of being labeled or misdiagnosed because of their race. Another theme that emerged was that of cultural sensitivity. Participants discussed fears that therapists may hold stereotypes or that they simply lacked knowledge of African American culture. Similarly, participants indicated that they may not discuss issues related to race for fear that therapists will not understand their experiences. Sanders Thompson et al., (2004) also found that African American clients believed that Caucasian therapists hold stereotypes of African Americans, limiting the client’s openness and comfort with therapists. This suggests that, in order to promote trust, Caucasian therapists should be comfortable addressing race-related issues with African American clients and be ready to validate their clients’ perceptions and experiences.

Utsey, Gernat, and Hammer (2005) examined Caucasian counselor trainees’ reactions to racial issues presented in cross-cultural counseling relationships. They found that, although the Caucasian trainees were aware of racial issues among them,
they tended to minimize the issue of race, which is a form of racial microaggression. Furthermore, the researchers found differences between African American therapists and Caucasian therapists in their willingness to address race-related issues in therapy; Caucasian therapists were less likely to address race than African American therapists (Utsey et al., 2005).

Similar to the research conducted by Utsey et al. (2005) Knox et al., compared five African American and seven Caucasian therapists’ experiences in addressing race in therapy. The results indicated that African Americans addressed race-related issues more frequently, while Caucasian therapists reported feeling uncomfortable doing so. Thus, it is clear that addressing issues of race, color, or racism may provoke a sense of discomfort among Caucasian therapists.

Despite all of the studies that have been done, there are limited empirical data that address the factors that hinder or promote the therapeutic process with African American men. The purpose of this study is to identify factors that hinder or promote the therapeutic process with this population.

**Conceptual Framework**

Researchers as well as practitioners have been concerned about the role that race and cultural issues play in cross-racial counseling and the therapeutic relationship (Constantine, 2007; Thorn & Sarata, 1998). Researchers have tried to identify factors that hinder or promote the therapeutic process but there is limited empirical data addressing the effectiveness of psychotherapy with African American men (Thorn & Sarata, 1998).
This researcher will use the theory of Racial Microaggressions and the concept of cultural competence in evaluating the African American men’s perception of psychotherapy and the psychotherapists at the African American Family Services (AAFS), and the factors that they consider therapeutic or helpful. Racial microaggressions were first defined by Peirce, Carew, Pierce-Gonzalez & Willis (1978) but Sue and his colleagues (2007) expanded this definition and identified three forms of racial microaggressions.

The first form that was identified is micro-assaults or subtle assaults, which are verbal, nonverbal, or visual communication. This form of subtle assaults is usually directed towards people of color and is often automatic or unconscious and meant to hurt the intended victim. An example of this is name-calling, avoidant behavior, or purposefully carrying out discriminatory actions against the target person or group. Another example is referring to someone as “colored” or “Oriental,” using racial phrases, discouraging interracial interactions, deliberately serving a Caucasian person before someone of color, and displaying symbols that are derogatory to an individual or group.

The second form of racial microaggression is micro-insult. Micro-insult is characterized by communications that show rudeness and insensitivity and degrades a person’s racial heritage or identity (Sue et al., 2007). This type of behavior is frequently unknown to the perpetrator but sends a hidden insulting message to the person of color who is at the receiving end (Sue et al., 2007, Constantine, 2007). An example of this is to ignore or behave coldly towards someone, dismiss, or turn down a person (Sue et al., 2007).
The third form of microaggression is micro-invalidations. “Micro-invalidations are characterized by communications that exclude, negate, or nullify the psychological thoughts, feelings, experiential reality of a person of color” (Sue et al., 2007, p. 274). An example that Sue et al., (2007), gave is telling an African American person you do not see color or that we are all humans. This is like denying the African American experiences as racial or cultural beings.

Having an understanding of the various forms of contemporary racism is a key aspect in becoming a culturally competent therapist (Smith et al., 2008). The African American male may harbor a sense of cultural mistrust toward Caucasian therapists, which might make him less likely to seek and continue therapy or even hesitate to disclose information about himself for fear of being misdiagnosed (Sanders Thompson et al., 2004; Constantine, 2007). In a broad sense, counseling and psychotherapy is the formation of a very personal relationship between a helping professional and a client that involves appropriate and accurate interpersonal interactions and communications (Sue et al., 2007). For effective therapy to take place, the therapist and the client must team up to form a positive coalition between them (Sue, et al., 2008; Sue & Sue, 2003). This positive coalition has been referred to as the “working relationship,” the “therapeutic alliance,” or the “establishment of rapport” (Sue & Sue, 2003).

The therapeutic relationship is strengthened when the clients perceive the therapists as credible and trustworthy and they themselves feel understood (Sue, et al., 2008). Therapists, counselors and all those in the helping professions are trained to listen, to show empathy, to be objective, to value the client’s integrity, to
communicate understanding, and to use their professional knowledge and skills in helping clients to solve their problems. When the therapeutic team is formed, it creates a sort of bond between the therapist and the client in a way that better prepared both of them to tackle problematic areas that the client might not face alone (Sue & Capodilupo, 2008).

Research suggests that the therapeutic alliance or working relation is one of the major factors of any helping relationship and it leads to successful outcome and client’s self-disclosure (Sue & Capodilupo, 2008). However, research findings indicate that when clients perceives the therapeutic alliance as accepting and positive, it become a better predictor of successful outcome than is a similar perception by the counselor. On the other hand, if the clients do not perceive their therapists as trustworthy and they feel misunderstood and undervalued, the therapeutic success is less likely to occur and may lead to premature termination, or failure to return for schedule visits (Sue, et al., 2007).

In a cross-cultural therapeutic setting, where the clients’ race, ethnicity, culture and sexual orientation differ from that of the therapists, it becomes very challenging to establish such trusting therapeutic relationships (Sue & Capodilupo, 2008). Caucasian therapists who are conditioned to their culture may be prone to engage in racial microaggressions towards their clients of color (Sue, et al., 2007). Once the client of color perceives the Caucasian therapist as biased, prejudiced or unlikely to understand them as racial/cultural beings, the therapeutic alliance is weaken, and the client may terminate therapy.
Cultural competency, is the next concept this researcher is going to use to evaluate the African American men’s perception of the psychotherapy they are receiving at the AAFS and the factors that they consider helpful or therapeutic. Cultural competence as defined by the US Department of Health and Human Services, Office of Minority Health, is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups (Sue, 1998). The Caucasian psychotherapists’ self-awareness of their own culture, their knowledge of minority cultural and their cross-cultural skills pertaining to work with non-dominant client populations are some of the factors that influence the provision of culturally competent services by White psychotherapists (Sue, 1998).

Methods

Research Design

This qualitative study was purposive and incorporated semi-structured interview design using a non-probability sample. This design facilitates access to a deeper understanding of the research participants’ subjective experience – a better understanding of why the participant makes the decisions he makes as well as how he implements those decisions (Monette, Sullivan, & DeJong, 2008). As this researcher explored the African American men’s perception of psychotherapy in a cross-cultural setting, using the theory of Racial Microaggression and cultural competence, the
research design reflected the researcher’s interest in both the African American men’s perception of the psychotherapy they are receiving from the African American Family Services Agency and the factors that they consider therapeutic or helpful. The semi-structured interview consisted of seven interview questions (Appendix B) that were asked during an in-person, audiotaped interview.

The research population consisted of the participants in the men’s trauma group at the African American Family Services Agency, who were identified as having co-occurrence or dual diagnoses: Mental Illness and Chemical Dependence (MICD). Data collected was in the form of transcribed interviews, which underwent content analysis using open coding, which enabled the researcher to better identify factors that the participants attach value to as therapeutic.

**Sampling**

The clinical sample for this study consisted of eight African American men who were in the dual diagnoses program, the Mental Illness & Chemical Dependency (MICD) program at the African American Family Services agency (AAFS). The men in this program were selected initially based on the Global Assessment of Individual Needs-Short Screener (GAIN-SS) which is a 25-items scale used by the African American Family Services as a screening tool for the possible mental health, chemical health and crime or violence concerns.

Most of these men were court ordered into treatment for Chemical Dependency at the African American Family Service agency, which is a day treatment facility, to get treatment for their Alcohol and drug abuse issues. While going through their treatment for chemical dependency, they were told of other options that were
available to them — trauma group and individual psychotherapy. The men who were interested in the trauma group and psychotherapy, voluntarily took the GAINS-SS. The result was explained to them and they decided if they wanted individual therapy and/or group therapy. Those who were diagnosed with Trauma and wanted to be in the MICD program, then took the Trauma Symptom Inventory (TSI), a 100-item scale that measured the severity of their trauma.

**Protection of Human Subjects**

A consent form was prepared based on the University of St. Thomas Institutional Review Board (IRB) template. The principal investigator (PI) got a written permission from the agency to have the participants in this program take part in the research. The PI was given permission to meet with the participants at one of their group meetings and explained the purpose and the procedure of the research to them. All the participants got an informed consent form outlining the study, potential risks and benefits, and statement of confidentiality that the researcher reviewed with them before beginning each interview.

The consent form informed all participants that one of the psychotherapists at the AAFS is on the researcher’s committee; however, no information to identify participants would be made available to the committee members. The consent form indicated to participants that their involvement in the interview was completely voluntary and that they may choose not to participate without any repercussions from the agency, the researcher, the committee members or St. Catherine University/University of St. Thomas. If during the interview a participant wanted to leave, he may do so without any repercussions and data collected would remain
confidential. Participants were informed that they could withdraw any information they wish to withdraw during the research project but said information could not be withdrawn after final printing and submission of the project to the St. Catherine University/University of St. Thomas.

The consent form indicated that if the interview brought up any emotional issues for the participants, there would be a therapist/counselor on site that they could talk with. To further protect the identity of the participants, the interview consisted of limited demographic questions. The interview questions were approved by the University of St. Thomas Institutional Review Board before proceeding with the research.

All the data that was collected, including audiotaped interview and interview transcripts were kept confidential. No information that would identify participants was included in the research findings. All research records were stored in a locked filing cabinet in the researcher’s home and will be erased or destroyed by June 15th, 2012. The principal investigator (PI) transcribed the interview, in keeping with best practice. All the participants were given contact information for the researcher’s advisor and the University of St. Thomas’s Institutional Review Board, should they have any questions or concerns.

**Data Collection Instrument and Process**

The data for this research was collected in the form of answers from a series of semi-structured interview questions. The interview questions were in five categories: Limited demography, participant’s knowledge of psychotherapy, participants’ perception of psychotherapist, factors participants’ value as therapeutic or helpful
and factors that discourage African American men from seeking and using mental health services. The questions were open-ended questions. The PI asked additional probing questions to facilitate the collection of more in-depth responses from the participants. Each interview was audiotaped and lasted for about 20 minutes.

**Data Analysis**

The PI conducted a content analysis of the data, taking into consideration the key themes that emerged from the data in accordance with Berg (2009). Content analysis according to Berg, (2009), is a systematic way of examining and interpreting data in an effort to identify themes. In order to identify the codes in the data, open coding was used, which involved examining the data line by line for similarities and differences.

**Findings**

This section of the research presents the results of this qualitative study on the African American Men’s Perception of Psychotherapy. Data were collected and analyzed through semi-structured interviews. It will begin with a summary of the participants’ data and conclude with a description of the themes and subthemes that emerged from the analysis.

The first three questions are about participants’ ages, level of education and length of therapy. The last four questions have to do with participants’ knowledge of psychotherapy, participants’ perception of psychotherapists, factors participants value as therapeutic or helpful and factors participants believe discourage African American men from seeking and using psychotherapy.
Description of Participants

The principal investigator conducted interviews with eight African American Men who were at the time in group and individual therapy. These men ranged in ages from 26 years old to 65 years old. Three of them had their GED, three of them had some high school, one had some college education and one was a college graduate. Their length of time in therapy at the time of the interview ranged from one week to six months. All of the participants were receiving group and individual therapy at the same agency.

Participants’ Knowledge of Psychotherapy

In order to answer the above question, participants were asked to state in their own words, what they thought was the purpose of therapy, when they thought someone should seek therapy, what types of problems they thought therapy should address, who they thought therapy would help, what therapy meant to them and why was therapy important to them.

The themes that emerged from the first question concerning the purpose of therapy were, a way to seek help and solve problems, a way to solve drug and mental illness problems without using medication. The following respondent quotes communicate these themes. One respondent stated:

“The purpose of therapy is to help people see if you are on drug or the type of mental problem you are having and to see to get to the grass root of the problem instead of treating things with medication, they want to try to get to the bottom of why someone acting a certain way and to see if they can help you figure that out”.

Another respondents stated:

“Help you stop drinking and smoking and take a better path to getting off the street and get better with your life. So I figure it will be, better like knowing about the tricker, like what tricker your mood to smoke and drink and learn how to not go with the tricker, and figure out other ways to go pass that and do better with your life”.

When they were asked as to when a person should use therapy, participants said when someone feels suicidal, when someone has depression and when someone is going through emotional stages. The following respondent quotes communicate these themes.

One of the participants stated: “When they are in depression and have no one else to turn to. When going through emotional stages, people at home don’t have answer so you turn to a therapist maybe they can help you”.

Another respondent stated:

“I think someone should seek therapy when their life become really unmanageable and they can’t function right. When they know they have a problem and they know they need help and they can’t find nobody else to help them. I think someone should seek therapy when they feel like harming themselves, something like that. If someone hurt them they should go talk to someone”.

They all agreed that psychotherapy should address any problem that a person has to deal with. The following respondent quotes communicate this.

One respondent stated:

“Marital problem, chemical dependency problem, problems in general”.
Another participant stated:

“Life. You come to get therapy because you think that something is wrong in your life to where you just don’t understand it. Going to see a therapist you know might just open your eyes to a broader situation. That’s what make therapy work for you if you take hee to it and not be walking around that same corner again”.

Participants were asked as to who they thought therapy would help. All of the eight participants agreed that psychotherapy will help anyone and that it was not just a “white man’s thing. ” However, they also all felt that psychotherapy will only help if an individual allows it to help. One of the participants put it this way:

“Therapy helps everyone if you allow it to. Therapy is not a giving, it’s an opportunity for you to look at yourself and see that things are right instead of walking around with blindness on. ”

Another respondent commented:

“People who are in the street looking for drug and stuff, they are the one who need to be here too just as well as we, so I say they need to be here too because they are already on the wrong path already. They are destroying their life so I say other people that really need that think that they don’t got problem but they really do. Therapy could be for anybody. It depends on how your life’s going. Some people think wrong. They probably thinking about hurting others or doing something bad so they probably need a therapist to clear their mind of the crazy things they are thinking about”.

Participants’ perception of psychotherapists
Participants were asked two questions in looking at their perception of psychotherapists. The first question addressed how they would like for their therapist to interact with them and the second question addressed their choice of a therapist in terms of race and gender. To the first question, participants said, their therapist should be real, straight forward, honest, a listener, confident and in control. One of the participants stated:

“Be a silent board. Listening and pretty much to see if they can point me in the right direction. For instance if I don’t have a job maybe I can explain my problem and the therapist can send me to the resource center. I figure you are there to benefit from something so I figure therapist is there to help you with something, so vent your problem”.

Another participant commented:

“I want my therapist to help me or anybody else who need it. I want my therapist to be in control so that way I can feel comfortable so I think he should show me more confident”.

Participants were asked what type of therapist would they choose in terms of race and gender. Four of the participants (50%) said race did not matter. Four of the participants (50%) said race mattered. Six of them said that the sex of the therapist did not matter. Two of the participants would prefer female.

All of the participants were asked a follow-up question as to whether they ever felt “putdown” or disrespected by their therapist in anyway. All of the eight participants said that they have not felt “put down” or disrespected by their psychotherapist in any way.

Factors participants value as therapeutic or helpful
Participants were asked what motivated them to seek mental health services and in what areas of their lives was therapy treatment helpful. To the first question, the common team was, court order. Most of the participants said they were court ordered into counseling. Some of the participants said they needed someone to confide in and get their life back in order.

When the participants were asked in what areas of their lives was therapy helpful, participants said that therapy helped them improve their relationship with their family, with personal development and with their drug problem. One of the participants stated: “Right now it has help me get on my feet and so far, everything I have wanted to do I am finally getting the chance to do it cause I seek help. If I didn’t, like I said I would probably be in more trouble, more trouble. My kids need me, and my family need me so that’s why I seek help, therapy. It has help me with my relationship with my kids and wife”.

Factors to discourage seeking and using of psychotherapy

The participants indicated that African American men do not seek therapy because of the fear of being misdiagnosed and medicated, the fear of being labeled crazy or weak, the lack of knowledge of therapy and self-pride. The following respondents quotes communicate these common themes:

“You don’t want be label as crazy. When people know that you are seeing a therapist, they label you as crazy so that’s a stigma try to avoid it. Some think when you are going to see a therapist, you must be loosing you mind he must be going crazy so that’s why lot of black men try to avoid therapy”.

Another participant stated:
“African American men don’t want to come to therapy because they think they will always be trying to get the medicine that will make them jump off the bridge or something, that’s why they do that”.

Another commented:

“A lot of men can’t adapt to somebody else telling them something they need to know because they have to be strong independent person. You are not strong and independent if someone tell you something you feel you might be weak putting your way in different ways. …. Coming to therapy is a sign of you not taking control of your life. You have lost your boundary you are not able to comprehend at a high level especially interacting with others. If you don’t have the knowledge and understanding to compensate and be able to demonstrate different things going on in your life and not being able to handle or resolve things in a manly fashion, that could be a sign itself that you are not able to adjust to the world and you are consider weak”.

Discussion

This section of the paper is going to discuss the results of the research, its implications for clinical practice and suggestions for future research. The original purpose of this study was to explore the African American men’s perception of psychotherapy and if psychotherapy was helpful to them. There were similarities and differences in the data, however, the results of this study clearly indicated that all of the participants had a positive perception of psychotherapy and that therapy helped them to improve their relationship with their family and with others. Many of the participants in this study were involved in cross-cultural therapy. The findings of this study are contrary to those of Sanders Thompson et al., (2004) that discussed the
negative perceptions that African American men have toward psychotherapy, towards psychotherapists in a cross-cultural setting, and the doubts about whether psychotherapy even works for African American men (Constantine, 2007). The participants of this study, however, agreed that psychotherapy is for anyone who is willing to use the information they get from therapy and apply it to their lives and is not something just for the White man.

The themes that emerged from this research can be summed up into four main categories and are the subjective interpretations of the primary investigator of this study for the purpose of the discussion section. These four categories are: to solve problems; keeping it real; personal growth/development and modeling therapists.

To Solve Problem

The participants in this research overwhelmingly, indicated that psychotherapy helped them solve their problems. These participants embraced psychotherapy as a tool to help them solve their problems despite the stigma and shame associated with mental health (Sanders Thompson et al.,) held within the African American community. They looked at psychotherapy as an empowering tool to help them deal with their anger, mental health, drug and alcohol problems and relationship issues.

Keeping it Real

The participants reported that their therapists should be themselves and be authentic in their manner. They do not want their therapist to be fake in their dealings with them. This is what Sue et al., (2008), made reference to in their research with White confederates who were verbally friendly towards people of color but their non-verbal communication sent messages of racial microaggressions. It is important for the
therapist to be genuine in dealing with the African American men to reduce the cultural mistrust (Sanders Thompson et al., 2004).

**Personal Growth/Development**

The participants reported that African American men are considered weak if they go to therapy, as indicated in previous research (Sanders Thompson et al., 2004). Contrary to this, the participants in this research reported being empowered by their therapist to use the skills and knowledge from therapy for their personal growth and development. This is an important finding because it indicates that the perception that psychotherapy weakens the African American man is not uniform, but rather it equips them with the tools needed to solve their problems and take control of their lives.

**Modeling the Therapist**

Modeling the behavior of their therapists is another sign of strength for the African American men in this research. For example, when their therapist listened to them vent their problems, they learn how to listen attentively and can practice this in their home setting. This is an important finding that is contrary to the doubts that some therapists have, wondering if psychotherapy even works for the African American men (Constantine, 2007).

Earlier researchers, (Sue, et al.; Constantine), indicated in their studies that in order for psychotherapy to work effectively within the African American population, the mental health facility should be in the African American community, should be easily accessible, and that the therapist should be culturally competent. The agency, AAFS, is located within the African American Community and is easily accessible. The therapists at this agency live within the inner city and are culturally competent. It is
no wonder that the African American men that participated in this research had a positive perception of psychotherapy.

**Implications for Clinical Practice and Policy**

This study suggests that under the right conditions, African American men want assistance solving problems through psychotherapy and reported that they have benefited from it. One of the conditions is that therapist must learn to address racial issues in therapy and how these internalized racial issues affect the African American males in coping and succeeding in life (Muran 2007). Other conditions reported by the participants in this research are that the therapist be straightforward, honest, “keep it real”, learn about African American culture through experiences, and learn the cultural specifics of how African Americans tend to use language (for example, use everyday language and not use therapeutic terms). The language that a therapist uses to get the attention of the client is very important because, according to Sanders Thompson et al., (2004), the participants in his research reported that the therapist high academic level is intimidating.

Some of those factors that have been discussed that discourage African American men from seeking psychotherapy could be resolved by therapists involvement in increasing the knowledge of psychotherapy among the African American male population to reduce the stigma of mental illness. Therapist could embark upon a program to increase the awareness of psychotherapy and its benefit in dealing with daily stressors, relationship problems, and drug and alcohol problems.

Social workers should advocate for all therapists to learn the skills necessary to develop culturally specific methods of working with African American men in order to
reduce their fear of being misunderstood by therapist (Sue et al., 2008). Therapists should be trained to discuss racial issues in therapy in order to reduce the African Americans’ fear of being misdiagnosed (Sue et al., 2008; Constantine, 2007). This can be done by having all graduate schools in psychology schools develop curriculum in working with minority groups, conduct workshops, seminars and conferences to prepare social workers to be culturally competent.

**Limitation and Future Research**

Although the study has contributed to some insight into African American men’s perception of psychotherapy and the factors they consider helpful, it has several limitations. The sample size was narrowed to one agency and included only those who were presently receiving therapy. Participants from other agencies may have provided adequate power to compare outcome. In addition, two major problems inherent with this research are the possibility of desirable responses being influence by most of the participants being on probation and the presence of one of the therapists at the agency being on the PI’s committee. Although the PI assured the participants of the confidentiality of their responses, this may have had some impact on their responses. For example, all of the participants had a positive outlook on psychotherapy. For the efficacy of psychotherapy, future research sample size should be increased and include pre-therapy, present therapy, drop out and post-therapy participants. It should also include permission to interviews significant others.

**Conclusion**

The outcomes of this study indicate that African American men would benefit from psychotherapy if they have adequate information as to what psychotherapy is
and how they could benefit from it. All the participants in this study indicated that psychotherapy has a positive impact on their lives. They indicated that it has helped them manage their drug and alcohol problems and given them control over their anger problems, contrary to literature reviewed that indicated psychotherapy may not even work for African American men. All of the African American men in this study expressed their satisfaction with the therapy they were receiving.
References


Appendix A. Participant Inform Consent

CONSENT FORM

Please read this form and ask any questions you may have before agreeing to participate in the study.
Please keep a copy of this form for your records.

<table>
<thead>
<tr>
<th>Project Name</th>
<th>African American Men's Perception of Psychotherapy at a Mental Illness &amp; Chemical Dependency (MICD) Program: What factors do they Consider Therapeutic</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRB Tracking Number</td>
<td>290756-1</td>
</tr>
</tbody>
</table>

General Information Statement about the study:
This study is to give participants, African American Men the opportunity to express in their own words their perception of the psychotherapy they are receiving at the African American Family Services. Data for the study will be collected through interview and will be audio taped.

You are invited to participate in this research.
You were selected as a possible participant for this study because:
You are an African American male in the MICD program at the African American Family Services. You are also involved in psychotherapy.

Study is being conducted by: Tou Jean Killen
Research Advisor (if applicable): Dr. Choi Jeong-kyun
Department Affiliation: Social Work

Background Information
The purpose of the study is:
The purpose of this study is to explore your perception of the psychotherapy you are receiving at the African American Famimy Services. It is also to find out from you, the participants, the factors that you consider therapeutic.

Procedures
If you agree to be in the study, you will be asked to do the following:
State specifically what the subjects will be doing, including if they will be performing any tasks. Include any information about assignment to study groups, length of time for participation, frequency of procedures, audio taping, etc.

If you agree to be in the study, you will: 1. sign this consent form and mail it to the researcher within a week. 2. Read the interview questions that will come with this consent form. There will be about 7 semi-structured interview questions. The questions may be open-ended. Additional probing questions may be asked to facilitate a more in-depth response from you. If during the interview you want to leave, you may do so without any repercussions and data collected will remain confidential. You may withdraw any data collected from you on or before April 1, 2012. After April 1, 2012, data collected would have been analyzed and it may not be possible to withdraw you data at that time. 3. Schedule a date and
time for the one-on-one interview with the researcher. The interview will be audio taped. 4. Prepare to stay 45 minutes to an hour for the interview. 5. You will receive a ten dollars gift card and two bus tokens before the interview starts. You will keep the gift card and bus token even if you decided to withdraw from the interview.

**Risks and Benefits of being in the study**

The risks involved for participating in the study are:

One of the psychotherapists who works at the agency is on my research committee and may be some of the participants' therapist. However, no information to identify you will be made available to any of my committee members. Participants will be assured that during the one-on-one interview with them, a therapist will be present in the facilitator, that they could talk to if the interview brings out painful memories that might create trauma for them.

The direct benefits you will receive from participating in the study are:

You will be given the opportunity to express your view of what you think about psychotherapy. Each participant will receive a $10.00 gift card and two tokens as an appreciation for participating in the research.

**Compensation**

Details of compensation (if and when disbursement will occur and conditions of compensation) include:

*Note:* In the event that this research activity results in an injury, treatment will be available, including first aid, emergency treatment and follow-up care as needed. Payment for any such treatment must be provided by you or your third party payer if any (such as health insurance, Medicare, etc.). There is no compensation for being in the research.

**Confidentiality**

The records of this study will be kept confidential. In any sort of report published, information will not be provided that will make it possible to identify you in any way. The types of records, who will have access to records and when they will be destroyed as a result of this study include:

All consent forms, audio-tapes and transcripts will be destroyed by June 15, 2012. Only the researcher will have access to records and data collected.

**Voluntary Nature of the Study**

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with any cooperating agencies or institutions or the University of St. Thomas. If you decide to participate, you are free to withdraw at any time up to and until the date/time specified in the study. You are also free to skip any questions that may be asked unless there is an exception(s) to this rule listed below with its rationale for the exception(s).

No exceptions

**Should you decide to withdraw, data collected about you will be used in the study**

**Contacts and Questions**

You may contact any of the resources listed below with questions or concerns about the study.
Institutional Review Board
University of St. Thomas

Reviser name: Tou Jean Killien
Reviser email: kill0327@stthomas.edu
Reviser phone: 612-636-3531
Research Advisor name: Dr. Jeong-kyun Choi
Research Advisor email: choi0691@stthomas.edu
Research Advisor phone: 507-205-2077
UST IRB Office: 651.962.5341

Statement of Consent
I have read the above information. My questions have been answered to my satisfaction and I am at least 18 years old. I consent to participate in the study. By checking the electronic signature box, I am stating that I understand what is being asked of me and I give my full consent to participate in the study.

Signature of Study Participant
☐ Electronic signature
Date

Print Name of Study Participant

Signature of Parent or Guardian (if applicable)
☐ Electronic Signature
Date

Print Name of Parent or Guardian (if applicable)

Signature of Researcher
☐ Electronic signature*
Date

Print Name of Researcher: Tou Jean Killien

*Electronic signatures certify that:
The signatory agrees that he or she is aware of the policies on research involving participants of the University of St. Thomas and will safeguard the rights, dignity and privacy of all participants.
• The information provided in this form is true and accurate.
• The principal investigator will seek and obtain prior approval from the UST IRB office for any substantive modification in the proposal, including but not limited to changes in cooperating investigators' agencies as well as changes in procedures.
• Unanticipated or otherwise significant adverse events in the course of this study which may affect the risks and benefits to participation will be reported in writing to the UST IRB office and to the subjects.
• The research will not be initiated and subjects cannot be recruited until final approval is granted.
Appendix B. Interview Questions

The research questions for this study are: (1) What is the African American Men's perception of the psychotherapy they are receiving in the MICD program? (2) What factors do these men value as therapeutic or helpful?. This qualitative study will incorporate semi-structured interview design.

Interview Questions:

1. How old are you?

2. What is your educational level?
   (1) Some high school
   (2) High school graduate or GED
   (3) Some college
   (4) College graduate

3. How long have you been in therapy?

4. Participants’ knowledge of psychotherapy
   (1) In your own words, what do you think is the purpose of therapy?
   (2) When do you think someone should seek therapy?
   (3) What types of problems do you think therapy should address?
   (4) Who do you think therapy will help?
   (5) What does therapy mean to you? Why is it important to you?
5. Participants’ perception of psychotherapist

(1) How would you like for your therapist to interact with you?

(2) If you had to choose your own therapist, what type of therapist would you choose in terms of race and gender?

6. Factors participants value as therapeutic or helpful

(1) What motivated you to seek mental health services?

(2) In what areas of your life is therapy treatment helpful?

7. Factors to discourage seeking and using of psychotherapy

(1) What makes it difficult for African American men to seek mental health services?