A QUALITATIVE STUDY: AFRICAN AMERICANS' PERCEPTIONS OF FAMILY THERAPY AND TREATMENT

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BY

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DEDICATION

To God be the glory, it is by his grace and mercy that I have completed this task. This accomplishment is dedicated to my mother, Queen E. Billingsley, whom has provided me with the foundation that has enabled me to realize my potential and shaped the person that I have become.

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Sankofa - "*We must return and reclaim our past to move toward the future. It is in understanding who we were that will free us to embrace who we are now*" (DeGruy, 2017).

ABSTRACT

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The purpose of this qualitative study was to examine and explore African Americans' perception of family therapy and treatment as it pertains to key barriers of service utilization. Specifically, the study examined the role that culture plays on the lack of service utilization as well as how cultural factors shape the attitudes and beliefs of African Americans regarding mental health, family therapy, and treatment. In addition, this study was designed to link historical and present-day ecological systems that continue to impact the African American community.

Focus groups were utilized to explore the research question that guided this study: How do African Americans perceive family therapy and treatment? 18 African Americans, 25 years of age and older discussed their perceptions, attitudes, and beliefs regarding family therapy and treatment. Focus groups were audio recorded and transcribed for analysis. Emerging themes were cultural understanding, cultural barriers, cause of mental strain, coping mechanisms, cultural support, and cultural communication. Findings support previous research that highlight the uniqueness of African Americans and the important role that culture plays on treatment-seeking behaviors. Suggestions for overcoming barriers and future research are discussed.

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CHAPTER I

INTRODUCTION

African Americans are currently the second largest minority group and third largest racial group in the United States, totaling 45.7 million of the population (U.S. Census Bureau, 2014). The number of African Americans both alone or in combination with other racial and ethnic groups has increased by 1.3%, according to the 2014 U.S. Census Bureau and with these upward trends, it has been projected to increase to 74.5 million by 2060 (U.S. Census Bureau, 2014). As the population increases so does the need for more comprehensive research in the field of family therapy that will focus on more effective ways to overcome barriers to treatment and increase service use in African American communities. Diverse disciplines, like, medicine, marriage and family therapy, and public policy have contributed new information regarding this topic. Researchers agree that a combination of factors account for reason ethnic minority groups continue to be underserved by the current mental health system (Chow, Jaffee, & Snowden, 2003; Davey & Watson, 2008). Although these diverse disciplines have explored this topic there is still no relevant model that has addressed variables that would influence mental health service utilization for minority groups such as African Americans (Davey & Watson, 2008).

Recent research in the field of family therapy addresses the growing imperative regarding historically underserved populations in the United States (Davey & Watson,

2008). A prime example of a minority group that continues to be underserved by the current mental health system is African Americans (Davey & Watson, 2008). Research reveals that the field of family therapy has been deficient in addressing African American barriers to treatment (Bean, Perry, & Bedell, 2002; Davey & Watson, 2008; Hall & Sandberg, 2012).

Family therapy is a collection of therapeutic approaches that share a belief in family-level assessment and intervention. The family is viewed as a system, and within the system each part is related (Center for Substance Abuse Treatment [CSAT], 2014). Family therapy is a type of psychological counseling that helps family members improve communication and resolve conflicts (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013). It is designed to identify family patterns that contribute to behavioral disorders or mental illness and helps family members break those habits (Brazier, 2016). This psychotherapeutic approach focuses on altering interactions between the couple, nuclear or extended family and other interpersonal systems, with the goal of alleviating problems presented by individuals, family members, subsystems, and the family as a whole (Doherty & McDaniel, 2010; Center for Mental Health Services, 2004).

A key element of this type of therapy is the family systems theory. Family systems theory is a model that arose from the fields of biology, physics, chemistry, and cybernetics. The focus group documented by Doherty and McDaniel (2010) is that

individual problems must be understood within the larger family and environmental context. This often provides the key to successful treatment. Family therapy includes a systems-oriented approach that considers the biological, environmental, and cultural influences of a client (Doherty & McDaniel, 2010).

A central focus of family therapy is on changing relationships and interactions to address family dysfunction (Doherty & McDaniel, 2010). Family therapists focus on healing family relationships as a primary pathway to recovery and applying a systems approach by forging collaborative relationships between families and community organizations (Doherty & McDaniel, 2010). The family has an essential role in the treatment of any health problem and family therapy has become a strong and continuing treatment approach.

Other goals of family therapy focus on the establishment of healthy boundaries to improve functioning, change negative patterns of interaction and build positive relationships with family members. Doherty and McDaniel (2010) describe family therapy as a way of thinking in systemically, using relational terms that add a set of strategies for intervening with individuals, couples, families and other systems.

African Americans have been identified as far less likely than Caucasians to seek mental health treatment (Joo, Morales, de Vries, & Gallo, 2010; Suite, La Bril, Primm, & Harrison-Rosa, 2007; U.S. Department of Health and Human Services, 2001). Since 2000, two major reports have indicated that this is due to historical adversity, which

includes slavery, disenfranchisement, and race-based exclusion from health, education, social and economic resources (USDHHS, 2001). The historical impact of slavery and discrimination continues to influence African Americans' perception in many areas. One area of great importance is the healthcare field. Many African Americans reflect on incidences such as the Tuskegee Experiment and have developed a mistrustful attitude toward many government-operated institutions (USDHHS, 1999). For many African Americans, negative historical events have created a level of cultural mistrust that shapes the current climate of family therapy care and service utilization (USDHHS, 2001; Williamson, 2014).

The Surgeon General's Report on Mental Health: Culture, Race, and Ethnicity, points to low socioeconomic status as having the most measurable effects on rates of mental illness (USDHHS, 2001). African Americans have unique experiences that have contributed to a reluctance seek treatment, including mistrust, misdiagnosis, lack of knowledge, lack of insurance, and stigma (Williamson, 2014). Until recently, little research has examined how African American beliefs and attitudes influence treatment-seeking behaviors (Ward, Clark, & Heidrich, 2009).

African Americans have a long history of being underserved by the therapeutic community. In turn, it is important to understand African Americans' perceptions in order to address disparities properly (Hall & Sandberg, 2012; McGee, 2014). Many African Americans underestimate the impact of mental health and family therapy on

their lives due to the resiliency and strength that has enabled many to overcome the adversity of slavery and discrimination while maintaining good mental health (Holliday, 2009; Mental Health America, 2016). According to the U.S. Department of Health and Human Services (2010), African Americans are 20% more likely to report serious psychological distress than Caucasians. According to the U.S. Department of Health and Human Services, Office of Minority Health (2016), African Americans of all ages are more likely to be victims of serious violent crimes, making them more likely, to meet and exhibit the diagnostic criteria for depression, anxiety, and post-traumatic stress disorder.

It is important that practitioners effectively address cultural beliefs of African Americans and discuss better practices that will assist African American participants with overcoming barriers to therapy (Carten, Siskind, & Greene, 2016; Hall & Sandberg, 2012). Family therapist and other practitioners who gain a better understanding of how the complex role of culture has impacted African American perceptions may be able to offer more culturally competent services and treatment to this underserved population.

Statement of the Problem

Research indicates that African Americans are vulnerable to many mental health disparities and face unique challenges pertaining to therapeutic care (Holden et al., 2014; Jackson et al., 2004; Safron et al., 2009). Yet, little information has been disseminated to

help increase utilization of family therapy services in the African American community. Limited information is available regarding current perceptions of family therapy and treatment as it pertains to key barriers to family therapy and treatment-seeking behavior for African Americans. Research has failed to link historical exclusion and segregation as contributing factors that may impact African Americans' understanding and interpretation of family therapy and treatment seeking behaviors in their communities (USDHHS, 2001; Williamson, 2014).

Although the supplement to the Surgeon General's report gained recognition and highlighted the role of cultural factors that perpetuate family therapy incongruity, there are still wide disparities in mental health services for African Americans and other ethnic minorities (Holden et al., 2014; USDHHS, 2001). The Center for Disease Control and Prevention (2013) revealed inadequate progress has been made toward eliminating health disparities among African Americans and other portions of the U.S. populations defined by race/ethnicity, sex, sexual orientation, education, and income.

African American culture has been influenced, by racism, discrimination, stigma, and distrust. These factors impact family therapy care and treatment seeking behaviors (MHA, 2016; USDHHS, 2001; Ward et al., 2009; Williamson, 2014). For many African Americans as well as the general population, culture and society cultivate meaning on family therapy, mental illness, and treatment seeking behavior (USDHHS, 2001). There is a need for further research that will address the impact of culture on the practice of

family therapy services as well as strategies to implement a best practices approach of engaging African Americans through discussion, education, and community resources (USDHHS, 2001).

Statement of the Purpose

The purpose of this qualitative study is to examine and explore African Americans' perception of family therapy and treatment as it pertains to barriers of service utilization. In addition, the proposed study is designed to better understand the social conditions that impede effective and culturally sensitive ways to address the therapeutic needs of the African American community and to enhance the best practices of family therapy services.

Research Question

To fulfill the purpose of this study, the overarching research question that will guide this investigation will be: How do African Americans perceive family therapy and treatment?

Definitions of Terms

To ensure mutual understanding of the terminology used in this study, the following definitions clarify concepts and misinterpretations of terms used in this study:

- African Americans: An intimate association of persons of African descent who are related to one another by a variety of means, including blood, marriage, formal

adoptions, informal adoption, or by appropriation; sustained by a history of common residence in America and deeply embedded in a network of social structures both internal to and external to itself (Billingsley, 1992).

- Barriers: Obstacles that exist as it pertains to service utilization, retention, and treatment outcomes in mental health care for ethnic minority families (Metrosa, 2006).
- Behavior: An overt response or activity by an organism (Weiten, 2010).
- Culture: A group's individual and collective way of thinking, believing and knowing, which includes shared experiences, consciousness, skills, values, and forms of expression, social institutions, and behaviors (Tillman, 2002).
- Cultural Mistrust: The belief acquired by African Americans, due to past and ongoing mistreatment (Neville, Tynes, & Utsey, 2009).
- Disparities: Inequalities that are potentially unexpected, undesirable, and problematic (Hurt et al., 2012).
- Double Consciousness*:* Seeing oneself from the perspective of the dominant culture and from the perspective of the African American community (DuBois, 1968; 1903).
- Ethnicity: A common heritage shared by a particular group (Zenner, 1996). This also includes a part of the social self. It is through ethnicity that one develops a sense of peoplehood and a shared community with others who are members of the same group (Boss, Doherty, LaRossa, Schumm & Steinmetz, 1993).

- Family Therapy: A collection of therapeutic approaches that share a belief in family-level assessment and intervention. The family is a system, and in the system each part is related to all other parts (Center for Substance Abuse Treatment, 2004). A type of psychotherapy, usually provided by a licensed family therapy professional, that helps family members communicate, handle conflicts and solve problems better (MHA, 2016).
- Mental Health: A state of well-being in which every individual realizes his or her own potential, cope with the normal stresses of life, work productively, and make a contribution to his or her community (World Health Organization, 2014; Center for Disease Control and Prevention, 2013). The successful performance of mental functions, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity (USDHHS, 1999).
- Mental Illness: The term that refers collectively to all mental disorders. These are health conditions characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning (USDHHS, 1999).
- Perceptions: The selection, organization, and interpretation of sensory input (Weiten, 2010).
- Psychotherapy: Also known as "talk therapy." When a person speaks with a trained therapist in a safe and confidential environment to explore and understand

feelings and behaviors and gain coping skills (National Alliance on Mental Illness, 2014).

Delimitations

This study is limited in the following ways: this study is limited to the perceptions of African Americans who are 25 years of age or older, who voluntarily agree to participate in this study, who self-identify as being African American, and who currently reside in Texas.

Summary

Research has identified African Americans as being far less likely than Caucasians to utilize family therapy services (Joo et al., 2010; Suite et al., 2007; USDHHS, 2001). As the second largest minority group and third largest racial group in the US, African Americans are 20% more likely to experience and report more serious psychological distress than Caucasians (USDHHS, 2010). The historical impact of slavery and discrimination continue to influence many African Americans perceptions regarding the field of family therapy and healthcare.

African Americans continue to be identified as a population that is vulnerable to family therapy disparities. They face unique challenges pertaining to family therapy care (Holden et al., 2014). The supplement to the Surgeon General's report highlighted cultural factors that continue to contribute to the lack of service utilization for African Americans (USDHHS, 2001). The culture of a patient influences many aspects of family therapy and patterns of utilization (USDHHS, 2001). For many African Americans,

culture can be referred to as a driving force behind their decision-making, particularly in regard to medical issues (Williamson, 2014).

While there has been an increased focus on the field of family therapy, there continues to be a lack of research documenting African Americans' perceptions of family therapy, mental illness, and treatment-seeking behavior. Few studies have allowed African Americans the opportunity to verbalize their perceptions, understanding, and grievances about the field of family therapy.

CHAPTER II

REVIEW OF LITERATURE

INTRODUCTION

African Americans are less likely to receive the care needed and if they do receive care, it is often poor quality. African Americans have similar rates of mental health diagnoses compared to the general population, but nearly 60% do not receive care (Hall & Sandberg, 2012). The prevalence of mental health disparities and underutilization of family therapy services is a major public concern. The underutilization of family therapy and other therapeutic services leaves African Americans at greater risk for severe mental health issues because untreated mental illness can create devastating personal and societal consequences (Russell, 2010; Williams, 2013). The US census bureau reports that thirteen percent of its population identify as African American, and of those over 16% are reported as having a diagnosable mental illness (U.S. Census Bureau, 2014). According to the National Center for Health Statistics (2012), African Americans are 20% more likely than non-Hispanic Caucasian Americans to report serious mental illness and/or family issues.

Mental health access rates and utilization patterns are well documented for many minority groups in the United States because each ethnic minority group has its own unique and distinct history, and this literature review will focus primarily on African Americans (Davey & Watson, 2008; USDHHS, 2001). Two major reports addressed mental health and mental illness beginning in 1999, setting the groundwork for open

dialogue and action regarding this topic. These reports released by the Surgeon General acknowledged that mental health is fundamental to overall health and productivity. The overall message of the initial Surgeon General's report inspired hope for people suffering from mental illness by providing evidence regarding prevention and treatment (USDHHS, 1999). It is also illuminated system disparities, revealing that all Americans do not share equally in the hope for recovery from mental illness.

> Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. The disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender (USDHHS, 1999, p. vi).

In the 2001 Surgeon General report entitled *Mental health: Culture, Race, and Ethnicity,* the Surgeon General urged Federal, State, and local leaders to identify and eliminate many barriers to quality family therapy care faced by racial and ethnic minorities. The Secretary of Health and Human Services (2001) stated that diversity and equal opportunity are inherent to the American way of life. The Secretary of Health and Human Services illuminates the relevance of history and culture to better understand how the strengths of different minority groups' cultural and historical experiences may be drawn upon to help prevent/reduce mental illness in their communities. Thompson (USDHHS, 2001) urged public health communities to understand the roles of culture, race, and ethnicity and to overcome obstacles that would keep anyone with family therapy problems from receiving the highest level of family therapy services. Secondly,

Thompson discussed inconsistent variances in diagnostic and treatment procedures by using evidence-based medications and psychotherapies. Lastly, continued research will aid clinicians in understanding how to tailor interventions that will address age, gender, race, culture, and ethnicity (USDHHS, 2001).

The supplement report focused on family therapy disparities affecting racial and ethnic minorities (USDHHS, 2001). Among the foremost-recognized racial and ethnic minority group was African Americans. These reports from the Surgeon General were groundbreaking and laid the foundation for further research and course of action regarding the elimination of disparities and equal access. This literature review will preview only a small representation of a long historical link between racism, medicine, and African Americans. These illustrations do not attempt to include all accounts of the historical trends related to race and medicine in the United States.

Theoretical Perspective

Bronfenbrenner's ecological systems theory (later renamed bioecological theory of human development) will frame this body of research. Bronfenbrenner's bioecological systems theory asserts that each person is located within many environments, including the family, society, culture, and physical surroundings (Bronfenbrenner, 1979). This theory defines complex layers of one's environment that each has an effect on one's life. Bronfenbrenner's original ecological systems theory was composed of five organized subsystems that support and guide human growth (Bronfenbrenner, 1979). These subsystems include the microsystem, mesosystem,

exosystem, macrosystem, and chronosystem. The microsystem is the layer closest to the individual and the developing person's immediate setting. The mesosystem provides the connection between structures of the microsystem and is the level in which the developing person participates. The exosystem includes the larger social system. The macrosystem is the outermost layer of the environment and setting, where patterns of ideology and social organization of characteristic of a particular society or culture exist. Lastly, the chronosystem encompasses the dimension of time as it relates to the individuals' environment (Bronfenbrenner, 1979). Bronfenbrenner's ecological perspective focused on revealing the interconnectedness occurring not only within, but also between, the different system levels (Bronfenbrenner, 1979). Bronfenbrenner's theory illuminates the values and culture of the African American family experience (Bronfenbrenner, 1979). Bronfenbrenner (1979) asserts that

> . . . by analyzing and comparing the micro-, meso-, and exosystems characterizing different social classes, ethnic and religious groups, or entire societies, it becomes possible to describe systematically and to distinguish the ecological properties of these larger social contexts as environments for human development. (p. 8)

Bronfenbrenner's (1979) earlier work was very important in understanding African Americans in a systematic approach of human and social development. The microsystem subsystem incorporates Billingsley's (1992) definition of the African American nuclear family. Billingsley (1992, p.28) essentially described the African American family as an "intimate association" of persons, who are related to one another

by a variety of means. This intimate association includes blood, marriage, formal adoption, informal adoption, and by appropriation sustained by a history of common residence in America which are deeply embedded in a network of social structures both internal and external to itself. This model of the nuclear family allows researchers to move away from the linear viewpoint that African Americans are solely responsible for the challenges they face to incorporate a subsystem of social structures that have impacted the development of the African American family (Bell-Tolliver, 2004).

Bronfenbrenner (2005) expanded his theoretical design for the scientific study of human development over time, renaming it the bioecological model. In the bioecological model, development is defined as a phenomenon of continuity and change in the biopsychological characteristics of human beings, both as individuals and a group (Bronfenbrenner & Morris, 2007). The phenomenon extends over the life course across successive generations and through historical time (Bronfenbrenner & Morris, 2007). The African American experience has been one riddled with obstacles they needed to overcome. The key theoretical underpinnings of Bronfenbrenner's ecological systems model is an organizing theory, an umbrella theory, that may provide a framework for understanding African Americans' underutilization of family therapy and other mental health services.

Historical Foundation

Throughout history, there has been an ongoing struggle among African American leaders to have African Americans evaluated by culturally appropriate

standards rather than those of the dominant culture (Black, Spence, & Omari, 2004; Guthrie, 2004; 1998; 1976). The encouraged focus in this review is that African American culture is different from other cultures, but different does not constitute inferior (Black et al., 2004).

Tillman (2002) defined culture as a groups' collective way of thinking, believing, and knowing including their shared experiences, consciousness, skills, values, forms of expression, social institutions, and behaviors. For far too long, African Americans have been compared to European Americans. With these comparisons comes a level of distortion that fails to take into account the uniqueness of the culture and to capture the ethos or emotional tone of the African American people (Parham, 2009). The concept of ethos, as suggested by Ani (1980), refers to the emotional substance of a cultural group solidified by a common heritage, a set of shared experiences and a common culture (Parham, 2009*)*. Failure to acknowledge and include this synthesis of energy or spirit within the culture will lead to a lack of understanding and misconception of the African American culture as a whole (Parham, 2009).

Since the early 1900s, African American scholars have taken on the task of defining and reframing the discipline of psychology from an African American perspective. During this time African American scholars began to chronicle the African American journey, from the pioneering work of W.E.B. DuBois (1968; 1903) *The Souls of Black Folks,* where he chronicled the psychological struggles of African Americans and introduced the phenomenon of double consciousness to Cecil Sumner. Referred to

as the *Father of Black Psychology*, Cecil Sumner became the first African American to receive a doctoral degree in Psychology from an American university in 1920 (Black, Spence, & Omari, 2004). Sumner was interested in understanding racial bias and supporting educational justice for African Americans (Thomas, 2006). Others such as Lerone Bennetts (1966) *Before the Mayflower,* J. H. Franklins (1974) *From Slavery to Freedom,* Thomas and Sillens (1972) *Racism and Psychiatry* or Van Sertima's (1976) *They Came Before Columbus,* just to name a few, sought to dispel myths and add description to African American life. With natural selection, genetics, heredity and instincts theories contributing to early psychology, the worldview of African Americans was that they were emotional, genetically and intellectually inferior (Parham, 2009).

Thomas and Sillen (1972) examined the applied aspects of traditional psychology and psychiatry, discussing racist ideologies and the contaminated way of diagnosing mental disorders and disease in African Americans. On the other hand, Guthrie's work (2004; 1998; 1976) focused on the scientific aspects of psychology, in *Even the Rat was White*, which revealed shameful practices utilized by White psychologists to reinforce and validate notions of superiority. These scholars spoke to the dilemma and overviewed comprehensive overviews of how the current theories and techniques of traditional psychology contributed to the psychological struggles of African Americans. In addition, they provided a platform for the continued dehumanization of persons of African American descent (Parham, 2009). These

recordings of the African American experience gave more of a comprehensive look into the lives of African Americans.

While it may be hard to understand or gauge the extent to which African Americans have internalized institutional and public racism. It is apparent or it can be argued that the belief among African Americans is that the scientific, medical, and psychiatric community has played a continuing role in contributing to their unethical and inhumane treatment (Poussaint & Alexander, 2000; Suite et al., 2007).

Racism in Healthcare

Evidence suggests that there were historical interactions within the African American and medical communities (Suite et al., 2007). There is a legacy of mistrust and underutilization of medical and family therapy services in the African American community. It is highly impractical for health care professionals to ignore the true depth of history and its relevance to the African American underutilization of family therapy treatment.

For African Americans, there is a unique and troubling history of racism entrenched in medical research, diagnosis, clinical management and experimentation (Suite et al, 2007). Historical racism and discrimination led to African American skepticism and mistrust, as it pertains to medicine and family therapy that has been passed down through generations. Historical trends include the medical experimentation on African Americans during slavery. For instance, African American bodies were viewed as preferential experimental targets for medical personnel in the antebellum

South (Suite et al., 2007). Harris, Gorelick, Samuels, and Bempong (1996) gave accounts of Southern African Americans becoming prime targets for medical dissection disclosing that

> Southern blacks became a prime source for medical school dissection experiments and autopsy specimens. This practice continued in the post bellum South in the form of night doctors who stole and dissected the bodies of blacks. (p. 631)

Due to their status as slaves and the resulting poor socioeconomic status, African Americans were forced to participate and fill hospital beds to help doctors' practice and perfect their craft (Harris et al., 1996). Painful and brutal experimentations were reported but continued to create new techniques and remedies. A slave named Fed was put into an open pit in the ground that was then covered and heated to test what medication would enable him to withstand heat (Harris et al., 1996). In Montgomery, Alabama, African American slave women were used to search for a cure for vesico-vaginal fistulas, up to 30 painful operations between the years of 1845 to 1849 using no anesthetics (Suite et al, 2007). Gamble (1997) reported that Dr. James Marion Sims referred to as the "Father of Modern Gynecology" reflected on the agony of this type of operation

> The first patient I operated on was Lucy…..that was before the days of anesthetics, and the poor girl, on her knees, bore the operation with great heroism and bravery. (p. 1774)

Gamble (1997) also noted that this operation failed several times and was only attempted on Caucasian women using anesthesia. Although to those medical professionals this appeared to be legitimate medical research, it is clear that the priority was not to safeguard the welfare of the patient or slave (Poussaint & Alexander, 2000). Other examples of mistrust, unethical, and inhumane treatment of African Americans in the field of medicine occurred during the 1932 Tuskegee Syphilis experiments (Suite et al., 2007). The Tuskegee Syphilis Experiment was described as a long-term study of the effects of syphilis on a group of African American men in Alabama. Initially, there was no antibiotic treatment but when the antibiotic was developed in the 1940s, it was deliberately withheld without patient knowledge or consent (Gamble, 1997). The Tuskegee Syphilis Experiment became one of the most notorious cases of human rights violations and has been referred to as the longest running non-therapeutic experiment on humans (Harris et al., 1996). Other acts of unethical medical practices continued with the involuntary sterilization of black women who were admitted to the hospital for other procedures (Suite et al., 2007).

> Based on earlier accounts of experiments and inhumane treatment from the medical community, Poussaint and Alexander (2000), remarked, "it is not hard to imagine, however, that news of this and similar incidents spread through the local Black population, giving rise to a not unreasonable fear of White medical doctors (p. 69)."

Decades later, the relationship between African Americans, misinformation regarding African American lives, and harmful medical practices have improved. But, it is unclear how far the medical field has come, especially regarding mental health.

African Americans, Family Therapy and Healthcare Needs

The fields of family therapy and family sciences have trained many with the assumption that when families are ready to change, they will pursue treatment. This train of thought fails to include the unique barriers faced by African Americans (Snell-Johns, Smith, & Mendez, 2004). Other theories and techniques have been influential as theories began to address the study of human behavior (Parham, 2009). The inclusion of the African American culture within that of the healthcare field was understood against the backdrop of U.S. history during this era (Holliday, 2009). The early 19th century revealed a time of enslavement, oppression and Jim Crowism for African American people (Holliday, 2009). Theories and techniques derived from this time only contributed to the dehumanization of African Americans (Parham, 2009). During this era, traditional psychology lacked objectivity in regards to African Americans and reverted to principles of Darwin's survival of the fittest, Galton's science of heredity, McDougall's theory of instincts, and Mendel's theory of genetic differences. These theories influenced scientist observations, comprehensive overviews and the study of African Americans as a culture (Parham, 2009). African Americans were viewed and depicted as being inferior with multicultural issues as portrayed (Parham, 2009; Thomas & Sillen, 1972; Parham, White, & Ajamu, 1999).

Examples of this lack of objectivity as well as racist behavior is illuminated through instances, such as the U.S. Census Report which deliberately falsified the insanity rates of African Americans to show that the further north African Americans lived, the higher the rates of mental illness, orchestrated by Dr. Edward Jarvis (Suite et al., 2007; Williams & Fenton, 1994). During the 19th century, Dr. Samuel A. Cartwright, coined and/or invented two disorders known as *drapetomania* and *dysaethesia aethiops*, which were defined as African slaves uncontrollable urge to escape and the evidence of disobedience and refusal to complete work (Myers, 2009).

The knowledge of African Americans and family therapy during the beginning of the 20th century more research focused on the severely mentally ill and/or hospitalized patients (Williams, 1995). The sampling most often included predominately state hospitals, which led to serious methodological flaws in research (Williams, 1995). State funded hospitals continue to be a primary source of family therapy care for African Americans of lower socioeconomic status (Williams, 1995). In contrast to African Americans, Caucasian patients generally were able to avoid the stigma of family therapy hospitals by obtaining private care outside of the psychiatric sector (Williams, 1995).

African American psychologists and other scholars aggressively began to challenge or deconstruct the theories, methods and scientific beliefs as well during the early 20th century. Although current research regarding family therapy for African Americans is no longer tainted with blatant acts of racism and harmful behavior

however, barriers still remain that contribute to a lack of family therapy service utilization for African Americans (Williams, 1995).

Barriers to Healthcare and Treatment

The mental stability and culture of African Americans can only be appreciated within its wide historical context (USDHHS, 2001). The long legacy of slavery and discrimination continues to affect and influence treatment-seeking behaviors of African Americans (Carten et al., 2016). African Americans have used adaptive traditions to assist as they navigated through hardships yet appear to be determined and resilient as they overcome lingering discriminatory behavior that continues to influence their economic and social standing (USDHHS, 2001).

Poverty and lower socioeconomic status remain an important issue within the African American community. Data from the U.S. Census Bureau shows that in 2005, African Americans were 7.3% more likely to live in impoverished neighborhoods with limited or no access to family therapy services (American Psychological Association, 2011). A growing number of studies indicate that low-income urban environments are at a higher risk for exposure to traumatic events leading to the possibility of posttraumatic stress for African Americans (Davis, Ressler, Schwartz, Stephens, & Bradley, 2008). This analysis revealed that nearly 25% of African Americans were uninsured and more likely to use the emergency room or their primary care doctor for psychological services (USDHHS, 2001). While this may be helpful, an emergency room or primary care specialist may lack the training necessary to accurately diagnose and treat both medical

and behavioral health issues. The American Psychological Association (2011) notes that psychologists and family therapy clinicians are better trained to identify mental illness and create a plan of treatment.

Conner et al. (2010) examined the experience of being depressed among African American elders and their perceptions of barriers confronted when thinking about seeking mental health services. These researchers also examined how African American elders utilize coping strategies instead of seeking professional help (Conner et al., 2010). This qualitative study acknowledged disparities and barriers to treatment engagement and retention (Conner et al., 2010). This study reveals that African American elders are significantly less likely to seek treatment and participants identified barriers such as ageism, shame, stigma, fear, negative attitudes, distrust of the treatment system, lack of information, lack of insurance and lack of transportation as barriers to treatment utilization (Conner et al., 2010). The random digit dialing (RDD) telephone sample identified four hundred and forty nine adult participants ages 18 and older who were willing to participate in the survey along with semi-structured in-person interviews to examine: (1) their experience with depression; (2) their process of whether or not they would seek professional help; (3) barriers experienced when attempting to seek treatment; and (4) cultural strategies used to cope with depressive symptoms (Conner et al., 2010). The study concludes by identifying a number of experiences living in the African American community that impact their treatment seeking behavior, revealing a

vulnerable group of older African Americans hiding their symptoms and denying their depression (Conner et al., 2010).

Mental Health America (2016) recently issued facts regarding African Americans and mental health care, the report revealed that attitudes, treatment issues, and accessibility continue to be major barriers to family therapy treatment in the African American community. Ward, Wiltshire, Detry, and Brown (2013) conducted a study that revealed that African American males are concerned with the stigma associated with mental illness and African Americans have beliefs related to stigma, psychological openness, and help-seeking, affects their coping behaviors.

The National Alliance on Mental Illness (2016) reports that only about 25% of African Americans seek family therapy care compared to 40% of Caucasians. There are many different reasons that prevent African Americans from seeking and receiving family therapy assistance those listed below are just a few acknowledged by the National Alliance on Mental Illness (2016)

- Lack of information and misunderstanding: The lack of knowledge in the African American community leads many to believe that having an issue that may require family therapy is a weakness.
- Lack of discussion: Many African Americans misunderstand the need for family therapy and what a disorder or condition is, and fail to have an open dialogue regarding mental illness.

- Failure to see signs and symptoms: Some have trouble recognizing the signs and symptoms and underestimate the impact of a family therapy condition.
- Seeking treatment: due to the lack of information some African Americans are not clear about where to find or obtain family therapy assistance.
- Distrust and misdiagnosis**:** Historically, African Americans have been and continue to be negatively affected by prejudice and discrimination in the healthcare system. Misdiagnoses, inadequate treatment and lack of cultural competence by health professionals cause distrust and prevent many African Americans from seeking or staying in treatment.
- Socio-economic factors: play a part too and can make treatment options less available. According to the U.S. Census Bureau, as of 2012, 19% of African Americans had no form of health insurance. The Affordable Care Act is making it easier and more affordable to get insured.
- Lack of African American family therapy professionals: Only 3.7% of members of the American Psychiatric Association and 1.5% of members in the American Psychological Association are African American" (NAMI, 2016).

Summary

This review of literature addressed the disparities in the African American community. It identified this group as less likely to use family therapy services, and if services are utilized they are likely to be poor quality (Thompson, Bazile, & Akbar,

2004; USDHHS, 2001). This review attempts to connect the historical experiences of African Americans to the current underutilization of family therapy services. The review also explores African American perceptions of mental illness, family therapy and treatment as it pertains to those barriers of service utilization.

Groundbreaking reports from the Surgeon General acknowledge disparities in the family therapy system as it pertains to African Americans and other minority groups. Unique barriers to therapy and family therapy were introduced, which included stigma, mistrust, socioeconomic factors, and lack of information, and family therapy professionals of African American descent. Many clinicians often struggle to address race, ethnicity, and culture in African American communities (Thompson, Bazile & Akbar, 2004).

Now more than ever, African American communities are more culturally diverse. Yet, little literature has been disseminated to address strategies that will address the reluctance of African Americans to seek family therapy treatment. Although there is evidence that African Americans are increasingly seeking family therapy care, historically African American perceptions of mental illness and family therapy treatment have been riddled with social stigmas and cultural biases.

It is vital that the family therapy community acknowledge African Americans understanding and misperception of mental illness and family therapy treatment. This therapeutic community also needs to develop strategies that will allow African Americans to seek and receive quality care within the family therapy system.

CHAPTER III

METHODOLOGY

This qualitative research focuses on African Americans' perceptions of family therapy and treatment. This study explored a human issue with the purpose of gaining insight into its meaning using a phenomenological lens. Phenomenology is an approach to qualitative research in which the researcher describes the lived experiences of individuals about a phenomenon as described by participants (Creswell, 2014; Marshall & Rossman, 2016). Phenomenology focuses on the commonality of lived experiences within a particular group (Creswell, 2014). This approach has strong philosophical underpinning and typically involves conducting interviews (Creswell, 2014).

The phenomenological design of inquiry is derived from the school of philosophical thought, psychology, and education. This design focuses on the essence or structure of an experience (Merriam, 2009). The procedure involved observation of subjects through their engagement in focus groups designed to explore African American perceptions of family therapy, treatment and service utilization. The techniques helped identify patterns and relationships that guided the research objectives and process (Creswell, 2014). To understand the experiences of the participants involved in this study, the researcher withdrew personal experiences associated with the identified topic (Creswell, 2014).

For this study, data collection involved focus groups conducted in a natural setting (Creswell, 2014). Focus groups are defined as a small group of 6 to 10 people led through

open discussion by a skilled facilitator (Eliot, 2005). Well executed focus groups can reveal a wealth of information and insight. Focus groups can create accepting environments that allow participants to thoughtfully answer questions adding their own meaning and using their own words (Eliot, 2005). This qualitative methodology used a phenomenological research lens that was utilized to explore the research question: How do African Americans perceive family therapy and treatment?

Procedure

Protection of Human Subjects

The researcher followed the guidelines of the Texas Woman's University (TWU) Institutional Review Board (IRB) and took all precautions not to harm the mental or physical well-being of the participants. Approval was obtained from the IRB before beginning the study (see Appendix A). Community locations were also found and approved for recruitment of potential focus group participants (see Appendix B).

The participants of the study were provided with written information concerning the research and participant requirements (see Appendix C). Risks associated with this study were reviewed, such as loss of time, the risk of breach of confidentiality, physical, and emotional distress or fatigue during the signing of the informed consent (see Appendix D). The informed consent also included ways to minimize each risk. This procedure was incorporated to protect the integrity of the study and study participants.

Confidentially, each participant was protected by the assignment of alphanumeric codes. Participant names appear only on the signed informed consent form (see Appendix

D), which will remain in a secured file cabinet in the researcher's private office. No identifying information will appear on any other documents including transcripts and demographic surveys. The audio recordings, hard copies of transcripts, demographic surveys and researcher field notes will be erased, destroyed and/or shredded four years after the completion of the study.

Participants

This study identified perspectives, insights, and meanings related to beliefs regarding family therapy, mental illness, and service utilization. Three focus groups were organized. Each focus group was comprised of six participants, ages ranged from 25 to 60 years of age and above. Protocols ensured that all participants were asked the same questions for aid in the natural narrative flow.

Sample

Purposive sampling, a non-probability sampling technique, was utilized to locate participants who met the research criteria: (a) 25 years of age or older,
(b) self-identify as African American, and (c) reside in Texas.

Snowball sampling was also incorporated which is often used when members of a special population are difficult to locate. In snowball sampling, the researcher collects data on a few members of the target population then asks those individuals to provide the information needed to locate other members of that population (Babbie, 2013). Individuals who responded to the flyer and met the research criteria were asked if they

knew others who met the research criteria and asked to pass out recruitment flyers (see Appendix C).

Sample Recruitment

The main goal of purposive sampling was to focus on characteristics of a population, which enabled the researcher to answer the research question (Babbie, 2013). The researcher informed participants about the study using a recruitment flyer (see Appendix C). The recruitment flyers explained participant criteria, contact information, the potential risk of loss of confidentiality and informed each participant that their name would be entered in a random drawing for a chance to win a $25 Visa gift card.

Data Collection

Focus groups were selected as the instrumental method for gathering information. The facilitator described the topic and ideally, a non-threatening environment was created (Patton, 2002). A predetermined number of questions (referred to as the "questioning route") were developed to ensure that all relevant aspects of the topic were discussed (Patton, 2002). The environment created was one where all group members felt free to express or communicate their opinions, attitudes, and experiences even if they differ from those of other group members. Focus groups typically lasted 60 to 90 minutes (Patton, 2002). The data collection steps are as follows:

Step 1. Flyers will be posted at each approved location (see Appendix B). Prior to attending a focus group, the primary investigator (PI) pre-screened all interested

participants, explained the informed consent (see Appendix D), and demographic form (see Appendix E), as well as be assured confidentiality to the extent allowed by law.

Steps 2. Participants were informed of their right to ask questions at any time including (a) during recruitment, (b) when the PI explained the intent of the study and informed consent, and (c) during the focus groups. Participants were also informed that they may contact the PI, faculty advisor, or the Office of the TWU IRB via phone or email with their questions or concerns. Primary investigator, faculty advisor, and TWU IRB contact information were included on the informed consent form (see Appendix D). The participants were asked at various times in the research process if they had questions. Participants were left with a copy of the informed consent (see Appendix D), as well as a list of local counseling resources (see Appendix F).

Step 3. Three focus groups were scheduled. Each group consisted of six participants: male, female or both sexes, at least 25 years of age to discuss the specific topic. The PI leads each focus group and held the responsibility of describing the topic and ideally creating a non-threatening environment.

Step 4. The first few moments of the focus group discussions were critical and a pattern for introducing the group discussion was as follows (see Appendix G): (1) welcome, (2) overview of the topic, (3) group rules, and (4) first question. A predetermined number of questions were developed to ensure that all relevant aspects of the topic were discussed (see Appendix H).

Step 5. Six focus group questions along with probing questions were utilized to explore the research question (see Appendix H): How do African Americans perceive family therapy and treatment?

Focus group and probing questions that guided this study are as follows:

1. What is your understanding of family therapy?

   Probing Questions (PQ):
   What is your understanding of family therapy treatment?
   How does your family perceive family therapy and treatment?

2. What family dynamics or historical events have influenced your attitudes and behaviors regarding family therapy?

   PQ:
   Give me an example of an influenced attitude or behavior.

3. Thinking about circumstances that may cause severe stress or psychological dysfunction (mental strain), what are some of these circumstances?

   PQ:
   Let's list these on the flip chart.
   If you had to pick one, which circumstance would be the most severe requiring family therapy or treatment?

4. How do you cope with life stressors?

   PQ:
   How effective are these coping mechanisms?

5. Whom do you use for support?

   PQ:
   How effective is your support?

6. How do your family and/or community discuss issues that may require family therapy treatment?

PQ:
If anything, what needs to improve?

Step 6. Focus groups were audio recorded, transcribed and inspected for patterns. Emerging themes were compiled and data were further corroborated through analysis and synthesis. The PI and peer reviewer had access to these recordings.

All participants names were entered into a random drawing for a chance to win a $25 Visa gift card after each focus group. Three separate Visa gift cards will be awarded, one per focus group.

Data Analysis

Qualitative research requires the organization of data; the process involves making sense out of text and image data (Creswell, 2014). Qualitative data analysis aims to understand the meaning of the described phenomenon. Data analysis began immediately following each focus group session. The researcher reviewed notes, observations, surroundings and other pertinent information. Audiotapes were transcribed, and all transcripts were read carefully. To gain a deeper understanding of the data the researcher thoroughly read the data to identify pertinent codes and themes to determine larger meaning (Creswell, 2014).

Coding

Codes are labels that assign symbolic meaning to descriptive information compiled during a study and are usually attached to data chunks, the coding process of

grouping data together based on similarities (Miles, Huberman & Saldana, 2013).

To present and analyze the findings in the study, the researcher coded responses. The coding method requires researchers to stop and make analytic inquiries into the data they have gathered. The first objective is to assist researchers in understanding the issues they are investigating. In the context of the present study, coding will assist the researcher in gaining crucial insight into African Americans' perception of family therapy and family therapy based treatment. The second objective of the coding process is to assist the researcher in guiding the subsequent data analysis process by maintaining its relevance to the objectives of the study. This second objective is important because it ensures that the analysis process maintains its focus on the core objective of the study (Charmaz, 2006). Coding prevents these outcomes by guiding the data analysis process (Given, 2008). In the context of this study, the coding approach will direct the subsequent data analysis by ensuring that the researcher focuses on analytic issues that are relevant to the primary aim of the study. In this case, the coding ensured that the analysis process focuses on issues that are essential for determining African Americans' perception of family therapy and family-based treatment.

The essence of coding is that it provided the bones of the researcher's analysis. Coding provides the basis for the theoretical integration that enables the researcher to assemble a clear sketch of African Americans' perception of family therapy and

family-based treatment. Coding provides insight into the factors that lead African Americans to develop a negative attitude or harbor negative views about family therapy and the strategies that key stakeholders can implement to enhance African Americans' acceptance of the treatment approach. The coding process consisted of two phases. The first phase entails the identification of the keywords and phrases as communicated by the research participants (Charmaz, 2006). The second entails a systematic, selective process that identifies the most frequent or significant codes utilized by the research participants (Charmaz, 2006). After identifying these codes, the researcher organized and synthesized them to appreciate the insight they provided on the question of African Americans' perception of family therapy and family therapy based treatment.

In the first phase of the coding process, the researcher remains open for possible patterns and themes that emerge from the collected data. The researcher had very little influence on the theoretical directions emanating from the data. The researcher merely identified the most significant phrases in relation to each of the questions asked during the focus group interviews. In the second part, the researcher focused on the collected codes because it was necessary for pinpointing the most significant categories of codes in the large data sets. This is the point where the researcher asked what the data says about African Americans' perception of family therapy and treatment. It is also the point where the researcher links insight from the data with theories and arguments espoused in existing publications.

In Vivo Coding

In vivo codes denote the special terms or phrases that research participants' use during the focus group interviews (Saldana, 2013). Identifying and recording these special terms is important because it gives the researcher an opportunity to present the analytic departure point (Oktay, 2012). The codes are important because they play the role of symbolic markers of the research participants' views and meanings (Oktay, 2012). Possession of the research participants' meaning and interpretation of the phenomenon under evaluation makes them a good platform for guiding the integrated analysis. Therefore, the process of identifying and presenting the in vivo codes is crucial to determining the quality of analytic integration in the data analysis chapter of the study.

Holistic Coding

Holistic coding will also be used as a second cycle coding method. Second cycle coding will be used to reorganize and condense initial analytical details of the data (Saldana, 2013). Holistic coding applies a single code to each larger unit of data, capturing a sense of the overall contents and possible categories that may develop (Saldaña, 2013). Described as an attempt to grasp basic themes, holistic coding allows the researcher to absorb the data as a whole rather than analyzing line by line (Saldaña, 2013).

The Researcher

As noted by Creswell (2004) "qualitative research is interpretive research, with the inquirer typically involved in sustained and intensive experience with the

participants" (p. 134). The role of the researcher compels the identification of personal assumptions, values, and bias at the onset of any research study (Creswell & Clark, 2007).

The researcher is a doctoral student in the graduate school of Texas Woman's University, College of Professional Education in the Department of Family Sciences. She is African American and has been a Licensed Professional Counselor for 10 years, seeing clients with multiple presenting issues including borderline personality disorder, depression, anxiety, bipolar disorder, and PTSD. The researcher is a certified DBT therapist and skills trainer. She has previous experience as a Juvenile Probation Officer and currently works as a professor at Houston Community College. As a clinician, the researcher is aware of the many challenges that African American families face and desires to explore the experiences of African Americans' and their perceptions of family therapy as it pertains to treatment-seeking behaviors. With the described experience and perspective, the researcher guarded against personal biases and assumptions throughout this study. The researcher conducted this study with a constant mindfulness of personal biases to explore this phenomenon without the intrusion of judgments.

Summary

This chapter discussed the methodology used for this research study including the research design, subjects, sample, protection of human participants, and procedure for collecting data, and data analysis. The study employed both a qualitative and a

phenomenological approach providing the researcher with an opportunity to understand the participants' lived experiences and perspectives regarding family therapy and treatment. The sample was gathered using purposive sampling, which allowed the researcher the opportunity to focus on the unique characteristics of African Americans' perceptions of family therapy and treatment as it pertains to barriers of service utilization. The data was gathered using focus groups, which were analyzed using *in vivo* and holistic coding.

CHAPTER IV

RESULTS

This study investigated how African Americans' understand and interpret family therapy, mental illness, and treatment-seeking behaviors in their communities. More specifically, the study explored African Americans' perceptions of family therapy and their perception of its appropriateness as a treatment option for mental strain and mental health disorders. Social conditions were evaluated to explain African Americans' limited utilization of family therapy and treatment services.

Data collection included the transcription of recorded focus group data, reading, rereading and analysis of the data, coding (*in vivo* and holistic) and peer debriefing. Six themes emerged from the analysis, cultural understanding, cultural barriers, cause of mental strain, coping mechanisms, cultural support, and cultural communication.

This chapter presents findings of the focus group interviews. As noted, three focus groups were conducted with 18 African Americans' regarding their perceptions of family therapy and treatment. The first section of this chapter will outline findings on the demographic characteristics of the research participants. The second section will outline key findings from the focus groups in relation to African Americans' perception of family therapy and treatment. The third section of this chapter will outline key concepts and categories that emerged from the *in vivo* and holistic categorizations during the coding process.

With the aid of *in vivo* and holistic coding, this researcher will outline and explain some of the short phrases drawn from the focus group transcripts.

Cultural identity has a profound impact on our sense of mental and physical wellbeing (McGoldrick, Giordano, & Garcia-Preto, 2005). African Americans are underserved in therapeutic settings and research reveals that the field of family therapy has been deficient with regard to addressing this phenomenon (Bean et al., 2002; Davey & Watson, 2008; Hall & Sandberg, 2012). As the second largest minority group and third largest racial group, African Americans are one ethnic minority group that continues to be underserved by the current mental health system (Chow, Jaffee, & Snowden, 2003; Davey & Watson, 2008). It has also been suggested that African Americans do not typically seek therapy many reasons including the use of other coping mechanisms, such as extended family and spirituality (Boyd-Franklin, 2003).

Utilizing a qualitative methodology in conjunction with a phenomenological research strategy, this researcher gained an understanding of participant's perceptions of family therapy and treatment seeking behavior by utilizing focus groups and demographic questionnaires. The data from the focus groups conducted was analyzed to gain a rich, contextualized understanding of their perceptions of family therapy and treatment as it pertains to service utilization. This researcher's analysis generated six themes that captured participants' perceptions of family therapy and treatment: cultural

understanding, cultural barriers, cause of mental strain, coping mechanisms, cultural support, and communication.

Sample Demographics

The sample consisted of 18 participants who lived in Texas and were 25 years of age or older. All participants reported as Baptist. Half of all participants reported having earned at least a high school education, with one participant reporting having earned a GED. The other half reported earning an associate degree or higher. In addition, most of the participants identified as single, while the next largest group identified as married, with one participant being married but separated. The general perspective towards our current mental health system varied among participants, with the largest number of six participants reporting as being neutral, while the next largest group of five participants identified as being not satisfied. There were three participants who reported being satisfied while four participants identified as being very satisfied (see Table 1).

Table 1 *Demographic Data of Focus Group Participants*

	GROUP 1	GROUP 2	GROUP 3
MALE / FEMALE	3 Male – 3 Female	6 Female	3 Male – 3 Female
Ethnicity	African American	African American	African American
Age Group	1 – 60 – older 1 – 50 - 59 3 – 40 – 49 1 – 25 - 29	3 – 50 – 59 1 - 40 – 49 1 – 30 – 39 1 – 25 – 29	2 – 60 – Older 2 – 50 – 59 2 – 30 – 39
Education	4 - Completed High School 1 – Associates Degree 1 – Master Degree	2 - Completed High School 1 – GED 1 – Associate Degree 1 – Bachelor Degree 1 – Master Degree	2 - Completed High School 2 - Associate Degrees 1 – Bachelor Degree 1 – Master Degree
Marital Status	3 – Married 2 – Single 1 - Separated	1 – Married 5 – Single	4 – Married 2 – Single
General perspective towards our current Mental Health System	2 – Satisfied 3 – Not Satisfied 1 - Neutral	3 – Very Satisfied 1 – Satisfied 2 - Neutral	1 - Very Satisfied 2 – Not Satisfied 3 – Neutral
Optional: Religion	6 - Baptist	6 - Baptist	6 - Baptist

Findings

This researcher utilized three focus groups to examine African Americans' perceptions of family therapy and treatment as it pertains to key barriers of service utilization. The following overarching research question that guided this study was: how do African Americans perceive family therapy and treatment? This question was explored below using selected focus group and probing questions. Incorporated in this method is *in vivo* coding or *verbatim coding* (Saldana, 2013), which uses the unique vocabulary or short phrases of African Americans to extract indigenous terms collected from the qualitative data records. Focus group and probing questions were developed to explore the overarching research question. Example of focus group one responses to focus group questions (FGQ1) and probing questions (PQ) are listed below (see Table 2).

Table 2 *Data Collection Example*

RQ: How do African Americans perceive family therapy and treatment?
FGQ1: What is your understanding of family therapy?
FG1 "Family therapy, to me, is a place where you can go and seek counsel for financial difficulties or maybe not even difficulties, but for maybe blended families. Marriage counseling, to come as a couple that may have been married for a long time. Just to come to say, "We may not be coming together anymore. We just come to get some counseling to see how we can better our marriage," and so forth." "Family counseling. Anything that pertains to the family as a whole. Like the participant said, marriage counseling, living with relationships with parents, siblings, children; anything that pertains to the family." **FG2** "My understanding of family therapy is help for the family as a whole family, not as an individual. Giving them opportunity to talk and say what's on their minds so you'll know what, how to help them." "That was a good answer." "Counseling"
Continued Table 2 focus group responses

FG3 "Therapy that engages the whole group. that helps to, helps cohesion." "Getting the family together to get on the same page." "Something that helps get to the root of any underlying problems." "Without a biased opinion" "Helping each and everyone reach their full potential."

PQ: What is your understanding of family therapy treatment? **FG1** "Treatment is actually the counseling itself, just a therapy that you will receive from a therapist." "That's just about what I was going to say. Treatment, to me, is to the individual going to the counselor, expressing their thoughts, their feelings, their issues and allowing the counselor to provide counsel or words of wisdom, words of what they feel that they can do to help to remedy. It may not always be something wrong. It could be something to be just expressed to say how they feel dealing with a sick child or something. It's just something that the counselor can give words. I don't, necessarily, think it's medicinal. I think it could be just words, thoughts, or solutions."
Continued Table 2

FG2 "I think that it could go all together, but it also could be just the treatment, But no, you need everybody in order to do the treatment part, because everybody has a part in it, the problem, and everybody needs to share it equally and have an opportunity to get the help." **FG3** "Treatment means expressing yourself, being truthful and sometimes it may mean medication for some of the members." "I see treatment as a solution, it could also mean medicine of some sort, or it could just be an action."
PQ: How does your family perceive family therapy and treatment? **FG1** "From my personal family's perspective, going to the therapist meant something was wrong. You're crazy, you have a problem, you have an issue. Then, I found out in my adulthood, going to premarital counseling, I found out it's just the opposite. It's just somewhere to go to get a different opinion, to receive vital information, just to help along in the process of what we thought we were getting into and then it turned out to be something more beneficial for us." **"**And I think because a lot of families do not know what to expect when they go to therapy, it makes it even more difficult. It's good for them to have an understanding that when they do go to therapy, it's not really, obviously per se, their opinion of the therapist, it's the therapist helping them or leading them into a better understanding of why they feel the way that they do." Continued Table 2

FG2

"Well, my family thinks everything has to go through the church first before real therapy."

"Take it to the Lord first."

FG3

"Most families want to lay the blame on the other family member for what's going on wrong, instead of taking responsibility for your own actions."

"And they tend to be just a little less receptive to treatment."

"I think, sometimes families are resistant cause families sometimes, especially in our community, with that we've been told what happens in this family, Stays."

"Stays in this family. Don't be telling our business to all them other people. Skeptical because often times we don't know, it's hard for us to understand how you gone us this? It may come back to haunt us. So that paradigm is real pervasive for us. I don't know what you gone do with this so, I ain't telling them people nothing. We are coming not disclosed."

During the initial review of participant responses to the FGQ1 participants appeared to have had a general understanding of the concept of family therapy. Evidence of their understanding of the concept emerges from their responses to the question that sought to determine their understanding of the term "family therapy." The responses elicited phrases like "engages the whole family," "helps cohesion," "getting the family on the same page," "get to the root of the problem," "everyone reach their full potential," "seek counsel on anything that pertains to the family as a whole," and "counseling." Although general understanding family therapy was revealed, few focus group participants were able to define the term family therapy as a form of psychological counseling that assists members of families as a unit in resolving conflicts and improving communication (SAMHSA, 2013).

Probing questions dug deeper for more information regarding socially learned and taught behaviors of African Americans. Many of the focus group responses to the probing question of their understanding of family therapy treatment were generalized, yielding responses such as, "treatment is actually the counseling, therapy that you will receive from a therapist." The analysis of the participant responses to FGQ1 and PQ1 generated one major theme: cultural understanding.

Themes and concepts were identified in the data through multiple rounds of coding using the following focus group, probing questions and themes (see Table 3).

Table 3 *In vivo Coding*

FGQ	In-vivo Codes	PQ	In-vivo Codes	Themes
FGQ1What is your understanding of family therapy?	"Engages the whole family", "helps cohesion", "getting the family on the same page", "get to the root of problems", "everyone reach full potential", "seek counsel, anything that pertains to the family as a whole", "help for the whole family", "counseling"	What is your understanding of family therapy treatment?	"Expressing yourself", "being truthful", "medication", "a solution", "medicine", "counseling", "going to a counselor expressing thoughts, feelings & issues", "everyone sharing equally in the problem"	**Cultural Understanding** Help for the whole family Solution
		How does your family perceive family therapy and treatment?	"Lay blame", "resistant", "in our community what happens in the family stays in the family", "don't tell our business", "Skeptical", "something wrong", "crazy", "have a problem", "don't know what to expect"	Taught, learned

Focus group question – FGQ and Probing Question – PQ. In vivo coding, verbatim coding, actual language of participants. Continued

FGQ2 What family dynamics or historical events have influenced your attitudes and behaviors regarding family therapy?	Not the norm, Ginny pigs, "marriage", "mistrust", "don't look like us can't help", "stigma", "never seen", "we don't talk about it,""just deal with it", "reluctant", "prayer", "God can fix it", "cover up"	Give me an example of an influenced attitude or behavior.	Prayer, reluctant, "mistrust", "stigma"	**Cultural Barriers** don't look like us can't help, just deal with it
FGQ3 Thinking about circumstances that may cause severe stress or psychological dysfunction (mental strain), what are some of these circumstances?	"PTSD", "grief", "abuse", "incarceration", "missing parents", "addiction", "hurricane", "relationships"	Listed, If you had to pick one, which would be the most severe requiring family therapy or treatment?	Relationships	**Cause of mental strain**
FGQ4 How do you cope with life stressors?	"Ignore", "eat", "anger", "cry", "shut down emotionally", "talk then explode", "spirits", "prayer", "turn it over to God", "hold it in", "smoke & drink", "shop", "exercise"	How effective are these coping mechanisms?	Not very, Can be very expensive	**Coping Mechanisms**

Table 3 continued

FGQ5 Whom do you use for support?	"Church family", "spiritually mature sisters in Christ", "God", "the Lord", "counselor", "psychiatrist", "therapist", "my mother"	How effective is your support?	Church family, God, my mother	**Cultural Support**
FGQ6 How does your family and/or community discuss issues that may require family therapy treatment?	"We don't", "As a culture we've been taught to keep things inside our home", "do not discuss or take them anywhere", trying to find somewhere to fit in", "we are a people of heart if it doesn't if we don't feel it", "keep to ourselves", "someone identifying that your crazy", "Ignore it", "Covering it up", "Don't admit issues"	If anything, what needs to improve?	"Deal with the facts of things", "Educate ourselves", "Understanding therapy", "Our thought process", "Be more open-minded"	**Cultural Communication**

The researcher decided to separate raw data from the focus group interviews using *in vivo* codes. The tabulated *in vivo* codes highlight some of the key concepts that emerged from the focus group interviews. The tabulation of the codes suggests that the researcher categorized the phrases that were salient in the responses to each of the focus group questions. Six broad themes emerged from the coding process, including cultural understanding, cultural barriers, cause of mental strain, coping mechanisms, cultural support, and cultural communication. In addition, three broad concepts became apparent to the researcher. In turn, the researcher developed three theoretical codes. These were "family," "stigma," and "religion."

Coding Analysis

Codes, Concepts, and Themes

Having used *in vivo* codes to identify key phrases in the focus group transcripts, the next step was to group the *in vivo* codes into broader categories and concepts. This researcher grouped the *in vivo* codes into the concepts that emerged for categorization. For this narrative holistic coding was used as a second cycle coding method. Holistic coding was used to capture a sense of the overall contents, concepts, and categories that were developing. Using the holistic coding process, single codes were extracted from the larger units of data. Specifically, six broad concepts emerged from the coding process. These concepts included the need for culturally sensitive definition, social factors undermining the use of family therapy, alternative ways of dealing with mental

health issues, conditions that necessitate therapy, religion, and collectivism. Using the identified concepts, the researcher identified six broad categories emerging from the concepts. The tables below offer an illustration of each of the six categories (see table 4).

Table 4 *Codes, Concepts and Themes*

A. "Cultural Understanding"

Codes	Concepts	Themes
"Engages the whole family" "Helps cohesion" "Getting the family on the same page" "Get to the root of problems" "Everyone reach full potential" "Seek counsel, anything that pertains to the family as a whole" "Help for the whole family" "Counseling" "Expressing yourself" "Being truthful" "Medication" "Medicine" "Counseling" "Going to a counselor expressing thoughts, feelings & issues" "Everyone sharing equally in the problem" "Lay blame", "resistant", "In our community what happens in the family stays in the family" "Don't tell our business"	General understanding or knowledge regarding family therapy Need for a Culturally Sensitive Definition	**Cultural Understanding**

Table 4 Continued

"Skeptical" "Something wrong" "Crazy" "Have a problem" "Don't know what to expect"		

B. "Cultural Barriers"

Codes	Concepts	Themes
"Not the norm" "Ginny pigs" "Marriage" "Mistrust" "Don't look like us can't help" "Stigma" "Never seen" "We don't talk about it" "Just deal with it", "Reluctant" "Prayer" "God can fix it" "Cover up" "Prayer" "Reluctant" "Mistrust" "Stigma"	Social Factors Preventing Use of Family Therapy& Treatment	**Cultural Barriers**

Table 4 Continued

C. "Cause of Mental Strain"

Codes	Concepts	Themes
"PTSD" "Grief" "Abuse" "Incarceration" "Missing parents" "Addiction" "Hurricane" "Relationships"	Conditions that Necessitate Family Therapy	**Cause of Mental Strain**

D. "Coping Mechanisms"

Codes	Concepts	Categories
"Ignore" "Eat" "Anger" "Cry" "Shut down emotionally" "Talk then explode" "Spirits" "Prayer" "Turn it over to God" "Hold it in" "Smoke and drink" "Shop" "Exercise"	Alternative Ways of Dealing with Mental Strain or psychological dysfunction	**Coping Mechanism**

Table 4 Continued

E. "Cultural Support"

Codes	Concepts	Themes
"Church family" "spiritually mature sisters in Christ" "God" "the Lord" "I pray" "I have a wife to talk to" "counselor" "psychiatrist" "therapist" "my mother"	Kinship & Religion	**Cultural Support**

F. "Cultural Communication"

Codes	Categories	Themes
"We don't" "As a culture we've been taught to keep things inside our home" "do not discuss or take them anywhere" trying to find somewhere to fit in" "we are a people of heart if we don't feel it" "keep to ourselves" "someone identifying that your crazy", "Ignore it" "Covering it up" "Don't admit issues"	Collective in thought/Collectivism	**Cultural Communication**

The research confirms that the research participants know that family therapy exists as a possible intervention and resource, but failed to mention it for various reasons. The responses indicate that mental health issues exist among all races, including African Americans (U.S. Department of Health and Human Services, 2013). However, in very few instances of the current focus group responses did the *in vivo* codes reflect that African American participants considered family therapy as a treatment option that they would utilize when faced with mental strain or psychological dysfunction. Generally, participants chose family therapy and treatment as a last resort.

The *in vivo* and holistic coding suggest that this group of research participants cope with mental strain by exercising, eating, shopping, smoking, drinking, holding it in, turning to God, and shutting down emotionally. The research participants also reference terms such as "prayer," "turning over to God," and "ignore" which suggests that these interventions are acceptable within the African American culture. The failure to list family therapy as a possible resource underscores their perceptions that family therapy and treatment may be culturally inappropriate and somehow incompatible with their worldview and way of life. The findings indicate that African Americans' attitude towards family therapy is one of indifference, which may be due to the absence of culturally sensitive definitions.

The second issue that emerges from the findings relates to the prominence of the extended family model in addressing social problems at the family level. The codes on

the concept of cultural communication suggest that the respondents attach value to the involvement of the extended family in addressing problems that might necessitate the involvement of family therapists. These codes demonstrate that the respondents see the extended family model as the most appropriate strategy for dealing with the types of challenges that might require family therapy. The responses suggest that the respondents' definition of the extended family includes blood relatives and non-blood kin. Therefore, non-blood kin like church leaders, respected friends, and African American community leaders can become members of the extended family that they turn to when dealing with problems that require family therapy treatment.

Summary

In this qualitative study, the researcher collected and analyzed data collected from three separate focus groups. A total of 18 African American participants from different educational and demographic backgrounds shared the way they regard, understand, and interpret family therapy, mental illness, and treatment seeking behavior in their communities. The researcher identified six themes based on African Americans' perceptions to family therapy and treatment, including cultural understanding, cultural barriers, cause of mental strain, coping mechanisms, cultural support, and cultural communication.

Chapter V

DISCUSSION

This research study examined the perceptions of African Americans regarding family therapy and treatment utilization. This study was designed to explore culturally competent ways of engaging the African American community, be supportive of cultural traditions and to increase family therapeutic service utilization. The study also encourages the development of more inclusive and culturally sensitive practices that influence treatment-seeking behaviors for African Americans and all minority families.

This study explores cultural factors that shape the African American community. Focus groups were conducted in various African American communities in Texas. Focus group participants were asked about their perceptions of family therapy and treatment as it pertains to barriers of service utilization. Several observations were made from focus group sessions regarding the research question: how do African Americans' perceive family therapy and treatment? Six broad themes emerged during the coding process.

Themes

Through the analysis of participant data, six themes related to African American perceptions of family therapy and treatments were generated. This researcher identified the following themes: cultural understanding, cultural barriers, cause of mental strain, coping mechanisms, cultural support, and cultural communication.

Cultural Understanding

A key finding of this study was the significant role of the family in perceptions of family therapy and treatment in the African American community. Participants discussed how their families viewed family therapy and treatment using responses such as "crazy, issues," "resistance, stays in this family," and "telling our business" (see table 3). This suggests that African Americans as a culture have been taught to keep things within their homes/private lives, rules of the family and family loyalty are sacred, and what family members think affect behavior. This infers that having culturally sensitive definitions that support African American experiences may encourage more help-seeking behavior.

Cultural Barriers

There are many factors that are related to the underutilization of family therapy and treatment for African Americans. Participants reveal factors such as, "Ginny pigs," "mistrust," "stigma," "just deal with it," and "reluctant." The focus group participants revealed that they were influenced by family dynamics or historical events that have shaped their attitudes and behaviors regarding family therapy. Findings of African Americans' doubt of the effectiveness of family therapy and their reluctance to participate in family therapy treatment is consistent with arguments suggesting family therapy is not a culturally appropriate treatment option. Scholars report that African American women have a strong preference for interventions and use of informal coping mechanisms such as family, friends, and church (Ward, Clark, & Heidrich, 2009). Studies also suggest that

African Americans will avoid treatment options that are perceived as ineffective because of their incapacity to accommodate the unique needs of the culture (Spiegler & Guevremont, 2009).

Cause of Mental Strain

There are broad systemic factors that impact African Americans. The long legacy of slavery and discrimination continues to affect and influence treatment-seeking behaviors among African Americans (Carten, Siskind, & Green, 2016). African Americans have used adaptive traditions as they navigate through hardships. A lingering discriminatory behavior continues to influence the economic and social standing of African Americans (USDHHS, 2001). Many scholars report that African Americans have developed their own cultural guidelines in an effort to interact with society, which includes larger care institutions, in order to cope with perceived racial prejudices (Davey & Watson, 2008). Conditions that affect African American or cause mental strain include PTSD, grief, abuse, incarceration, missing parents, addiction, hurricane, and relationships as reported by focus group participants.

Coping Mechanism

The *in vivo* codes suggested that this group of research participants cope with mental strain by exercising, eating, shopping, smoking, drinking, holding it in, turning to God, and shutting down emotionally. The research participants also reference terms such as prayer, turning over to God, and ignore. This suggests that these interventions

are acceptable within the African American culture. Research indicates that African Americans suffer from the same cognitive disorders as other racial and ethnic groups in the U.S. but, family therapy does not appear to be a coping strategy for African Americans (Ward, Clark, & Heidrich, 2009).

Cultural Support

Faith and spirituality in the African American community provide a great deal of strength and support. African Americans rely on faith, family, and social communities for emotional support rather than health care professionals (NAMI, 2016). Research shows that African Americans are resilient, rely heavily on family and church for support, and have negative views of the use of family therapist and other mental health professionals in times of difficulty (Boyd-Franklin, 2003). When asked about who they used for support participants responded with, "church family," "spiritually mature sisters in Christ," "God," "the Lord," "I pray," "I have a wife to talk to," "counselor," "psychiatrist," "therapist," and "my mother".

Family plays a key role in the mental health of African Americans. The role of religion and spirituality provide strength to African Americans and many other cultures. For African Americans, spiritual and religious practices have been associated with positive family ties (Kelly, Maynigo, Wesley& Durham, 2013). African Americans have been identified as being more religious than other racial and ethnic groups (Newport, 2012; Sahgal & Smith, 2009).

Cultural Communication

When addressing the question of how does your family or community communicate about family therapy or mental health issue one participant responded, “we don’t.” More responses regarding communication regarding mental health, family therapy and treatment were, “as a culture we’ve been taught to keep things inside our home,” “do not discuss or take them anywhere,” “trying to find somewhere to fit in,” “we are a people of heart if we don’t feel it,” “keep to ourselves,” “someone identifying that your crazy,” “ignore it,” “covering it up,” and “don’t admit issues.”

Theory Connection

The review of Bronfenbrenner’s (1979) ecological systems and its application to the African American culture offered insights into the salient features of the African American culture. Bronfenbrenner (1979) posited that an analysis and comparison of the micro-systems, the meso-systems, and the exo-systems that characterize different religious, ethnic, and social groups is essential to determine the ecological properties of the cultures. While using the ecological systems theory to evaluate the African American culture, Billingsley (1992) discovered that the African American nuclear family was akin to an “intimate association” of individuals related by informal adoption, formal adoption, marriage, and blood. This description offered insight into the nature of the family relationships that exist within the African American society. The description suggested that the African American family is close-knit. African American

members of the same family will share a strong bond and have common interests. In fact, their bond will be similar to that of a man and woman in an intimate relationship.

The presence of strong bonds suggests that members of African American families will come to the aid of their relative and protect them from ridicule where mental health problems are causing a strain in the family. The protectiveness of the members of the African American family will influence them to avoid interventions that will draw attention to the behavior of one member of the family. They will avoid such interventions because they perceive such attention as betrayal despite the needs of the family member. This is the main factor that explains the responses that African Americans gave when asked the types of actions they would take when faced with a mental health problem. Focus group participants reveal that they exercise, shop, hold it in, smoke and drink, prayer, turn it over to God, and ignore. Each of the interventions represents an attempt to react in a way that does not draw attention to the family member or individual whose cognitive disorder is creating a strain on the family. The private nature of the reactions of the respondents suggests a desire to deal with the mental health problem in a way that does not lead strangers to learn about it. These *in vivo* codes confirm the intimate character of the African American family and the influence of that intimacy on the solutions that African Americans recommend for dealing with mental health problems (see table 3). The intimate character of the African

American family influences them to opt for solutions that do not embarrass or draw undue attention to the family member with the mental health issues.

Other distinguishing features of the African American culture include authentic communication, genuineness, and solution-oriented therapy sessions. African Americans value authentic communication and genuineness because they perceive it as evidence of a person's respect towards them and their family members. Authentic communication and genuineness are evidence of the therapist's respect for their needs and unique circumstances (Rathod, Kingdon, Pinninti, Turkington, & Phiri, 2015). A therapist can demonstrate genuineness and authentic communication by discussing the problem from a cultural standpoint, asking the clients how they would want their therapist to address them, and by addressing individuals by their titles throughout the therapy session (Rathod et al., 2015). The solution-oriented therapy suggests a therapeutic relationship that focuses on solutions rather than the weaknesses of one of the members of the family. Their intimate association means that they will protect family members against situations that may lead to the development of undue attention on them. Therefore, they will avoid statements that lead them to lay the blame on one person. This implies that the therapist must implement a vertical relationship to provide solutions to many of the things that are afflicting the family.

Additionally, the presence of the extended family model suggests that African Americans believe extended family is an important component of family therapy and

treatment. Indeed, sociohistorical evidence suggests that African American families have strong cultural values and filial piety is a core component of the cultural value (Dilworth-Anderson & Goodwin, 2005). Filial piety is the tendency to seek the guidance of mothers, fathers, elderly relatives, church leaders, and respected opinion leaders to resolve problems that arise at the family level. The filial piety culture has been an influence behind African Americans' dependence on the extended family for the functioning of their families. Under the extended family model grandparents, elderly relatives, and other respected members of the culture care for their sons, daughters, and grandchildren. Older grandchildren, sons, and daughters give back by sharing their homes with their middle-aged children and grandparents (Dilworth-Anderson & Goodwin, 2005). Elderly parents, church leaders, and other opinion leaders reciprocate by providing guidance and mediation to resolve family problems. Their affinity towards this model suggests that they would family therapy treatments based on the extended family model.

Limitations

Limitations of the current study should be noted. Limitations included focus group participants who met the research criteria for this study were 25 years of age or older, self-identified as African American, and lived in the state of Texas. African Americans were the only racial population recruited for exploration of perceptions of family therapy and treatment. Because this was qualitative study using a

phenomenological lens, no research tool was utilized. The sample size is limited and not a representation of all African Americans perceptions of family therapy and treatment. This qualitative study was limited to 18 participants who were all recruited from African American owned businesses in the community.

Another limitation was the lack of random sampling. A random approach counteracts charges of researcher bias in the selection of participants (Shenton, 2004). Limitations were also noted in the major data collection strategy. The use of different methods was limited to only focus groups as a data collection strategy. Triangulation of this data could have also been supported using frequent debriefing sessions, peer scrutiny and member checks (Shenton, 2004). Future efforts should include a broad range of overlapping methods that demonstrate creditability and dependability in the data collection procedures.

Implications for Future Research

Despite the limitations, the present study contributes to research and practice of family therapy in African American communities. The study identifies African Americans' perceptions of family therapy and treatment as it pertains to key barriers of service utilization. This research presents an invaluable insight into the perceptions of African Americans regarding family therapy and treatment and identifies cultural behaviors that suggest that African Americans will avoid treatment options ineffective for their culture.

This study reveals the major role that culture plays in coping styles and strategies endorsed by the African American community. It reveals that African Americans have strong cultural factors that shape their attitudes and beliefs regarding seeking family therapy and treatment-seeking behavior. Understanding the impact of racism, social injustice, and cultural behaviors of African Americans is essential to address the barriers that impact their mental health. These barriers identified highlight future research opportunities to expand knowledge and understanding while creating strategies that will capture the African American audience and increase family therapy service utilization and treatment.

This study also highlighted the African American culture and family behavior, revealing strong cultural values and filial piety. Filial piety suggests respect owed to parents, elders, church leaders and respected leaders in the community. The African American church has historically been a safe haven where many African Americans receive community support (Bilkins, Allen, Davey, & Davey, 2015). As an extension of the African American family, church leaders are becoming the gatekeepers who can facilitate mental health, family therapy and treatment seeking services (Bilkins et al., 2015). Researchers have reported that African Americans tend to trust and find comfort in the church community versus outside services, therefore clinical providers and therapist should openly discuss therapeutic issues with respected clergy in the African Ameri-

can community (Bilkins et al., 2015). Church leaders and clinicians should develop a more collaborative partnership to better meet the needs of the African American community.

Summary

The study identified African American perceptions of family therapy and treatment as it pertained to key barriers of service utilization. The research explored perceptions that revealed internal and external factors that prevent treatment-seeking behavior in the African American community. An analysis of participant responses revealed six themes: cultural understanding, cultural barriers, cause of mental strain, coping mechanisms, cultural support, and cultural communication. The participants also identified the role of historical trauma and how it has influenced current barriers. The results were consistent with previous research that has identified African Americans as reluctant to seek family therapy and treatment. Based on the information provided, it is imperative that barriers are addressed and culturally competent services to all mental health clients are provided.

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APPENDIX A

Institutional Review Board Letter

Institutional Review Board
Office of Research and Sponsored Programs
P.O. Box 425619, Denton, TX 76204-5619
940-898-3378
email: IRB@twu.edu
http://www.twu.edu/irb.html

DATE: July 31, 2017

TO: Ms. Dauphine Billingsley
Family Sciences

FROM: Institutional Review Board (IRB) - Denton

Re: Approval for A Qualitative Study: African Americans' Perceptions of Family Therapy & Treatment (Protocol #: 19632)

The above referenced study has been reviewed and approved by the Denton IRB (operating under FWA00000178) on 7/28/2017 using an expedited review procedure. This approval is valid for one year and expires on 7/28/2018. The IRB will send an email notification 45 days prior to the expiration date with instructions to extend or close the study. It is your responsibility to request an extension for the study if it is not yet complete, to close the protocol file when the study is complete, and to make certain that the study is not conducted beyond the expiration date.

If applicable, agency approval letters must be submitted to the IRB upon receipt prior to any data collection at that agency. A copy of the approved consent form with the IRB approval stamp is enclosed. Please use the consent form with the most recent approval date stamp when obtaining consent from your participants. A copy of the signed consent forms must be submitted with the request to close the study file at the completion of the study.

Any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any adverse events or unanticipated problems. All forms are located on the IRB website. If you have any questions, please contact the TWU IRB.

cc. Dr. Karen Petty, Family Sciences
Dr. Joyce Armstrong, Family Sciences
Graduate School
Dauphine Billingsley

APPENDIX B

Approved Focus Group Locations

2306 Texas Pkwy, Missouri City, TX. 77489
346-980-4188

June 3rd, 2017

To whom it may concern

I give permission to Dauphine L. Billingsley, doctoral student at Texas Woman's University to conduct research to examine and explore African Americans' perceptions of family therapy treatment as it pertains to key barriers of service utilization at my facilities located at 2503 Texas Pkwy, Missouri City, TX. 77489.

Graylen Houston

Graylen Houston
President
EFIN: 797505
P01906921

360 Tax Group, LLC
2306 Texas Parkway
Missouri City, TX. 77489
graylen@360taxgroup.com
346-980-4188 office
561-667-6615 Cell

Raimon's Salon de Beaute' home of

May 24, 2017

Linda Pickney, Owner
Raimon's Salon de Beaute'
11902 S. Gessner Rd.
Houston, TX 77071

Re: Research

Dear Owner:

I am currently enrolled in the doctoral program at Texas Woman's University in Denton, Texas, and am in the process of writing my dissertation. I am writing to request permission to recruit participants from Raimon's Salon de Beaute" to participate in my research study entitled A Qualitative Study: African American Perceptions of Family Therapy and Treatments. The purpose of this research study is to examine and explore African Americans' perceptions of family therapy treatment as it pertains to key barriers of service utilization.

If permission is granted, it is my hope to recruit African American participants who are 25 years and older, identify as being African American, reside in Texas and who voluntarily agree to participate in this study. My data collection method may include some or all of the following: focus group, audio recording, observations, and/or individual interviews.

If approval is granted, in a quiet, private location participants will discuss questions regarding the research topic in a group setting of between 6-8 participants for approximately 60 to 90 minutes. Confidentiality will be discussed within the constraints of a group setting and participants will be asked not to share information outside of the focus group.

Recruitment flyers will be posted, volunteers meeting the research criteria will be contacted via phone regarding the date and time of the focus group. Participants will be asked to sign a consent form prior to taking part in this focus group. Light refreshments will be served, a random drawing for a $25 Visa gift card and one person will be randomly selected to complete an individual interview.

Sincerely,

Dauphine L. Billingsley
Doctoral Student Texas Woman's University

To whom it may concern

I give permission to Dauphine L. Billingsley, doctoral student at Texas Woman's University to conduct research as described above at this location.

Linda Pickney 5-26-17
Signature Date

FRESH START
COMMUNITY CHURCH

14556 Almeda Road | Houston, Texas 77053 | (713) 654-8998 | www.freshstartchurchhouston.org

REQUEST

May 26, 2017

Troy T. Johnson, Senior Pastor
Fresh Start Community Church
14556 Almeda Rd.
Houston, TX 77053

Re: Research

Dear Pastor Johnson,

I am currently enrolled in the doctoral program at Texas Woman's University in Denton, Texas, and am in the process of writing my dissertation. I am writing to request permission to recruit participants from Fresh Start Community Church to participate in my research study entitled A Qualitative Study: African American Perceptions of Family Therapy and Treatments. The purpose of this research study is to examine and explore African Americans' perceptions of family therapy treatment as it pertains to key barriers of service utilization.

If permission is granted, it is my hope to recruit African American participants who are 25 years and older, identify as being African American, reside in Texas and who voluntarily agree to participate in this study. My data collection method may include some or all of the following: focus group, audio recording, observations, and/or individual interviews.

If approval is granted, in a quiet, private location participant will discuss questions regarding the research topic in a group setting of between 6-8 participants for approximately 60 to 90 minutes. Confidentiality will be discussed within the constraints of a group setting and participants will be asked not to share information outside of the focus group.

Recruitment flyers will be posted, volunteers meeting the research criteria will be contacted via phone regarding the date and time of the focus group. Participants will be asked to sign a consent form prior to taking part in this focus group. Light refreshments will be served, a random drawing for a $25 Visa gift card and one person will be randomly selected to complete an individual interview.

Sincerely,

Dauphine L. Billingsley
Doctoral Student Texas Woman's University

To whom it may concern

I give permission to Dauphine L. Billingsley, doctoral student at Texas Woman's University to conduct research as described above at this location.

Signature Date

"It is of the LORD's mercies that we are not consumed, because his compassions fail not. They are new every morning: great is thy faithfulness." Lamentations 3:22-23

APPENDIX C

Recruitment Flyer

VOLUNTEERS WANTED FOR A RESEARCH STUDY

AFRICAN AMERICANS' PERCEPTIONS OF FAMILY THERAPY & TREATMENT

Be a part of the conversation

- **Are you African American?**
- **Are you 25 years of age or older?**
- **Do you reside in the state of Texas?**

If you answered YES to these questions, you are eligible to participate in this research focus group. Participation is voluntary, and participants may withdraw at any time without penalty.

The purpose of this research study is to examine and explore the way African Americans regard, understand, and interpret family therapy and treatment seeking behavior in their communities.

Your participation will help address the gap in research of African Americans' perceptions, and attitudes towards seeking family therapy treatment and possible barriers of service utilization.

Please feel free to attend one of three focus groups that will be conducted in private community locations. The maximum time commitment is approximately 2 hours; 30 minutes to complete the consent and demographic forms as well as 60 – 90 minutes per focus group.

Participant names will be entered into a random drawing for a chance to win a $25 Visa gift card. Three separate Visa gift cards will be awarded, one per focus group. Refreshments will be served.

For more information please contact Dauphine Billingsley at (281) 777-5033 or Dr. Joyce Armstrong (940) 898-2690 or jarmstrong@twu.edu.

Your participation is greatly appreciated.

Please note that there is a potential risk of loss of confidentiality in all email, downloading, and internet interactions.

Appendix D

Consent to Participate in Research

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title: *A Qualitative Study: African Americans' Perceptions of Family Therapy and Treatment*

Investigator: Dauphine L. Billingsley, B. A., M.A., M.S., LPC **Phone:**(281) xxx-xxxx

Advisor: Joyce Armstrong, Ph.D. **Dept:** Family Sciences **Phone:** (940) 898-2690

Explanation and Purpose of Research

You are being asked to participate in a research study for Ms. Billingsley's dissertation at Texas Woman's University. The purpose of this research is to explore African Americans' perceptions of family therapy and treatment as it pertains to key barriers to service utilization. Specifically, this study will examine the way African Americans regard, understand, and interpret family therapy and treatment seeking behavior in their communities.

Research Procedures

For this study, focus groups will be selected as the instrumental method for gathering information. Three separate focus groups will be organized. Each group will be comprised of five to seven members: male, female or both, participants 25 years of age and older. The focus groups will be conducted at an approved and convenient community site in a private area. All focus groups and will be audiotaped. The purpose of audiotaping is to provide a transcription of the information discussed in the focus group and/or interview and to assure accuracy in transcribing.

The PI will explain the consent form in person and/or over the phone prior to their scheduled focus group. All participants who speak with the PI face to face regarding the study and agree to participate will be asked to complete and return the demographic and consent form at that time. Participants who contact the PI by phone and agree to participate in the study will be asked to choose a convenient community location to meet with the PI to complete the demographic and consent form prior to the focus group. The maximum time commitment for the focus group process is appropriately 2 hours. An estimated 30 minutes to complete the demographic form and sign the consent form prior to the focus group, as well as 60 – 90 minutes to complete the focus group. If a potential participant is unable to meet with the PI prior to the focus group to complete necessary documentation (consent form and demographic form) they should arrive 30 minutes prior to the start of the scheduled focus to complete necessary documentation to be allowed to participate. PI will contact participants by phone prior to their scheduled focus group as a reminder.

Potential Risk

Potential risks associated with your participation in this study include loss of confidentiality, fatigue, loss of time, possibility of emotional discomfort, loss of anonymity and/or coercion.

Confidentiality will be protected to the extent that is allowed by law. The focus group will take

_____
Participant Initial

place at a community site in a private area with five to seven participants.

All recordings, transcripts and notes will be stored in a locked file cabinet in the investigators office. The master list with code numbers will be stored separately from all other data in a locked file cabinet at the PI's private residence. All recordings will be deleted and/or erased within 4 years from the end of this study. If electronic transmission of information (i.e., email, internet, online meetings, etc.) is used during this study, please be advised that there is a potential risk of loss of confidentiality in all email, downloading, electronic meetings and internet transactions. Due to the nature of the focus groups, anonymity cannot be guaranteed.

Your participation in this study is entirely voluntary, and therefore I must advise you of the potential risk in your loss of time that it takes to attend this focus group and/or interview if chosen. The approximate time to complete a group and/or interview can last up to an hour or more. Let me assure you that your time and commitment with the assistance of this study is greatly appreciated. If you agree to participate and find the time constraints to be too difficult for you, please feel free to let the researcher know. You are free to withdraw from the study at any time.

You may potentially experience fatigue during the interview process. Please feel free to ask for breaks and/or refreshments during the group and/or interview process. There is a possibility of emotional discomfort or psychological harm to which you will be provided a list of agencies that may provide counseling, crisis intervention, and/or other services.

To prevent the possibility of coercion, it is imperative that you understand that your participation in this study is completely voluntary and you may choose to withdraw your participation at any time without penalty. At no time will the researcher, force you to participate in this study.

The researcher and/or facilitators will try to prevent any problem that could possible arise due to your participation in this research. You should advise the researcher and/or facilitators of any issue that may arise and we will attempt to resolve this matter. However, TWU is not liable or responsible for any issue that may arise by participating in this research. TWU does not provide medical services or financial assistance for injuries that may possibly occur during your participation in this research.

Participation and Benefits

Each group member will be entered into a random drawing for a $25 Visa gift card for your participation in this study. Three separate Visa gift cards will be awarded, one per focus group. This study will be designed to contribute to a better understanding of how social conditions contribute to the lack of more effective and culturally sensitive ways to address the therapeutic needs in African American communities. This information could further help build culturally competent organizations that provide better resources and possibly contribute to better family therapy service utilization by African American clients.

_____

Participant Initial

Right to Refuse or Withdraw

The decision to participate in this study is entirely up to you. You may refuse to take part in the study or withdraw *at any time* without affecting your relationship with the investigator of this

study. Your decision will not result in any loss of benefits to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely from the interview at any point during the process; additionally, you have the right to request that the interviewer not use any of your interview material.

Consent

You have the right to ask questions about this research study and to have those questions answered by me before, during, or after the research. If you have any further questions about the study at any time, feel free to contact me, Dauphine L. Billingsley at dauphine.billingsley@yahoo.com or by telephone at (281) xxx-xxxx. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Texas Woman's University Office of Research and Sponsored Programs at (940) 898-3378 or via e-mail at IRB@twu.edu.

Your SIGNATURE below indicates that you have decided to volunteer as a research participant for this study, and that you have READ, UNDERSTAND and have had the opportunity to ask QUESTIONS about the information provided above. You will be given a copy of this signed and dated consent form to keep. You may request study results after study close date.

Participant Signature: _____

Print Name: _____

Date: _____

APPENDIX E

Demographic Questions

Demographic Questions

Please circle the response that most accurately describes you, the PARTICIPANT.

Male or Female

1. **What is your ethnicity or race?**
   Asian
   African American
   American Indian
   Caucasian
   Hispanic/Spanish/Latino
   Other race, please list: _____

2. **What age group best describes you?**
   25 - 29
   30 - 39
   40 - 49
   50 - 59
   60 or older

3. **What is your highest level of education? Please list your professional title.**
   Some high school
   Completed high school
   Associates Degree: _____
   Professional License/Certification: _____
   Bachelors Degree: _____
   Masters Degree: _____
   Ph.D., law or medical degree: _____
   Other: _____

4. **What is your marital status?**
   Single
   Married
   Divorced
   Separated
   Widowed
   Other: _____

5. **Please rate your general perspective towards our current family therapy system on the following scale** (circle one):
   Very satisfied satisfied neutral not satisfied opposed
   1 2 3 4 5

Optional: Religion
Baptist Catholic Muslim Protestant Jewish Other: _____

APPENDIX F

Counseling Resources

COUNSELING RESOURCES

Family therapy America of Greater Houston: MHA Houston mhahouston.org

Peer Support: Free

- **Depression and Bipolar Support Alliance** (multiple locations)
  713-970-7000 www.dbsahouston.org

Counseling: sliding fee scale for services

- **Houston Galveston Institute** (By appointment or Walk-In Clinic on Saturdays with no appointment)
  713-526-8390 2990
  Richmond Ave., Ste. 530
  http://www.talkhgi.org/

- **Family Services of Greater Houston** (multiple locations)
  713.861.4849 - call for appointment

Comprehensive Family Therapy Care: will require an eligibility process, fee is income based

- Federally Qualified Health Centers (FQHCs) or other low cost clinics

Gateway to Care Navigators: dial 713-783-4146 to find the closest FQHC

- **Harris Health Behavioral Health Program** (multiple locations)
  Eligibility: 713-566-6509
  Appointments: 713-526-4243
  www.harrishealth.org

- **Legacy Community Health Services** (multiple locations)
  832.548.5000
  www.legacycommunityhealth.org

- **The Harris Center for Family therapy and IDD** (multiple locations)
  713-970-7070
  Eligibility: 713.970.4444

In the event of a psychiatric emergency:

- Dial 911 and request a Crisis Intervention Team or CIT Officer

- Go to MHMRA Neuropsychiatric Center (NPC) — 24-hour emergency psychiatric facility
  1502 Taub Loop Houston TX 77030
  713.970.7070

APPENDIX G

Focus Introduction

FOCUS GROUP INTRODUCTION & WELCOME

Good afternoon/evening and welcome to our session. Thank you for taking the time and agreeing to be part of the today's focus group regarding African American Perceptions of Family Therapy and Treatment. My name is Dauphine Billingsley. I attend Texas Woman's University and I am currently completing research for my dissertation on the subject of African American Perceptions of Family Therapy and Treatment. I would like to discuss and gather information from you about African American perceptions of family therapy and treatment. I would like to gain a better understanding of how African Americans regard, understand and interpret mental illness, treatment seeking behaviors and if needed ways to improve mental treatment.

There are no wrong answers but rather differing points of view. Please feel free to share your point of view even if it differs from what others have said. Keep in mind that we're just as interested in negative comments as positive comments, and at times the negative comments are the most helpful.

You will probably notice several recording devices, as disclosed in the informed consent to participate, we will be recording our session today because we don't want to miss any of your comments. People often say very helpful things in these discussions and we can't write fast enough to get them all down. We will use participant numbers as identifiers today, for confidentiality purposes. We will not use any names in our research.

We ask that your turn off all cellular devices. If you cannot and if you must respond to a call please do so as quietly as possible and rejoin us as quickly as you can.

Well, let's begin.

APPENDIX H

Focus Group & Probing Questions

Focus Group and Probing Questions

1. What is your understanding of family therapy?

   Probing Questions:
   What is your understanding of family therapy treatment?
   How does your family perceive family therapy and treatment?

2. What family dynamics or historical events have influenced your attitudes and behaviors regarding family therapy?

   PQ:
   Give me an example of an influenced attitude or behavior.

3. Thinking about circumstances that may cause severe stress or psychological dysfunction (mental strain), what are some of these circumstances?

   PQ:
   Let's list these on the flip chart.
   If you had to pick one, which circumstance would be the most severe, requiring family therapy or treatment?

4. How do you cope with life stressors?

   PQ:
   How effective are these coping mechanisms?

5. Whom do you use for support?

   PQ:
   How effective is your support?

6. How does your family and/or community discuss issues that may require family therapy treatment?

   PQ:
   If anything, what needs to improve?