WHY CHOOSE FAMILY THERAPY? AFRICAN AMERICAN ADULT EXPERIENCES THAT LED TO THEIR ENGAGEMENT IN FAMILY THERAPY

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

DEPARTMENT OF FAMILY SCIENCES

COLLEGE OF PROFESSIONAL EDUCATION

BY

FELICIA J. HOLLOWAY, B.S., M.A.

DENTON, TEXAS

MAY 2015

TEXAS WOMAN'S UNIVERSITY
DENTON, TX

March 30, 2015

To the Dean of the Graduate School:

I am submitting herewith a dissertation written by Felicia J. Holloway entitled "Why Choose Family Therapy? African American Adult Experiences that Led to Their Engagement in Family Therapy." I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Family Therapy.

Linda Ladd

Linda Ladd, Ph.D., Major Professor

We have read this dissertation and recommend its acceptance:

Department Chair

Accept:

Dean of the Graduate School

ACKNOWLEDGMENTS

First, I would like to acknowledge my family. Thank you to my wonderful husband, Daren, and children, Nasir, Nia and Amari for managing so well when I had classes, studying or writing to complete. Without your endurance and support, I would not have reached my educational goals. You are so loved and appreciated. I would also like to thank my mother, Edna Shelley, for always being there for me throughout my long education journey and babysitting when I needed to work or go on a date with my husband. You are the best.

Next, I would like to thank my committee, Dr. Ladd, Dr. LeFlore, and Dr. Armstrong. I appreciate your encouragement and patience as I balanced work, family and my educational pursuits. Your guidance and mentorship over the years have helped me grow as an academician and researcher. I only hope to be able to build an academic career that models the passion, commitment and kindness to students you all demonstrate so effortlessly.

Lastly, I would like to thank God for allowing me to use the gifts he gave me to edify him and do his work.

ABSTRACT

FELICIA J. HOLLOWAY

WHY CHOOSE FAMILY THERAPY? AFRICAN AMERICAN ADULT EXPERIENCES THAT LED TO THEIR ENGAGEMENT IN FAMILY THERAPY

MAY 2015

The purpose of this study was to examine the experiences of African Americans who choose to attend family therapy. African Americans are often overrepresented in groups that are most at-risk for psychological distress. Most African Americans do not utilize family therapy due to a variety of barriers and negative perceptions about family therapy. Despite the underutilization of family therapy by African Americans, some are overcoming barriers and negative perceptions and engaging in family therapy when distressed. A phenomenological study was used to gain a rich understanding of the experiences of those African American adults who attended family therapy. Through convenience sampling, 39 African American adults who had attended family therapy within 18 months of the study participated in the research. The following four research questions were addressed in the study: (1) How did adult African Americans decide to go to family therapy? (2) How did adult African Americans perceive family therapy before they entered therapy? (3) What were the motivating factors and/or challenges, if any, they experienced in their efforts to utilize family therapy? (4) How likely is it that

African Americans who attended family therapy will return to family therapy in the future?

Using an online anonymous survey, data were gathered and analyzed to formulate themes. Five themes were generated: (1) Life Experiences that Led to Family Therapy, (2) Negative and Positive Perceptions of Family Therapy, (3) Positive Experiences that Encouraged Participants' use of Family Therapy, (4) Factors that Caused Participants' Hesitancy in Attending Family Therapy, and (5) Commitment to Attend Family Therapy in the Future. In addition, coping mechanisms used before participants engaged in family therapy were identified, such as, talking to family members about the problem, avoiding the problem and relying on spirituality or religious practices. Also, participants' perceptions of family therapy before and after attending therapy were analyzed. This analysis provided evidence that a positive experience in therapy typically changed a negative perception of therapy to an affirmative belief in the therapy process. Likewise, it was found that a positive perception of therapy was further solidified by a supportive family therapy experience. Based on the findings, recommendations for overcoming barriers to family therapy and implications for future research are introduced.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

According to the 2010 *Income, Poverty, and Health Insurance Coverage in the United States* (U.S. Census Bureau, 2011) report, African American children and families are suffering from inequities at a far greater proportion than other Americans as the poverty rate among African Americans is the highest among all ethnic groups at 27.4%. In addition, the National Alliance on Mental Illness's (2009) *African American Community Mental Health Fact Sheet* states that African Americans are disproportionately represented in populations at risk for mental health issues including the homeless population, people incarcerated, children in foster care and the welfare system, as well as people exposed to violence.

With the unbalanced representation of African Americans among at-risk groups such as those exposed to violence or the impoverished, they are more likely to suffer from stress that is often related to mental health impairment (National Alliance on Mental Illness, 2009). In fact, economic stress in families is associated with a number of negative mental health outcomes for the children. These include higher degrees of anxiety and depression (Grant et al., 2000; Gutman, McLoyd, & Tokoyawa, 2005) as well as aggression and antisocial behaviors (Solantaus, Leinonen, & Punamaki, 2004). Similarly,

children who have witnessed domestic violence in their family tend to have behavioral and development issues, while among women who are battered, there is an elevated incidence of anxiety and depression (Price, Price, & McKenry, 2010). Clearly, the disproportionate representation of African Americans in these populations increases their likelihood of suffering from mental health challenges, such as stress, anxiety and depression.

Statement of the Problem

Although African Americans tend to have many challenges facing them that could lead to issues with mental health (National Alliance on Mental Illness, 2009), research suggests that they are less likely than White Americans to utilize mental health services (Ayalon & Young, 2005). A study conducted by Obasi and Leong (2009) found that among African American children the utilization of mental health services is significantly lower than White American children. Similarly, research has also suggested that strong racial ties and characteristics that would be considered strengths in the African American community, such as communalism, strong family bonds, and spirituality may serve as barriers to mental health seeking behaviors (Richman, Kohn-Wood, & Williams, 2007). In fact, research suggests African Americans appear to be more likely to use kinship ties and spirituality to cope with emotional distress than therapy (Boyd-Franklin, 2006). Despite the general underutilization of mental health services by African Americans, 8.7% of African American adults over the age of 18 used mental health treatment in 2008 (U.S. Department of Health and Human Services, 2010). In fact, Diala et al. (2001)

analyzed data from a national comorbidity study of over 8,000 US citizens and showed that African Americans suffering from depression were more likely to seek mental health services than White individuals suffering from depression. Similarly, a study by Cooper-Patrick and colleagues (1999) suggest that, among their sample of Baltimore residents pulled from a NIMH longitudinal study, African Americans increased their utilization of mental health services from baseline interviews to follow-up interviews. This opposing evidence concerning African Americans utilization of mental health services generates an area of interest that should be examined. Little research has been conducted to examine the experiences that lead African American adults to therapy and little research has been done on why some adults choose family therapy. Examining the experiences of African American adults who seek family therapy is needed to better understand the meaning and essence of this phenomenon.

Statement of Purpose

The balancing act between preserving and recognizing the strengths of the African American community and overcoming the barriers to African Americans utilizing mental health services is a complex enigma. With all of the health and well-being risk factors that can affect African American families' mental health, it is imperative to better understand the life experiences that bring these families to the therapy room. Through this phenomenological study, this researcher attempted to provide a strong illustration of the experiences of the small population of African American adults who participated in family therapy. More specifically, the investigator explored a

rich understanding of African Americans' experiences that led them to choose family therapy for the treatment of mental health issues. The information gained from this study will hopefully help support mental health providers and those directly working in the African American community to assist in their mental health, well-being and to encourage their engagement in therapy.

Theoretical Framework

Although much of the existing research on this topic does not cite a specific theoretical perspective, Bioecological Theory frames the examination of this phenomenon. Bronfenbrenner's Bioecological Theory (Bronfenbrenner & Morris, 2007) posits that human interaction and development occurs in a frame work of five contexts/structures: microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The microsystem is the lowest level and involves personal interaction such as individuals in a family or an individual and their community. The mesosystem is the relationship between multiple microsystems, such as the interaction between a family and social service system. The exosystem is the influence of environments on the individual/family unit that does not directly involve the individual. The macrosystem is the overarching societal culture and beliefs that influence the microsystem. Lastly, the chronosystem is one's interactions pertaining to time which includes how the historical period and one's developmental stage in life effects the individual (Bronfenbrenner & Morris, 2007).

The foundation of the research presented, within this dissertation, is rooted in this theory because the experiences of African Americans impact their help-seeking behaviors across the five bioecological system structures outlined by Bronfenbrenner and Morris (2007). For instance, the macrosystem, or overarching societal value system or beliefs surrounding people of African descent, tends to be one of "fear" as described by Keaton and Robertson (2004). In fact, Keaton and Robertson suggests that this belief may influence how mental health and law professionals interact with people of African descent thus negatively impacting African Americans' perception of the mental health experience and their motivation to embrace mental health providers as resources in time(s) of emotional disturbance. In addition, within the mesosystem context, the families' highly valued interaction with their church increases the likelihood that church is used as a resource to assist the family when mental health issues occur (Ayalon & Young, 2005; Boyd-Franklin, 2006). In addition, the racism and prejudice that occurs within the mesosystem structure between the family and law enforcement, welfare system, health care system, schools may result in negative expectations and biases which serve as a barrier to the families' utilization of these services (Keating & Robertson, 2004; Price, Price, &, McKenry, 2010). By using Bioecological Theory as a framework, this researcher examined the experiences of African Americans who have sought out family therapy to address their mental health needs and, in turn, explored how help-seeking experiences are related to the different systems within the theory (Bronfenbrenner & Morris, 2007).

In addition, to using the Bioecological System model, Billingsley's (1968) work was also utilized to frame this research from the perspective of the history of the African American experience. The history and experiences of African Americans in the United States provides a framework for understanding their lack of engagement in mental health services (Dixon, 1983). The African American experience in this country has been riddled with perilous obstacles in which the Black family has had to adjust in order to maintain its functioning. The history of most African Americans begins with their abduction and entrance in to the United States as slaves. Slaves were packed like cargo with no consideration of tribe or culture in ships and sent across The Middle Passage. The separation of tribes caused Africans to be unable practice and preserve their tribal connections and culture, thus making it imperative to adjust their behaviors to maintain the family system (Frazier, E. F., 1971).

Furthermore, the conditions which nurtured the slave tradition in America were founded on the systematic oppression and dehumanization of Africans. Although slaves were freed in 1865, racism, which perpetuated the marginalization of Africans prevailed (Franklin & Moss, 2010). African American families were deprived the ability to freely grow and flourish economically and politically in the United States. The lack of rights to economic and political opportunities has socially isolated African Americans from society and caused the family to be the foundation for health and well-being of its members (Frazier, E. F., 1971).

Andrew Billingsley (1968) described three overarching types of Black family structures: nuclear, extended, and augmented and describes how these structures are categorized based on who is included in the family. The nuclear family structure consists of a husband and wife or individual with children or a husband and wife without dependent children. The extended family structure includes couples or single individuals who have other relatives in their household. The last family structure includes families who have taken on non-related guest for an extended period of time. In addition, to family structures, Billingsley (1968) distinguishes three general functions of the family as *instrumental* or economic function and maintenance of boundaries (i.e. preserving inclusion of members in the family), *expressive*, which encompasses attributes such as family cohesion, belonging and love, and *expressive-instrumental* or the functions of propagation and caregiving of children. Each function encompasses a variety of activities that are characteristic of families, including maintaining shelter, sense of belonging, reproduction, etc. Billingsley (1968) does not suggest that certain family structures perform functions better than others, but that structures will adapt and change in an effort to fulfill the needs of the family.

Billingsley (1968) states that because of the historical experiences of racism and oppression of African Americans, the aforementioned family structures have unique demands to help circumvent the negative effects of this history and support the family's well-being. One of the preeminent demands placed on Black family functioning, due to their history of disenfranchisement from society, is racial socialization. Black families

must teach younger generations to understand, appreciate and navigate their Blackness in White society (Billingsley, 1968). This socialization process may include understanding White Americans may not be accepting of them, as well as gaining an appreciation for themselves and teaching them to "deal with white people (Billingsley, 1968, p. 30). In learning to navigate interactions with White people as a survival tool, parents may instill a sense of "hatred and fear (Billingsley, 1968, p. 31)" of White society and their institutions. The cultural beliefs perpetuated in the African American family functions to ensure survival of family's well-being in a society that is not inclusive, provides context as to why African Americans may not choose to engage in family therapy. The fear and caution of White institutions potentially taught in the racial socialization process may derail the openness to engage with mental health providers during African American families'' times of distress. This aversion to White institutions may cause families to rely on themselves in time of mental distress and utilize other coping skills such as God and prayer. Utilizing Billingsley's (1968) research on the functioning of Black families, this researcher examined the experiences of African Americans who choose to attend family therapy.

Lastly, a phenomenological approach was utilized in this research. Creswell (2014) states that a phenomenological methodology seeks to describe the nature and characteristics of a specific phenomenon through the experiences and perceptions of the individuals experiencing the unique circumstance. This methodology allows for the perspective of the research participants to be the central component to the understanding

of the phenomena, usually through the use of in-depth interviews. By using phenomenological methodology, this researcher gained rich insight in the phenomena of African Americans who seek family therapy.

Research Questions

The following research questions were explored in this study:

1. How did adult African Americans decide to go to family therapy?
2. How did adult African Americans perceive family therapy before they entered therapy?
3. What were the motivating factors and/or challenges, if any, they experienced in their efforts to utilize family therapy?
4. How likely is it that African Americans who attended family therapy will return to family therapy in the future?

Central questions

1. What experiences led adult members of African American families to choose family therapy?
2. What perceptions about therapy did African Americans hold prior to going to family therapy?
3. What challenges did African Americans experience when initially considering engaging in family therapy?
4. What positive experiences encouraged African American families to initially engage in therapy?

5. What experiences did African Americans families have with other resources/coping skills to address their issue prior to pursing family therapy?
6. How did the experience of utilizing therapy increase or decrease the likelihood of African American families choosing therapy in the future?

The increased risk of mental health issues that impact the African American community and the research that documents the underutilization of mental health services such as family therapy led this researcher to the research questions listed above. This study addressed these questions and provides a descriptive picture of the experiences that motivated African American adults to attend family therapy. In addition, this study gives some insight into the meaning of the lived experiences of African American adults as they are choosing therapy as a treatment for mental health issues.

Definition of Terms

The following definitions are applicable to this study and its purpose.

1. Mental health issue: An emotional or behavioral disturbance, life stressor and/or drug dependence problem identified by at least one member of a family (Nichols, 2012).
2. Family Therapy: Therapy facilitated by a licensed mental health professional that focuses on the family interactional patterns and subsystems and includes at least two family members (Vetere, 2001).

3. Family: An interdependent group intended to support each other economically and emotionally (Boyd-Franklin, 2006).
4. Licensed Mental Health Professional: Any individual currently fully or provisionally licensed as a Marriage and Family Therapist, Professional Counselor, Psychologist or Clinical Social Worker.
5. African American: An American of African and especially of Black African descent (*Merriam-Webster.com*, 2013*).*For the purpose of this study, the terms African American, Black and non-Hispanic Black are used interchangeably.

Delimitations

1. The study is limited to the examination of the experiences of self-identified African American adults who fit all of the following criteria:
    - Have not been court mandated to attend family therapy
    - Have actively sought and participated in family therapy for emotional/behavioral disturbances or alcohol and drug addiction of at least one family member
    - Have participated in family/couple therapy within 18 months of their participation in this study, but are not currently participating in therapy at the time of the study
    - Participated in therapy with a Licensed Mental Health Professional as defined by this study

2. Due to the unique cultural and historical experience of African Americans and the limited resources to advertise the study that were available to this researcher, the study was limited to African American adults living in the United States of America.

Person of the Researcher

The researcher is a Family Therapy PhD candidate at Texas Woman's University in Denton, Texas. In addition, the researcher is an African American woman who is married and the mother of three children. The researcher has experienced couples therapy with her former spouse and current spouse, both of whom are African American males. The researcher is the product of a single parent home and an extended family that, for the most part, is under educated and has experienced mental illness, poverty, domestic violence, drug and alcohol abuse, and multi-generational single parenthood. The researcher has seen firsthand the stressors that weigh on her own extended family because of the aforementioned challenges. Despite the resiliency of the researcher's family to overcome many stressors without the use of family therapy, in many cases, she openly acknowledges her personal bias towards the benefit of family therapy for African American families.

The researcher is keenly in tune with the challenges that face many African American families today and desires to explore the experiences of those families who choose family therapy as a resource for their health and wellbeing. The researcher is aware that her education, family, and past experiences frame her perception of the issue

of African Americans' help-seeking behaviors. The researcher conducted this study with a constant mindfulness of her biases in an effort to explore the phenomenon without the intrusion of her own judgment.

Summary

Historically, African Americans are less likely than White Americans to utilize mental health therapy as a tool for dealing with mental health issues (Ayalon & Young, 2005). The stigma associated with mental health diagnosis as well as counseling and inability to access counseling services are just a few of the obstacles obstructing African Americans from engaging in therapy (Hall & Sandberg, 2012; Connor et al., 2010; Thompson, Bazile, and Akbar, 2004). Beyond the many obstacles, strengths associated with the African American culture, such as strong family ties and reliance on spiritual beliefs also hinder many African Americans from going beyond the resources of family and church when attempting to manage a psychological challenge (Lindsey et al., 2006; Ayalon & Young, 2005). Although there is a strong body of research detailing the obstacles to engaging African Americans in therapy, there is little exploratory research examining the experiences of those African Americans who choose to utilize mental health counseling. This study provides a better understanding of the experience of those African Americans who do choose family therapy as a tool to assist with mental health issues.

CHAPTER II

LITERATURE REVIEW

The underutilization of mental health services and greater risk of mental health issues among African Americans is a complex problem that researchers have attempted to unravel. Current research on African Americans show that utilization of mental health services is low compared to White Americans (Ayalon & Young, 2005; US Dept. of Health and Human Services, 2010). Several barriers exist that help reduce the probability of African Americans engaging in therapy, distrust of White therapists, negative perceptions of therapy and heavy reliance on family and religious support (Boyd-Franklin, 2006; Obasi & Leong, 2009; Richman, Kohn-Wood, & Williams, 2007). These barriers, among others, have assisted in the disparity between African and White American mental health service usage. Yet, despite the barriers, a small growing population of African Americans is engaging in mental health services (U.S. Department of Health and Human Services, 2010). There is very little research on why African American's do choose therapy and little is known as to why they choose family therapy. A few studies suggest that among the African Americans who do use mental health services, many are court mandated to engage in these services (Akutsu et al., 1996; Takeuchi & Cheung, 1998).

Prevalence of Mental Health Issues and Utilization of Mental Health Services among African Americans

African Americans are suffering from mental health distress at a greater rate than non-Hispanic White Americans. According to the National Center for Health Statistics (2012), African Americans are 20% more likely than non-Hispanic White Americans to report serious mental health problems. In fact, according to the Summary Health Statistics for U.S. Adults: National Health Interview Survey 2010, non-Hispanic Whites were less likely to have feelings of sadness than on-Hispanic Blacks (Schiller, Lucas, Ward & Peregoy, 2012). Similarly, African Americans were also more likely than White Americans to feel everything in life was an effort on a daily basis.

Despite this increased level of mental health strain, African Americans are attending therapy at a far lower rate than White Americans (Ayalon & Young, 2005). According to the 2010 National Healthcare Disparities Report (U.S. Dept. of Health and Human Services, 2010); Blacks were significantly less likely to engage in treatment for depression than Whites. The research shows that only 56% of Blacks dealing with a depressive episode sought treatment versus 70.4% of Whites. Of the African Americans that do utilize mental health services, studies suggest that African Americans are more likely to be referred to mental health services through the criminal justice system than White Americans (Akutsu et al., 1996; Takeuchi & Cheung, 1998). Even among children, similar trends of underutilization of mental health services by African Americans families have been found. In fact, one study conducted using data from the

National Longitudinal Survey of Youth and the Child/Young Adult found that Latinos and African American children (n=1270) ages 14-22 were found to be less likely to utilize mental health services than White children, particularly if a father was present in the children's life (Zimmerman, 2005). Obviously, the disparity in mental health utilization among Blacks compared to Whites does not reflect the need for services among the African American population. This data illustrates not only the need for mental health services among African Americans, but the trend among this population to forgo counseling during times of psychological distress.

Barriers to Mental Help-Seeking Behaviors among African Americans

Research has shown that a number of factors, inhibit how African American utilize mental health services including mistrust of White therapists, reliance on family and church, and negative views of the use of mental health professionals in times of difficulties (Boyd-Franklin, 2006). Several studies, discussed below, have been done to identify some of the specific barriers to African Americans seeking professional psychological support.

Racial Identity and Culture as a Barrier

Research suggests that one of the factors related to African American underutilization of mental health services is cultural beliefs. For instance, many African Americans believe it is important to keep their family issues private. This cultural belief could potentially hinder African Americans from feeling comfortable seeking therapy (Thompson, Bazile, Akbar, 2004; Conner et al., 2010). In addition, appreciation of

internal strength and the ability to overcome adversity are traits associated with African American culture (Thompson, Bazile, Akbar, 2004; Conner et al., 2010). Research suggests these cultural values could lead to African Americans who consider therapy to feel weak and thus dissuade them from engaging in mental health services.

Since African Americans' cultural beliefs lean toward reliance on family and internal strength, for example, then it may follow that African Americans who are more immersed in their culture will be less likely to seek mental health treatment. In fact, one study provided evidence of this connection. The study examined the relationship between psychological distress, acculturation and mental health seeking attitudes of African Americans (n=130) found a negative relationship between psychological distress and therapist confidence (Obasi & Leong, 2009). Moreover, this negative relationship was found to be more robust for participants who had stronger ties to traditional African American cultural beliefs. The authors suggested that emphasis in the African American culture on strong family ties, spirituality and communalism could be a barrier to engaging in mental health services and a lack of confidence in psychological professionals. It is likely most African American lean on their spiritual beliefs and family during times of distress (Obasi & Leong, 2009).

Likewise, another study that examined the relationship between racial identity, discrimination, and mental health service utilization yielded similar results (Richman, Kohn-Wood, & Williams, 2007). In this study, Black adults (n=505) and White adults (n=450) from three counties in Michigan completed face to face interviews facilitated by

trained graduate students and professional interviewers. The interviewers asked questions related to discrimination experiences, racial identity, psychological distress, and mental health utilization. From the data gathered, the researchers found that among African American participants with low racial identity increased discrimination was related to the increased utilization of mental health services. In addition, high racial identity among African Americans was associated with low probability of utilization of mental health services.

This research definitely provides evidence that more research on African American racial identity, associated cultural beliefs and mental health service utilization needs to be explored in more depth. In fact, future research needs to examine how to engage African Americans in therapy especially when their level of acculturation and/or racial identity is high (Richman, Kohn-Wood, & Williams, 2007).

Stigma

Concern over the negative perception of therapy by African American community and family members has been documented by researchers as a barrier for many Blacks engagement in therapy (Murry, Heflinger, Suiter, & Brody, 2011; Thompson, Bazile & Akbar, 2004). Researchers have also found that African Americans feel internal negativity for accessing therapy in addition to experiencing negative reactions from others in their community (Hall & Sandberg, 2012). One study specifically compared differences in attitudes concerning mental health treatment among a sample of African Americans and White Americans (Connor, Koeske, & Brown 2009).

The authors wanted to determine how stigma affects the different racial groups' attitudes toward mental health counseling. Upon surveying 101 African American and White American older adults the authors found that African Americans had more negative attitudes about mental health therapy. The researchers also noted that African American participants lived in communities that found mental health treatment more stigmatizing than White communities (O'Connor, Koeske, & Brown 2009).

Similarly, Thompson, Bazile and Akbar (2004) conducted 24 mixed gender focus group discussions on mental health to examine the attitudes and beliefs of African Americans (N=201) in regards to psychotherapy and psychotherapists. Participants in this study stated that there was a stigma concerning mental illness as a whole that caused disgrace and humiliation. The participants noted that the aforementioned feelings were a serious impediment to engaging in mental health services.

Likewise, Murray, Heflinger, Suiter, and Brody's (2011), mixed method study on help-seeking behaviors of rural African American families also found stigma as a significant barrier to treatment. In fact, half of their participants acknowledged that stigma associated with mental illness would be a barrier to mental health treatment for their children. These participants were most concerned with the negative reaction of their family and community.

Access

Several studies have provided evidence that the cost of treatment and ability to access therapy are major barriers for African Americans in seeking mental health

treatment. For instance, in a mixed method study which examined the perceptions of mental health services by rural African American families of mental health services, researchers found a number of participants described their access to mental health services was minimal (Murry, Heflinger, Suiter, & Brody, 2010). Similarly, in a focus group study that examined the perceptions of 201African Americans of psychotherapy, cost of mental health treatment was deemed a significant barrier to engaging in therapy (Thompson, Bazile, & Akbar, 2004). Likewise, Connor et al. (2010) found that among African American depressed older adults they interviewed concerning their barriers to treatment and coping strategies, the participants indicated a lack of access as a challenge to seeking to mental health treatment. The researchers found that not only physically getting to mental health providers was an issue, but cost and lack of health insurance were also barriers for this population.

Importance of Family

Beyond racial identity and acculturation, family also plays a key role in the mental health of African Americans. Research suggests that friends and family members (Boyd-Franklin, 2006; Lindsey et al., 2006; Murry, Heflinger, Suiter, & Brody, 2011) are typically utilized by African Americans in time of psychological distress. In fact, Boyd Franklin (2006) suggests African American families have a sense of "reciprocity (p. 53)" that precipitates the practice of sharing goods, services and supporting each other in times of need. Similarly, one recent qualitative study examined the help-seeking behaviors of 18 depressed African American adolescent boys. The boys aged 14-18 were recruited

from both mental health centers and after school programs and were asked questions concerning their symptoms, topics related to their problem recognition as well as their perceptions and help-seeking of mental health services (Lindsey et al., 2006). The researchers found the youth tended to talk about their problems with their family, particularly their moms. When the male participants did not have a family support system, professional mental health services were sought. Apparently, according to the results of this study, family support systems could be another hindrance of African Americans utilization of mental health services. Likewise, Murry, Heflinger, Suiter and Brody (2011) also found that among the African American rural mothers in their study, family was the most frequently cited means of support if their children were experiencing emotional or behavior issues.

Significance of Religion

Religion or spirituality tends to play a central role in the lives of African Americans (Boyd-Franklin, 2006). A research study by Ayalon and Young (2005) compared the help-seeking behaviors among Black and White college students. The researchers analyzed the survey results of 137 participants and found significant differences in health seeking behaviors between the races. In fact, it was found that among their sample, the use of mental health services was significantly less frequent for Blacks compared to their White counterparts. In addition, the research determined African American participants utilized religious services more frequently than the White participants.

While the significance of religion in the everyday lives of African Americans has been well documented, prayer, talking to a pastor during difficult times and the belief that God will see you through trials in life has also been seen to be prevalent in Black culture (Boyd-Franklin, 2006; Murry, Heflinger, Suiter, & Brody, 2011). For example, Conner's at el. (2010) qualitative study on the beliefs of African American elderly dealing with depression, found participants cited relying on God as "the most culturally accepted strategy for dealing with depression" (p. 980). The strong connection to religion and spiritually in the African American community, cited in the aforementioned research, suggests many African Americans may utilize their spiritual connection when facing mental health issues.

Mistrust

Several attributes of African American culture have been cited in the research as hindrances to their utilization of mental health professionals. Beyond cultural issues, one study cited the Black experience in western cultures as having an impact on mental health utilization. Keaton and Robertson (2004) in London examined the relationship between fear and mental illness among people of African and Caribbean descent. This study was based on the premise that a "circle of fear" exists which is fueled by discrimination, racism and prejudice. This circle of fear leads to the mistreatment of Blacks in the mental health community as well as distrust of mental health services.

Using qualitative methodology and a purposive sample, the researchers found several sources of fear exist about mental health services among the participants. These

included: fear of the perceptions of utilizing mental health services, attitudes that mental health services are used as social control, and fears of experiences of hospital care. The authors also cited perceptions by mental health providers of Black as being negative. They suggested that many professionals believe Blacks are more violent and have a general fear of Blacks that is difficult for them to acknowledge (Keaton & Robertson, 2004). This fear can cause discriminatory practices by mental health professional that may cause inadequate service provision. As a result, the researchers found Blacks have limited trust of psychological professionals, limited engagement in mental health services and delays in seeking help.

Although this study was done in London and does not address African Americans specifically, because Europe and America have similar histories of prejudice and discrimination against people of color by the White majority, the research does give insight in to the Black mental health experience (Franklin & Moss, 2010). Also, since this study was based on interviews of a small group of Blacks living in London, it cannot be generalized to all people of African descent. Despite these limitations, this research in an excellent catalyst to begin more discussion on how racism, discrimination, and prejudice can fuel fear that leads to barriers to mental health utilization by African Americans.

In looking at African Americans two other studies have also demonstrated a level of fear about seeking mental health services (Williams, Domanico, Marques, Leblanc, & Turkheimer, 2012; Copeland & Snyder, 2011). Researchers have found African Americans tend to feel a therapist will not understand their experience and that they will

be treated more harshly when they are given a mental health diagnosis (Thompson, Bazile & Akbar, 2004; Conner et al., 2010). In addition, it has been found that when seeking mental health treatment, African Americans fear they will be diagnosed with more severe illness and risk being hospitalized or having their children removed from their care (Williams, Domanico, Marques, Leblanc, & Turkheimer, 2012; Copeland & Snyder, 2011).

Summary

All of the barriers that persistently hinder African Americans engagement in therapy may lead one to believe few if any African Americans utilize therapy at all. This may typically be the case; however, more African Americans are using mental health therapy than in the past (U.S. Department of Health and Human Services, 2010). The question then arises as to what leads those African Americans who choose therapy to seek mental health professionals as a resource, despite the many barriers that may inhibit their help-seeking. This study explored the experiences of African Americans who sought family therapy. In addition, this research helps gain an understanding of the barriers African Americans faced in utilizing family therapy and the experiences that led them to use family therapy despite the barriers.

One's first step to engaging African Americans in mental health services is gaining an understanding that this cultural group has specific characteristics that may impact their help-seeking behavior. The body of research cited in this review provided evidence that cultural beliefs and behaviors, such as close familial ties, and level of

acculturation and enculturation all play a role in Black peoples' help-seeking behavior. From this perspective, we can begin to see the need to delve into the distinctions associated with African American help-seeking behavior. As the research suggested, many of the strengths of African Americans culture such as strong racial identity, communalism, and strong family ties have been seen to serve as barriers to help-seeking behavior.

Obviously, a greater understanding of the factors that contribute to hindering the utilization of mental health services among African Americans is desperately needed a well as those circumstances that lead some African Americans to using therapy. This study examines the rich experiences and perceptions of African Americans who choose to engagement in therapy. With this study, the researcher contributes to the body of knowledge concerning African Americans help-seeking behaviors, in hopes of contributing to an increase in African Americans utilization of mental health services.

CHAPTER III

METHODOLOGY

Qualitative research seeks to explore a human issue in an effort to gain insight into its meaning. Creswell (2014) states that a phenomenological methodology seeks to understand and find meaning in a specific phenomenon. By utilizing a phenomenological methodology, this researcher examined the experiences and perceptions that led African Americans to choose family therapy as well as the barriers they overcame in pursuing therapy. Using an online survey, the researcher gathered demographic and narrative data from participants concerning the experiences that brought African American adults to family therapy. This chapter will describe the sample and the methodology of this study as well as the data analysis used to understand and describe the information gathered from participants.

Sample

The final sample consisted of 39 participants who met the participant criteria and completed all questions on the online survey. The criteria for participating in this study were as follows: one had to be an adult who was 18 years of age or older, African American, and living in the United States. In addition, individuals had to have participated in family therapy, their participation in family therapy could not be a result of court mandate, and their family therapy experience must have been no more than 18 months prior to participating in the study. The participants could not be in mental health

therapy at the time of the study. Participants had to have access to the internet, know how to use a computer, and be able to read and write on at least a 5th grade level.

Sample Recruitment

This researcher recruited participants using convenience sampling, a non-probability sampling in which one uses participants that are easily accessible to the researcher (Babbie, 2010). The researcher informed potential participants about the study using two methods: sending email notices via Texas Woman's University list serve and through social media posts on Facebook. The e-mail and social media post described the confidential study, explained the participant criteria for the study, requested qualified individuals to participate in the study by completing the on-line survey, provided instructions on how to access the survey online and informed the participants of the $10 Target gift card they could receive for completing the survey.

First, the researcher posted a notice on the Texas Woman's University Family Therapy Program and Alum public group Facebook page (Appendix A) in order to contact potential participants and/or therapists who might recommend this study to their past clients. Second, in order to contact potential participants, the researcher sent an email notice (Appendix B) to the TWU list serve which consists of students, faculty and staff. Participants were instructed to complete the survey (Appendix C) by going directly to the website provided in the email and Facebook notice. Upon going to the website each participant was able to read the participant criteria and consent to participate on the first page of the website. A total of 59 participants attempted to complete the survey. Of the

59 respondents, four participants were disqualified for not meeting the ethnicity requirement, one was disqualified for being in mental health therapy at the time in which they completed the survey, and 15 did not complete their survey in full, or did not answer questions appropriately, leaving the sample consisting of 39 participants. Any participant that completed the survey but their data could not be used due to ineligibility was notified via email that their data would not be used in the study.

Upon completing the survey, participants were informed on the survey conclusion page that they could request an executive summary of the study and their $10 Target gift card by going to a secondary website to enter additional identifying information. This second survey (Appendix D) requested the participant's name and address and asked if they would like an executive summary and/or a Target gift card. The researcher provided a thank you card and a $10 Target gift card via US mail using the information the participants provided on the secondary website survey.

Procedure

Protection of Human Subjects

The researcher followed all guidelines of the Texas Woman's University IRB review board and took all precautions to do no harm to the mental or physical well-being of the participants. IRB approval was obtained before beginning the study (Appendix E).The subjects of the study were provided with written information concerning the research, the participant requirements and expectations. On the first page of the website, participants were told that their completion of the online survey constituted their

informed consent. In addition, the first question of the survey requested subjects to acknowledge their understanding of the information on the first page, including the eligibility requirements to participate in the study, of the website and to consent in participate in the study by clicking on the option of yes. Participants were informed in writing that participation in the study was voluntary and they could withdraw from the study at any time without penalty. The researcher also addressed the potential risk to subjects of breach of confidentiality, fatigue, and distress caused by recalling difficult times in their past in the informed consent. Within the consent, subjects were provided with the researcher's email address and phone number. Information on when and how the participants would be provided with the results of the study and the incentive of a $10 Target gift card were described to the participants at the end of the survey as well as information about how to contact a mental health provider.

Data Collection

Step one. Potential participants received a participant recruitment email via the TWU list serve or Facebook post. The email and post provided potential participants with information about the study, the participant requirements, gift card incentive, and web link information to enter the survey online using the PsychData web platform. Each participant entered the online questionnaire via an internet accessible computer at their own disposal. Upon entering the online Psychdata website that housed the survey, participants were given a brief description of the study, the approximate time it would take to complete the survey (20-30 minutes), the participant eligibility requirements as

well as information concerning their consent to participate. Subjects were given the opportunity on the first page of the website to read about the study, acknowledge their understanding of the study and the subject requirements needed to participate as well as to consent to participate. Participants were informed that every effort would be made to keep their information confidential. At the end of the survey, the web address of a separate survey was provided and a link provided to that survey. Once in this separate online survey, subjects entered their name, address, and email address to request their $10 gift card and/or an executive summary.

Step two. After participants reviewed the first page of the survey and indicated their informed consent in the first question of the survey, they proceeded to complete a short demographic survey. The subjects were informed of eligibility requirements to participate in the study on the first page of the study and had to agree that they fit the criteria before entering the study; all participants in the final sample did meet the eligibility requirements. Participants were requested to provide the following information: ethnicity, educational level, income level, and marital status. Some participant data the researcher intended to collect were not gathered due to a late change the researcher made in the survey which caused the underlying logic in the order of several questions to be incorrect. This error caused seven questions to be deleted from the survey. The deleted questions concerned the following demographic information: gender, age, when they last attended family therapy, how they paid for family therapy, who attended family therapy with the participant, what position they held in the family

when they attended family therapy and approximately how many sessions of family therapy they attended. This researcher and her dissertation chair discussed the lost data to determine if this loss would prohibit the researcher from analyzing her data. It was determined that, while disappointing, the loss did not impact the integrity of the data. In addition, this researcher and her chair met with the TWU IRB chair to discuss the possibility of re-contacting the sample to request that they re-take the corrected survey. The chair advised against such a move as it meant a loss of confidentiality.

Step three. After participants completed the demographic section of the survey, participants answered six semi-structured open- ended interview questions that addressed the research questions and central questions (see Appendix F). This portion of the survey instructed subjects to answer six questions that focused on their thoughts and experiences both before and, then, after they completed family therapy 18 months ago. Questions appeared on the screen under two headings:

A. Before Therapy/Counseling *(Answer the following questions based on your thoughts and experiences before you entered therapy/counseling, within the last 18 months)*
    1. What were your general thoughts about therapy/counseling before you ever attended a therapy/counseling appointment?
    2. Within the last 18 months, what happened that led you to go to family or couple therapy/counseling?

3. Did anything in particular keep you from going to couples/family therapy, at first? If so, please describe what kept you from going, initially.
4. What other ways did you try to solve your challenges before you actually went to couples/family therapy?

B. After Therapy/Counseling *(Answer the following questions based on your thoughts and experiences after you stop attending family or couples therapy/counseling)*

5. Will you go to therapy/counseling again if you have another problem in the future? Why or why not?
6. Is there anything else you want to say about your experience in couples or family therapy? Please share your thoughts below.

Upon completing the survey, participants received a message stating that their survey was complete and were prompted to click a link which led to a separate website to provide their mailing address in order to request their gift card and an executive summary. In addition, this researcher provided information concerning how to locate a mental health provider or gain information about mental health.

Step four. Upon entering the second website, the participants were asked if they would like an executive summary and a Target gift card. If the participant answered "yes" to either question, they then provided their email address so the executive summary could be emailed to them and their name and mailing address so their gift card could be mailed to them. Once the participants submitted their responses to the brief survey, a

message appeared stating that their gift card would arrive in 6-8 weeks and the executive summary would arrive following the completion of the research.

Data Analysis

Qualitative research requires organizing the data, thorough reading and rereading of the data, identification of codes and themes in an effort to gain a deeper understanding of the data (Creswell, 2014). This researcher conducted three levels of coding with the data resulting in the identification of significant themes related to the research questions. Coding is the process of grouping data together based on similarities into categories in an effort to identify patterns in the data (Saldana, 2009). The results are illustrated utilizing tables that list the themes, coding, and quotations of the data provided from the survey.

The researcher downloaded the participants' answers from the primary and secondary surveys on the PsychData website onto two separate Excel spreadsheets. This researcher then assigned each participant an identification code using sequential numbering and the researcher's initials. The researcher reviewed the transcripts to eliminate participants who did not complete the survey, were ineligible or who did not answer the survey questions appropriately. The researcher created a coding system to label participant data that would be omitted from the study. The following reasons for omission include: all survey questions were not answered, surveys questions were only partially completed, participants did not answer questions appropriately, and surveys answers indicated that the participants did not meet the study's requirements. A column called "Unusable Data" was added to the raw data spread sheet to label participants using

this coding system. In addition, all participants who completed the survey and met the criteria were identified as a part of the final research sample by leaving blank the Useable Data column of the raw data spread sheet.

The researcher began coding of the subjects' answers to the open ended survey questions. The data from the primary survey was read and reread before pre-coding began. Pre-coding in qualitative research is the process of highlighting significant words or phrases that stand out to the research that can be retrieved later for higher levels of categorization (Saldana, 2009). This pre-coding helped to identify significant words and phrases related to the participants' experiences. The researcher changed the color font of significant words and phrases among the participants quotes for each of the questions. The researcher then re-read the data with particular attention placed on the pre-coding work and in doing so gained a deeper understanding of the participants' experiences leading to their utilization of family therapy.

Next, a second level of descriptive coding was conducted by categorizing pre-coding words or phrases into groups with similar meaning and assigning each group a code that described the participants' quotes (Saldana, 2009). These descriptive phrases and respective quotes were placed in a table in which all of the descriptive second level codes were listed in the first column with each row housing the respective codes' relevant quotes. This researcher then reread the data and created a process column that listed each participant's process of how they felt about therapy before and after their experience in family therapy. This column indicated whether participants had a negative, positive, or

indifferent perspective on therapy before seeking family therapy and how that perspective changed after utilizing therapy. This researcher also reviewed demographic data and created a chart of descriptive statistics of the participant population.

A third level of coding using the pattern second cycle coding method was then conducted. Pattern coding involves the researcher looking for explanation or more meaningful categories from the initial coding (Saldana, 2009). Using this process, the researcher developed themes that provided an overarching description of the participants' experiences that led to their engagement in family therapy. A second table was then created to organize the codes and quotes under their more explanatory themes. After the dissertation was successfully defended, the researcher distributed the executive summary to the participants who requested the information.

Validity

In an effort to increase the validity of this study, peer debriefing was utilized. Peer debriefing allows the researcher to have their own biases and beliefs about the data revealed through the examination and analysis of the data by an impartial peer (Lincoln & Gupa, 1985). This researcher's major professor conducted her own pre-coding of raw data and met with the researcher to compare their findings. After discussion, the findings were modified for congruency between both reviewers. Upon completing the second level of coding, the researcher's major professor reviewed the codes and data and, again, the two coders discussed the incongruences and agreement was achieved concerning the codes. Next, this researcher recruited a graduate student in the family therapy program to

validate the coding. This colleague had completed all of her PhD coursework and was knowledgeable concerning the qualitative methods used in the study to analyze the data. The colleague reviewed the second level of coding. The researcher and her colleague compared their findings and the codes were modified for congruency. Lastly, the researcher's major professor then reviewed the final themes with the researcher to ensure they accurately reflected the data.

Summary

Through the use of qualitative research methodology the experiences that led African Americans to utilize family therapy have been explored in this study. The sample was gathered through convenience sampling and the data gathered from the survey was analyzed for themes. Finally, peer debriefing, throughout multiple steps of the data analysis process, was conducted to ensure the themes accurately reflect the experiences of the participants. Through this methodological process, this researcher gained a rich illustration of why the Africans American subjects usurped traditional cultural coping mechanisms and pursued family therapy to assist with psychological stress.

CHAPTER IV

RESULTS

African Americans seeking family therapy are a significant phenomenon in that researchers suggest that this population does not typically seek therapy for a number of reasons including utilization of other coping mechanisms, such as extended family and spirituality (Boyd-Franklin, 2006). Despite many barriers, some African Americans are pursing therapy as a resource to deal with mental distress (U.S. Department of Health and Human Services, 2010). Utilizing a qualitative research design, this researcher examined the experiences that led African American adults to participate in family therapy. This researcher gained an understanding of the subjects' perceptions of therapy before they participated in it, their motivating factors for utilizing family therapy, their obstacles to participating in therapy, and their beliefs about therapy after therapy was terminated.

Through the use of demographic and open ended questions via an online survey, this researcher gained data from African Americans who had attended family therapy in the last 18 months. This data from the subjects online survey submissions was analyzed in an effort to gain a rich understanding of their experiences in choosing family therapy. This researcher's analysis of the data generated five themes encapsulating the participants' experiences: Life Experiences that Led to Family Therapy; Negative and Positive Perceptions of Therapy; Positive Experiences that Encouraged Participants' use

of Family Therapy; and Factors that Caused Participants' Hesitancy in Attending Family Therapy; and, Commitment to Attend Family Therapy in the Future.

Sample Demographics

The sample consisted of 39 individuals who identified as African American, lived in the United States, and were 18 years old or older. Gender and specific age of the participants were not captured due to a technological error that occurred when this researcher was making a final revision to the online survey. Of the 39 participants, all reported having earned at least a high school education, with the majority earning an associate degree or higher. In addition, the majority of participants (n=24) identified their marital status as single, while the next largest group (n=11) identified as being in a domestic partnership or cohabitating. Household income varied greatly with a few more than half of the participants (n=22) reporting that their income fell below $45,999 and less than half (n=17) reporting their income at $46,000 and above (see Table 1).

Table 1

Demographic Data of Participants

Education Level		Frequency n=39	Percent
	Some college	14	35.9%
	Associate degree/vocational training	7	18%
	Bachelor's degree	10	25.6%
	Graduate degree	8	20.5%
Marital Status			
	Single, never married	24	61.5%
	Married/domestic partners/cohabitating	11	28.2%
	Separated	1	2.6%
	Divorced	3	7.7%
Household Income			
	Less the $25,999	14	35.9%
	$26,000 to 45,999	8	20.5%
	$46,000 to 75,999	10	25.6%
	$76,000 to 150,000	7	18.0%

Findings

This researcher utilized open ended questions in an online survey format to gain retrospective information about the experiences that African Americans reported concerning their participation in family therapy. The following research questions were explored in this study:

1. How did adult African Americans decide to go to family therapy?
2. How did adult African Americans perceive family therapy before they entered therapy?
3. What were the motivating factors and/or challenges, if any, that they experienced in their efforts to utilize family therapy?

4. How likely is it that African Americans who attended family therapy will return to family therapy in the future?

Analysis of the participant data yielded six themes which are discussed below along with selected factors and Participants' Quotes. The five themes are as follows: Life Experiences that Led to Family Therapy; Negative and Positive Perceptions of Therapy; Positive Experiences that Encouraged Participants' use of Family Therapy; and Factors that Caused Participants' Hesitancy in Attending Family Therapy; and, Commitment to Attend Family Therapy in the Future.

Research Questions and Central Questions

Research question one. The first research question: *How did adult African Americans decide to go to family therapy?* yielded two central questions (CQ):

1. *What experiences led adult members of African American families to choose family therapy?* (CQ1)
2. *What experiences did African Americans families have with other resources/coping skills to address their issue prior to pursing family therapy?* (CQ5).

Participant responses to the question *What experiences led adult members of African American families to choose family therapy* generated one major theme, *Life Experiences that Led to Family Therapy*, and three subthemes: Life events that caused stress, Interpersonal relationship distress, and Intrapersonal emotional distress (Table 2).

Table 2

Theme: Life Experiences that Led to Family Therapy

Subtheme: Life Events that Caused Stress (n=18)	
Event	Participants' Quotes
Death n=2	*Sudden passing of my Dad.* (FH31) *My dad died a few years ago, but most recently my grandparents died. I was close to both of them.* (FH43)
Divorce/Custody n=5	*My parents recently got a divorce.*(FH33) *My family and [I] went through a custody battle.* (FH48)
Infidelity n=2	*Infidelity and unfaithfulness in a variety do areas.* (FH40) *My boyfriend and I had gone to couple's therapy because of trust issues ... due to infidelity.* (FH53)
Child runaway n=2	*We attend family therapy because my son decide[d] to run away from home.* (FH28) *[M]y daughter ran away from home because I told her she was not going to date a boy* (FH44)
Initial medical diagnosis n=4	*I was diagnosed with an ASD heart defect and pulmonary hypertension that led me to go to counseling.* (FH3) *My brother had a psychotic break...We went to family counseling and even individual counseling after his "incident" to support him.* (FH4)
Life transition n=3	*W[i]th a new baby, my husband and I felt that we needed to seek counseling to kind of find that balance within our marriage again* (FH24) *I started college and my boyfriend and I weren't with each [other]as often as we were in high school which took a toll on our relationship* (FH37)

(Continued)

Subtheme: Interpersonal Relationship Distress (n=15)	
Issue	Participants' Quotes
General relationship issues n=2	*Relationship issues. I wanted to rebuild my relationship.* (FH34) *Family issues.* (FH12)
Parent-child issues n=6	*My mother and I would have disagreements frequently. That affected the overall state of the household.* (FH38) *Me and mother'[s] relationship is extremely unhealthy… It was a point in my life when I thought I hated her!* (FH10)
Partner issues n=7	*I had disagreements with my partner and we felt we had lost compatibility. We argued over the least things…* (FH 22) *My spouse and I would argue a lot. I wanted to be right and so did he. We needed to find a way to communicate with each other without yelling and getting nowhere. It was horrible a lot of fighting, disagreements, and hurt feelings.* (FH2)
Subtheme: Intrapersonal Emotional Distress (n=5)	
Issue or event	Participants' Quotes
Stress and/or depression n=3	*I am emotionally not stable because I feel no one is here for me.* (FH29) *I had a lot on my plate and I was truly over loaded with several things.* (FH6)
Past events n=2	*I had a desire to address possible dormant issues I could have had as a result of my absent father.* (FH47) *The past experiences that I went through with my ex-boyfriend (abortions, emotional and physical abuse)* (FH57)

Central question five. The question (CG5) *What experiences did African Americans families have with other resources/coping skills to address their issue prior to pursing family therapy?* completes this researcher's focus on RQ1 *How did adult African Americans decide to go to family therapy?* Analysis of participant responses yielded fourteen types of coping mechanisms that occurred a total of 62 times in the narratives; these coping mechanisms were used in an attempt to solve their mental health problems before they engaged in family therapy (Table 3).

Table 3

Coping Mechanisms

Coping Mechanisms	Frequency
Talk to friends or family	15
Talk within the family	8
Avoid the problem	7
Religion/Spirituality: prayed, talked to a minister, read the bible, or church classes	6
Changed communication	5
Coping in isolation	4
Journaling	4
Individual/ premarital counseling/ marriage retreat	3
Put the child on punishment	2
Separation	2
Setting boundaries	2
Art	1
Charts and schedules	1
Read about the issue	1
No coping mechanisms were reported	1

Research question two. The second research question *How did adult African Americans perceive family therapy before they entered therapy?* yielded one central question: *What perceptions about therapy did African Americans hold prior to going to*

family therapy? (CQ2). Coding of the data yielded one theme: *Negative and Positive Perceptions of Therapy* and two subthemes: Negative perceptions of family therapy and Positive perceptions of family therapy. These two subthemes encompassed eight perceptions (five negative and three positive) that describe more specific motivations or experiences that were associated with the participants' perceptions of therapy. The five negative perceptions include: Therapy doesn't work to solve problems; Stigma concerning needing therapy; Strong desire for privacy; The therapist will not understand the individual or their problem; and Using family therapy is a sign of weakness. The three positive perceptions include: Strong confidence in the outcome of therapy; Affirmative beliefs about therapy as a whole; and Hesitancy but willingness to use therapy to solve problems (Table 4).

Table 4

Theme: Negative and Positive Perceptions of Family Therapy

Subtheme: Negative perceptions of family therapy	
Perceptions	Participants' Quotes
Therapy doesn't work to solve problems n=9	*I thought this would never work, it was only on TV and I could never find relief with talking to someone about my problems.* (FH12) *...number one thought of going to counseling sessions period was that it will never work…I assumed it wasn't going to do any justice in my life...* (FH57)
Stigma concerning needing therapy n=8	*I thought that individuals who sought out counseling service had problems.* (FH24) *Yes, most of us African Americans don't want the stigma of people looking at us and judging us from going and seeking that kind of help.* (FH44)

(Continued)

Strong desire for privacy n=3	*I had a lot of walls up I didn't trust people [from] my past so telling a complete stranger my feelings was very hard for me.* (FH16) *I was not interested and very hesitant. I felt that my life was place[d] on public display for all to see.* (FH28)
The therapist will not understand the individual or their problem n=3	*…family therapy was not for African American[s] and therapist[s] were not trained to deal with the cultural dynamics and historicity of African American families.* (FH8) *...people do not understand your side of the story. The counselor would not fully understand why you choose to do the things you do.* (FH29)
Using family therapy is a sign of weakness n=3	*I hated the idea of counseling and talking to someone. I felt as if I could handle everything myself I did [not] need anyone to tell me what to do.* (FH10) *I looked at this as being something negative because I didn't want to admit that I needed help.* (FH24)
Positive perceptions of family therapy (n=14)	
Strong confidence in the outcome of therapy n=6	*I've always felt that therapy is a good idea to deal with major life interruptions* (FH 49) *I thought counseling would be a great way to address some underlying issues in order to move forward and having better relationships with my family member…* (FH 50)
Affirmative beliefs about therapy as a whole n=6	*My thoughts about entering counseling were positive* (FH 56) *I viewed therapy as something beneficial to me, overall.* (FH38)
Hesitancy but willingness to use therapy to solve problems n=2	*I was somewhat skeptical about it all. I did not really know if it would make a difference.* (FH 53) *I was hesitant of attending a counseling session.* (FH 39)

Research question three. The third research question: *What were the motivating factors and/or challenges, if any, they experienced in their efforts to utilize family therapy?* developed in two central questions:

1. *What positive experiences encouraged African American families to initially engage in therapy?* (CQ4)
2. *What challenges did African Americans experience when initially considering engaging in therapy?* (CQ3).

This researcher identified one major theme: *Positive Experiences that Encouraged Participants' use of Family Therapy* (CQ4) and four subthemes: Positive individual/family beliefs about therapy; Favorable past personal experiences in therapy; Favorable personal experiences of others in therapy; and Church encouraged use of therapy (Table 5).

Table 5

Theme: Positive Experiences that Encouraged Participants' use of Family Therapy

Subthemes	Participants' Quotes
Positive individual/family beliefs about therapy n=2	*I am from a family that believes in counseling therefore I had positive thoughts prior to attending a session.* (FH18) *I've always felt that therapy is a good idea to deal with major life interruptions* (FH49)
Favorable past personal experiences in therapy n=1	*My general thoughts about therapy/counseling before attending the appointment were good. I had attended counseling as a young girl after the death of my grandmother and I found that experience to be positive and helpful. Since then, I have always felt that some form of therapy/counseling is useful…* (FH59)
Favorable personal experiences of others in therapy n=2	*…once I felt like we needed to go to counseling I felt counseling have got to work, because I spoke to other couples who have been to counseling as well.* (FH2) *My husband had been to counseling for work stress and my son for behavior problems. I was very familiar with the counseling process for our martial problems…My husband was use to the interaction (with the counselor) because he went to a counselor for job stress. He opened up quickly and I think that made me more comfortable.* (FH39)
Church encouraged use of therapy n=1	*I also want to say that we went to a church in Boston that had a great marriage ministry. One of the things that was encouraged was attending marriage retreats, transparency, and marriage counseling.* (FH 59)

Central question four. The second CQ3: *What challenges did African Americans experience when initially considering engaging in family therapy* generated one theme: *Factors that Caused Participants' Hesitancy in Attending Family Therapy*. This theme includes eight subthemes: Strong desire for privacy; Lack of knowledge concerning therapy/mental illness; Refusal/unwillingness to attend therapy; Expectation of self-

efficacy in solving problems; Belief therapy would not work; Stigma related to needing counseling; ability to pay; and Time available to go to therapy. While the narratives of the sample generated several themes related to barriers they faced in seeking therapy, eleven participants did not report facing any barriers when they sought family therapy.

Table 6

Theme: Factors that Caused Participants' Hesitancy in Attending Family Therapy

Subthemes	Participants' Quotes
Strong desire for privacy n=8	*…I felt uncomfortable exposing myself or bearing out my personal information to a third party.* (FH 22) *I personally did not want no one knowing our business.* (FH51)
Lack of knowledge concerning therapy/mental illness n=5	*Generally, I did not think the therapist would be trained to deal with the intricacies and cultural values as they related to my life.* (FH8) *I just did not want the "couch" therapy session as we see on TV. But it was so much more to it that I later understood.* (FH 58)
Refusal/Unwillingness to attend therapy n=5	*My (ex) husband didn't want to go initially.* (FH55) *Yes, I didn't want to go at first but I noticed that if I would tell my daughter that she can't see that boy again she would run away from home again.* (FH44)
Expectation of self-efficacy in solving problems n=4	*Initially I thought we can surly discuss whatever our issues was and solve them. We didn't need a 3rd party person to get paid for listening to our problems, and he/she more than likely [had] problems of their own.* (FH2) *I felt that we could have solved the problem on our own...* (FH13)
Belief that therapy would not work n=4	*The only thing that kept me from going was the thought that it might not do anything and then we would just owe money for no reason.* (FH53) *Felt like it wouldn't help.* (FH 57)
Stigma related to needing counseling n=3	*We thought that going to counseling meant that we were a couple on verge of divorce, or that we would be looked at as lesser than. So, we held out on going to therapy.* (FH 24) *The only thing that kept me from going was the fear of being judge...* (FH 57)

(Continued)

Ability to pay n=2	*…initially the money but it turned out to be covered by my plan* (FH19) *Financial constraints I think prohibited us from going to couples/family therapy initially. Even though we do okay financially, during the time that we started counseling we didn't have a house and any additional expenses were a burden* (FH59)
Available time to go to therapy n=2	*Yes, I was involved in school and wanted to attend those function[s] though we had schedule appointments on some of those days* (FH48) *…well at the time I was a full time student and working two jobs. So I honestly didn't thin[k] I had time to go to counseling.* (FH16)

Research question four. The final research question for this study was *How likely is it that African Americans who attended family therapy will return to family therapy in the future?* This research question was developed into central question 6 *How did the experience of utilizing therapy increase or decrease the likelihood of African American families choosing therapy in the future?* All participants, except for one, stated they would utilize family therapy in the future; the majority of these participants expressed a strong commitment to attending therapy again.

One major theme was generated for CQ6: *Commitment to Attend Family Therapy in the Future*. This researcher categorized participants' affirmative responses and three subthemes concerning the participants past experiences in therapy that motivate their future willingness to attend were generated: importance of the provider; appreciation of the therapy process; and gaining a new skill/perspective. The one dissenting view simply believed therapy did not work and stated: *No, it didn't help, we still argue and act the same* (FH11).

Table 7

Theme: Commitment to Attend Family Therapy in the Future

Subthemes	Participants' Quotes
Importance of the provider n=11	*The critical thing seems to be finding a provider that you can trust who can provide for your needs.* (FH59) *... it would have to be a counselor that is understanding like mine was and not judgmenta*l. (FH41)
Appreciation of the therapy process n=10	*Therapy gave me a safe place to express everything I felt… It also allowed me to fully listen to my mother and understand how she was feeling.* (FH13) *I would because I realized that even if things do not work out as you wanted to at the end of the session, it helps to talk to someone. Your burdens feel lighter and it helps you to put things in perspective.* (FH22)
Gaining a new skill/perspective n=9	*We have learned to communicate better through the techniques that we were taught during counseling.* (FH21) *It was very beneficial for me to understand the reasons they were doing what they were doing. It helped me understand why they felt the need to be dishonest with me. It also showed me some of the things I was doing which did not help the situation.*(FH50)

Change in Perception Concerning Family Therapy

Finally, the researcher examined the process of how the participants' perspectives about therapy changed from before and after their therapy experience. Based on the qualitative data, this researcher noted whether the participants had positive, indifferent or negative feelings about therapy before entering and how those feelings may or may not have changed after their therapy experience. Three participants did not accurately describe what they thought about therapy before entering family therapy; another participant's responses could not be coded as positive, indifferent or negative about

therapy. Table 8 displays the therapy perception change process of the remaining 35 participants.

Table 8

Participants' Perception of Therapy Change Process

Before and After Therapy Perception Change Process	Participants' Quotes	Frequency n=35
Negative view to positive view of therapy	**Before therapy:** ... *I felt like I was being watched because I was brought up " What happens in the house stays in the house." which I know is the wrong* (FH44) **After family therapy**: *Yes, most definitely I will go and continue until we can get the problem solved* (FH44)	20
Positive view to positive view of therapy	**Before therapy:** *I thought counseling would be a great way to address some underlying issues in order to move forward and [have] better relationships with my family members…* (FH50) **After family therapy**: It was very beneficial for me to understand the reasons they were doing what they were doing. It helped me understand why they felt the need to be dishonest with me. It also showed me some of the things I was doing which did not help the situation. (FH50)	13
Indifferent view to positive view of therapy	**Before therapy:** *I thought that it wasn't really necessary and that I was doing it for the benefit of my family member. I have nothing against therapy and never have, I just didn't feel it was relevant to me.* (FH13) **After family therapy**: Therapy gave me a safe place to express everything I felt without subjecting myself to fighting and yelling. It also allowed me to fully listen to my mother and understand how she was feeling. (FH13)	1

(Continued)

Positive view to negative view of therapy	**Before therapy:** *I thought it would help my husband and I stop arguing.* (FH11) **After family therapy:** No, it didn't help, we still argue and act the same. (FH 11)	1

Summary

In this qualitative online study, the researcher collected and analyzed the narratives of 39 participants related to their experiences that led them to utilize family therapy. The participants shared their perceptions about therapy before and after attending, the obstacles and resources they encountered as they navigated the journey to family therapy, as well as the catalyst event that led them to the therapy room. This researcher identified five themes related to participants' family therapy experiences, including: Life Experiences that Led to Family Therapy; Negative and Positive Perceptions of Family Therapy; Positive Experiences that Encouraged Participants' use of Family Therapy; Factors that Caused Participants' Hesitancy in Attending Family Therapy, and Commitment to attend family therapy in the future. Finally, the analysis of the qualitative data revealed that the majority of participants (n=35) moved from a negative to positive attitude about family therapy. This researcher found only one participant viewed family therapy negatively after attending family therapy.

CHAPTER V

DISCUSSION

African Americans are disproportionately represented in many of the most at risk groups for mental health and behavioral issues, including the impoverished, people incarcerated, and children in the foster care system (U.S. Census Bureau, 2011). In fact, African Americans report mental health issues at a rate 20% higher than Non- Hispanic Whites (U.S. Department of Health and Human Services, 2010). Despite increased likelihood of stress, anxiety and depression related to the aforementioned risk factors, African Americans are far less likely to utilize mental health services compared to their White counterparts (Ayalon & Young, 2005; Obasi & Leong, 2009). In contradiction, Diala et al. (2001), found that, among their sample, African Americans with depression were more willing to utilize a mental health provider for their psychological issues than their White counter parts. This contradictory research provides evidence that some African Americans are utilizing mental health treatment.

A good deal of research has been conducted on the barriers and traits that decrease the likelihood of African Americans attending mental health therapy. Research suggests stigma concerning therapy, characteristics of African American culture and reliance on family and spirituality are just a few obstacles to African Americans seeking therapy (Conner et al., 2010). Despite the obstacles, some African Americans are attending therapy and very little research has been facilitated to understand why these

individuals move from the typical behaviors of their cultural group and utilize mental health therapy and more specifically family therapy (Diala et al., 2001).

Using a phenomenological approach, this researcher was able to gain an understanding of the experiences of African American adults who, within 18 months of their participation in the study attended family therapy. This researcher also explored the participants' perceptions before attending therapy, their resources for dealing with their issue outside of therapy, barriers to attending therapy, the events that led to using family therapy, their willingness to go to therapy, and their beliefs about therapy after attending. The exploration yielded five themes based on the participants' survey answers. Many of the themes that emerged were similar to previous research concerning African Americans and mental health therapy. In addition, this researcher identified connections between Bronfenbrenner's Bioecological Theory of Human Development and the themes generated from the study. A summary of the themes and their relation to previous research as well as Bronfenbrenner's theory are discussed.

Themes

Through the analysis of the participant data, five themes related to the sample's experiences concerning their path to family therapy were generated. This researcher identified the following themes: (1) Life Experiences that Led to Family Therapy; (2) Negative and Positive Perceptions of Therapy; (3) Positive Experiences that Encouraged Participants' use of Family Therapy; (4) Factors that Caused Participants' Hesitancy in Attending Family Therapy; and (5) Commitment to Attend Family Therapy in the Future.

Life Experiences that Led to Family Therapy

Despite little previous research on the events that led African Americans to utilizing family therapy, the research generated three distinct subthemes related to the sample's experiences: life events that caused stress, distress related to interpersonal relationships, and intrapersonal emotional distress. More specifically, many of the participants indicated intense emotional or relational distress as the factor that helped motivate them to attend family therapy. Very few participants cited relational maintenance or minor interpersonal or intrapersonal issues as reasons for entering into family therapy. The majority of the participants identified life events that caused stress in the family as the catalyst for attending therapy. Participants stated that occurrences such as a recent divorce, infidelity, initial mental health or health diagnosis, and a child running away from home as circumstances that helped to motivate them to use family therapy to deal with the problem or stressor.

This researcher found that many of the problems (i.e. child runaway, initial health diagnosis, divorce, and infidelity) that led African Americans to go to therapy identified in this study were reflective of what McKenry & Price (2005) described as *non-normative*. Non-normative stressors are unique unpredictable intense disruptions in the families' lives. Similarly, normative stressors, which are normal daily hassles of life and developmental life transitions (Price, Price, & McKenry, 2010), can cause intense stress particularly if the stressors are on-going. This researcher found that many participants in the current study identified ongoing normative stressors as their catalyst for attending

family therapy. Participants described continuous disagreements or arguments with family members as well as developmental life transitions such as a new baby as the stressful events that led them to family therapy. According to the ABC-X model of family stress and crisis, when a stressor that causes change in a family occurs, a family can encounter a crisis, if they have few or ineffective coping mechanisms, and/or a negative perception the problem (Hill, 1958).

This crisis disrupts the family's ability to function which could increase psychological distress. In congruence with the ABC-X model, many participants in the present study, described their stressors as making it difficult to function in their family. For instance, one participant stated the ongoing dishonesty on the part of her children stopped her from being …*able to do [her] best job at parenting and protecting them* (FH 50), while several other participants reported their ongoing issues in their marriages had pushed them towards considering divorce and another stated she …*felt like [she] was losing control* (FH16). All of the aforementioned events decreased the family's ability to function and provided the participants in this study with a strong catalyst for seeking family therapy.

Similarly, normative stressors and non-normative stressors (Price, Price, & McKenry, 2010) can cause intense stress if they began to pile up over time due to unresolved initial stressful events added to new stressful events or multiple stressful events occurring at once (McCubbin & Patterson, 1982). McCubbin and Patterson expanded upon Hill's (1958) ABC-X model of stress with the Double ABC-X model.

This model suggests that within a family, a pile up of stressors without the effective coping mechanisms and a positive perception about the stressor and their resources could lead to a crisis in the family. Some of the participants of this study also identified a pile up of stressors in their intrapersonal and interpersonal relationships. For instance, one participant reported experiencing financial problems as well as disagreements about household issues and a breakdown in their communication as their reasoning for attending family therapy. Likewise, another participant cited a health issue as well as communication problems within the family as the reasons she sought family therapy. The subthemes and associated factors identified by this researcher would suggest that a high level of stress or crisis in the family either concerning on going normative stressors, such as chronic arguing, non-normative stressors, such as a child running away from home, or a pile up of these stressors contributed to the majority of the samples' use of family therapy.

Coping mechanisms. Similar to the type and intensity of the stressors faced by the families in the study, the use of coping mechanisms and their apparent failure to produce the desired outcome provides insight into the participants' experiences that led them to use family therapy. Previous research suggests that African Americans typically use a variety of other resources to resolve mental health issues as an alternative to a trained counseling professional. Past studies provide evidence that African American adults and children will choose to talk to family and friends about problems they are facing before seeking a mental health professional (Lindsey et al., 2006; Murry,

Heflinger, Suiter & Brody, 2011). This researcher also found this to be true among participants' narratives described their help-seeking experiences in the present study. The sample indicated in their survey that talking to friends and family was one of the most common ways they dealt with their problem before seeking family therapy. This particular coping mechanism was the most frequently identified in the sample, which is in line with previous research.

About 20% of the participants attempted to avoid their problems before deciding to attend therapy. This particular coping mechanism may have been used because of the stigma associated with mental illness and therapy pervasive in the African American community (Murry, Heflinger, Suiter & Brody, 2011). Researchers suggest that many African Americans see themselves negatively if they feel they may have a mental illness (Thompson, Bazile & Akbar, 2004). In addition, previous research has indicated that among African Americans, attending therapy or being diagnosed with a mental illness is looked down upon by one's family and community (Hall & Sandberg, 2012; Connor, Koeske & Brown, 2009; Murry, Heflinger, Suiter & Brody, 2011). In the present study, avoiding the problem altogether may have been a coping mechanism used by the participants to circumvent the negative internal and external stigma associated with mental illness and therapy.

Two other significant coping mechanisms the sample relied on before attending family therapy were religion and spirituality. More specifically, participants cited praying, talking to a minster, reading the bible and attending church classes as ways they

dealt with their problem before seeking family therapy. A large body of research suggests that religion and spirituality plays an intensely significant role in the lives of African American families (Ayalon & Young, 2005; Boyd-Franklin, 2006). In addition, reliance on God during difficult times has been seen as a culturally acceptable coping mechanism in previous research (Conner et al., 2010). Similarly, in the present study, leaning on spiritually or religion was used more frequently than ten other reported coping mechanisms, which is supported by previous research.

Prior research provides some understanding of the coping experiences African American families' encounter when dealing with mental health issues (Hall & Sandberg, 2012; Connor, Koeske & Brown, 2009; Conner et al., 2010; Lindsey et al., 2006; Murry, Heflinger, Suiter & Brody, 2011). The current study generates additional evidence that many of the coping mechanisms used in the African American community were also used among the sample. One may suggest that since the participants of this study were not able to resolve their issues with the coping mechanisms identified in the research, they sought out family therapy as an alternative. Thus, for the participants of this study, tried and true tools to solve family problems were no longer effective which helped motivate them to use a mental health provider.

Negative and Positive Perceptions of Family Therapy

Negative perceptions of family therapy. The participants' perceptions of family therapy provide some understanding of the experiences that led African Americans to family therapy. By understanding the participants' thoughts concerning family therapy

before they attended, we gain some understanding of their internal experience in choosing family therapy. In the present study, the majority of the participants experienced a negative perception of family therapy before attending. The majority of participants stated that their negative perceptions stemmed from the following five concerns and beliefs: stigma related to therapy, personal or family privacy, the belief that therapy does not work, that the therapist will not understand, and that one should be able to handle their problem on their own. Previous research suggests that all of the aforementioned concerns are common among African Americans' perceptions of therapy (Conner et al., 2010).

In the current study, nearly a quarter of participants simply believed therapy would not work. Previous research on African American perceptions of therapy explicitly indicated African Americans possessed a strong belief that therapy would not work to solve their problems (Conner et al., 2010). Conner et al. (2010) interviewed 37 African American older adults who were dealing with depression in an effort to examine their barriers to mental health treatment as well as the coping mechanisms they commonly used. The researchers found that many of their subjects lacked confidence in the ability of mental health provider to help them with their depression. Likewise, Williams, Domanico, Marques, Leblanc and Turkheimer (2012) conducted a study examining barriers to treatment among African Americans with obsessive-compulsive disorder. The researchers surveyed 71 African Americans with obsessive compulsive disorder using a modified version of the *Barriers to Treatment Participation Scale* and the *Barriers to*

Treatment Questionnaire (BTQ). The researchers compared the findings of their African American sample to an internet sample of 108 European Americans BTQ scores. The researchers found that the African American participants reported significant concerns about mental health treatment. In fact, many of African American subjects described the belief that treatment would be ineffective and not meet their expectations, specifically because the mental health provider would not understand their perspective.

In addition, previous research does suggest that therapy tends to be a last option for African Americans facing emotional or behavioral issues (Ayalon & Young, 2005). Conner at el, (2010) found among depressed African American older adults psychological treatment was a last resort resource. The present study found that 38 of the 39 participants tried alternative coping mechanisms when facing mental health related problems before finally utilizing family therapy. In fact, one participant reported *My husband at the time and I decided to go as a last ditch effort to heal our marriage* (FH8) while several other participants reported they attended family therapy after trying a variety of other coping mechanisms and were at the point of considering divorce. The high use of alternative coping mechanisms and the last resort attitude about using therapy among some of the participants in the present study, could suggest skepticism that therapy cannot solve mental health issues among the subjects.

As mentioned previously, internal and external stigma related to therapy and mental illness has been found to be a major concern for African Americans. Previous research suggests that fear of negative reactions by people in their community and

internal feelings of disgrace often hinder African Americans from engaging in therapy (Hall & Sandberg, 2012; Thompson, Bazile & Akbar, 2004). In addition, a concern with privacy about family problems has been seen to be evident among African American families in prior research (Conner et al., 2010; Thompson, Bazile & Akbar, 2004). Past research suggests African Americans believe personal issues should be kept inside of the family and a small group of friends (Conner et al., 2010; Thompson, Bazile & Akbar, 2004). Consistent with former research, the current study found privacy was a concern that ignited a negative perception of attending family therapy before participants attended. In fact, many participants in this study reported a strong belief that their family business should stay within the family and their personal struggles should not be on display for others to see.

Lack of therapists' understanding of the individual's perspective and African American culture were also cited as beliefs that supported a negative perception of therapy by the African American participants prior to therapy (Copeland and Snyder, 2011). While two participants felt the therapist would not understand their perspective in general, one participant specifically stated they did not believe a therapist would understand their issues within the context of African American history and culture. The participants' belief that the therapist will not understand their experience and perspective has been documented in past research (Conner et al., 2010). Thompson, Bazile, and Akbar (2004) found that among their 201 African American participants, many believed

a therapist would not understand African American experiences such as racism and discrimination.

While there is solid research suggesting African Americans' belief that a mental health professional will not understand their point of view, this researcher's sample did not report this as a dominant negative perception about family therapy. In fact, only two participants identified this negative perception. It is reasonable to suggest the lack of evidence in this study supporting previous research may be attributed to the demographics of the sample. The current sample is well educated, as indicated previously, all participants had at least some college education. Higher levels of education may have impacted the participants' potential openness to the idea someone outside of their culture or a stranger, in general, could understand their perspective.

Participants in the present study also felt that they should be able to solve their mental health issues on their own. In fact, participants reported a negative connotation associated with asking someone for help. Likewise, many participants expressed the belief that they should be able to handle their own problems and not need a therapist. This expectation of self-efficacy in solving problems among African Americans has been well documented in previous research. Conner et al. (2010) found that some of their participants believed that since, historically, Africans Americans had endured so much oppression; they should be better able to handle issues like depression compared to other ethnicities. Similarly, Awosan, Sandberg, & Hall (2011) found that 38% of their sample of African Americans who attempted to seek family therapy reported "therapy is a sign of

weakness" (p.158). This researcher's study is congruent with previous research and provides further evidence that many African Americans may be hesitant about using family therapy because they feel they should be able to overcome mental health struggles on their own.

Positive perceptions of family therapy. Within the present study, about one-third of the participants indicated positive perceptions about family therapy. Participants' perceptions ranged from strong confidence in the outcome of family therapy and overall affirmative beliefs about family therapy to a hesitancy but ultimate willingness to use family therapy. The majority of the participants with positive perceptions of family therapy believed in the efficacy of therapy or had generally affirmative beliefs about it while only two participants were hesitant, but willing to give it a try. Within the present study, it appears that if African American families have an internalized belief that therapy can work or that it is a positive resource they are more likely to have a more affirmative perception of family therapy and willingness to use it.

Very little past research has shown positive perceptions of therapy by African Americans, yet a few studies have reported more affirmative beliefs. Thurston and Phares (2008) did find in their sample that African Americans mothers, when compared to their White counterparts, had a similar level of positive attitude toward mental health services for their children. Similarly, Diala et al. (2001) found more positive attitudes concerning help-seeking behaviors among African Americans compared to Whites in their sample. The present study supports this previous research and may suggest that African

Americans view therapy more positively today than in previous years. Again, the demographic characteristics of this sample may have some impact on this researcher's findings. This study's sample was a highly educated group and this may contribute to a more positive perspective on therapy.

Positive Experiences that Encouraged Participants use of Family Therapy

Previous research suggests that participants who have attended family therapy have had experiences with friends and family that have encouraged their use of it. Hall and Sandberg (2012) found in their qualitative study of African Americans who overcame barriers and attended family therapy that some participants stated family and friends encouraged them to go to therapy. In fact, one participant reported that he was encouraged by a friend who also had gone to therapy and assured him therapy "…was ok (Hall & Sandberg, 2012, p.450)."

Similarly, within the present study, the researcher found that some participants had positive experiences with their social support network that encouraged their use of therapy. One participant stated he or she spoke with other couples who emphasized that therapy would work, while another participant reported her husband's and son's previous use of therapy allowed her to have no barriers to utilizing family therapy. Other participants described positive individual and family beliefs about as well as a favorable past personal experience in therapy as encouragement for attending family therapy. Likewise, one participant stated that their church advocated for the use of mental health therapy which encouraged them to utilize it. This study provides some evidence that,

among African Americans, close intimate connections with others who advocate for the use of family therapy and who believe it is a useful tool may encourage the use of therapy among Black families.

Factors that Caused Participants' Hesitancy in Attending Family Therapy

African Americans in this study most frequently identified a strong desire for privacy as a hindrance to initially going to therapy. Many of the participants felt that their personal affairs should not be made public and indicated feeling uncomfortable with sharing intimate details of their lives with a stranger. This particular barrier to treatment is consistent with previous research that found African Americans believe in keeping family business private (Conner et al., 2010; Thompson, Bazile & Akbar, 2004). In addition, privacy as a hindrance for initially seeking family therapy is also in line with the current study's findings that some participants' negative view of therapy before attending was due to a strong desire for privacy.

Participants, in the current study, also indicated a lack of knowledge concerning therapy or mental illness as an initial barrier to seeking family therapy. The researcher found that some African Americans in the study had inaccurate information about therapists and the therapy process. Participants felt therapists either would not understand them or therapy would not be an empathetic collaborative process. Participant's lack of knowledge about therapy sessions and the therapist's ability to address their needs in a sensitive manner has been documented in past research as well. Copeland and Snyder's (2011) and Thompson and Bazile & Akbar (2004) both found that their participants

believed a therapist would not understand and be sensitive to the African American perspective. The current research study also provided evidence of this lack of understanding as indicated in the participants' concern that the therapist would not understand their perspective.

This researcher found that three other initial barriers to family therapy described by the majority of participants in this study were congruent with participants' negative perceptions of therapy; particularly, the expectation of self-efficacy in solving problems, the belief that therapy will not work, and concern about stigma related to counseling. As mentioned previously, participants negative beliefs about therapy concerning self-efficacy, therapy's effectiveness, and stigma related to mental health treatment are consistently supported by past research as being barriers for African Americans seeking therapy (Conner et al., 2010; Awosan, Sandberg, & Hall 2011; Copeland and Snyder, 2011; Williams, Domanico, Marques, Leblanc & Turkheimer, 2012; Hall & Sandberg, 2012; Thompson, Bazile & Akbar, 2004) . Despite this study's congruence with past research on barriers African Americans face in utilizing mental health treatment, this sample overcame those barriers and attended family therapy. Some participants attributed their ability to overcome these barriers to the intensity of the problem. For example, one participant stated …*though there is perhaps stigma about counseling we were both so frustrated and wanted a better marriage that we bypassed the stigma* (FH 59). Potentially, the desire to preserve the family unit and the difficulty of the problem helped to motivate many of this study's participants to utilize family therapy.

Another experience described as an initial barrier by the participants in the current study was the refusal of family members to attend therapy. A small group of five participants reported that they, or their family members, did not want to go to family therapy when the idea was first discussed. Scant research has been conducted on family members' reluctance to join family therapy among African Americans. However, the overwhelming evidence that identified negative perceptions of therapy held by African Americans and the related barriers to accessing therapy provides a strong indication that within families it may be difficult to get all members to join the session (Conner et al., 2010; Awosan, Sandberg, & Hall 2011; Copeland and Snyder, 2011; Williams, Domanico, Marques, Leblanc & Turkheimer, 2012; Hall & Sandberg, 2012; Thompson, Bazile & Akbar, 2004). Gaining knowledge on how to overcome these barriers and help to internalize a positive perspective of mental health treatment may make it less challenging to engage all members of family in therapy.

Previous research has provided support that access to therapy in the forms of available time to go to therapy and ability to pay are barriers to African Americans seeking therapy. Research by Williams, Domanico, Marques, Leblanc and Turkheimer (2012) suggests that African Americans diagnosed with obsessive-compulsive disorder did not see their mental health treatment as priority. Other obligations such as work and other activities took precedent. Similarly, two participants in the current study also indicated that their time was limited due to other obligations such as school and initially, did not feel they had available space in their schedule to attend family therapy.

As stated above, participants in this study also described concerns about the affordability of family therapy as a barrier to treatment. Participants initially believed that their treatment would not be covered by insurance or could not immediately find the discretionary money to pay for family therapy. Past research also supports financial constraints as a barrier for African Americans seeking therapy. Conner et al. (2010) found that participants in their study cited lack of health insurance, transportation and financial burdens as barriers to seeking therapy. The cost of mental health treatment and lack of health insurance were also identified as barriers to mental health treatment among the Williams, Domanico, Marques, Leblanc, and Turkheimer's (2012) sample of African Americans with obsessive compulsive disorder. Based on previous research and the current study, helping individuals understand their health insurance benefits related to mental health services and offering affordable mental health treatment, may reduce African Americans' real or perceived financial barriers to seeking family therapy. In addition, offering free initial sessions to African Americans may help reduce stigma and fear concerning therapy and its process. In addition, offering a free initial session to African Americans may help overcome the initial perceived/real financial barrier to therapy and potentially provide the positive experience that may facilitate ongoing use of the resource.

While two participants in the current study cited inability to afford family therapy as an initial obstacle to attending therapy, most participants in the report this as a barrier. The demographic make-up of the sample may partly explain the sample's accessibility to

family therapy. Nearly 45% of this study's subjects reported their annual household income as $46,000-$150,000. The higher incomes of the sample may have provided the participants the financial resources to pay for family therapy.

In addition, over half of the sample reported a household income of less than $46,000, with nearly 36% earning less than $25,999. This large proportion of the sample falling in the lowest income bracket may suggest participants would not have been able to afford family therapy and would have cited lack of financial resources as a barrier to accessing it. Yet, as mentioned previously, lack of access to therapy due to inability to pay was not reported as a barrier for the majority of the sample. The convenience sampling of the participants utilizing emails from a college database and the Facebook page of a college affiliated alumni group may provide some explanation as to why this sample deviates from previous research citing inability to pay as a barrier to mental health treatment for African Americans(Conner et al., 2010; Williams, Domanico, Marques, Leblanc, and Turkheimer, 2012). Many of the participants may have been students, faculty or staff of the university and therefore had access to free and low cost campus based family therapy.

Commitment to Attend Family Therapy in the Future

All but one participant in this study expressed a desire to utilize family therapy in the future and most of the subjects' commitment to use therapy again was very strong. Several participants described characteristics concerning the therapist that solidified their intention to use family therapy in the future. Having a non-judgmental therapist was the

most reported attribute described by the respondents concerning their wiliness to go to family therapy in the future. Previous research on barriers to mental health treatment suggests African Americans often feel they will be judged negatively if they attend therapy (Conner et al. 2010; Murry, Heflinger, Suiter & Brody, 2011). The current study is consistent with research whereby participants seem more willing to attend family therapy in the future if they felt they would not face stigma or bias from their therapist.

This researcher also found that participants who declared a willingness to attend family therapy indicated they found benefit in gaining a new skill or different perspective. Participants often described learning to communicate more effectively as a skill they gained in family therapy that motivates their future use of mental health treatment. In addition, participants described their ability to openly express their thoughts and feelings and the connection between sharing their emotions and feeling better as benefits to therapy they would want duplicated in the future. Similarly, a previous study found that among their small sample of African Americans who utilized family therapy, participants most appreciated the process of family therapy. More specifically, participants valued the ability to express their emotions and release stress (Awosan, Sandberg, Hall, 2011).

Participants' Perception of Therapy Change Process

Over half the participants' perceptions of therapy in the current study changed from before they attended to after they attend family therapy. These participants initially viewed family therapy as negative and identified many of the barriers, such as stigma,

privacy and the belief therapy does not work, cited in previous research as their reasoning for their perception. Despite the negative initial perception of therapy, participants reported moving to a positive belief about family therapy after attending. Likewise, among the participants who had a positive perception of therapy before attending family therapy all, but one continued to have a positive perception following their family therapy experiences. The one participant who was unwilling to attend family therapy in the future reported the treatment did not solve their problem. This consistently positive perception of all but one of the participants' following attendance in family therapy may indicate that an affirmative effective mental health treatment experience including a non-judgmental therapist can encourage African Americans future use of family therapy.

Connection to Theory

Bronfenbrenner's Bioecological Theory postulates that human development is a reciprocal and dynamic process influenced by five environmental structures, the microsystem, mesosystem, exosystem, macrosystem and chronosystem. The developing human, according to Bronfenbrenner, is shaped by their interactions with their ecological settings and these interactions provide insight into individual differences in development (Bronfenbrenner & Morris, 2007). This researcher drew specific inferences concerning the study and two of Bronfenbrenner's structures: the microsystem and the macrosystem.

Bronfenbrenner's five main structures are the microsystem, mesosystem, exosystem, macrosystem and chronosystem. Bronfenbrenner theorized that the microsystem is experiences of the developing person in a small intimate setting, such as

the family, school, etc. The mesosystem is the interaction between multiple microsystems such as in family and school, when parents participate in their child's education. An exosystem, as described by Bronfenbrenner, is those activities and relationships in which a developing person is not in direct contact, but influences their experiences. In addition, the macrosystem is the culture and society in which the developing person resides more specifically the beliefs, values and interactions that are characteristic of the group in which they belong. Lastly, the chronosystem is the person's interactions with their environment in terms of time which includes how the historical period and one's developmental stage in life effects the individual (Bronfenbrenner & Morris, 2007).

The current study provides evidence that the microsystem and macrosystem structures play important roles in the experiences of African American who choose to attend family therapy. Cultural beliefs which are encompassed within the macrosystem were often referenced or expressed by the participants in the current study when describing their experiences leading to therapy. Participants cited common cultural beliefs of African Americans found in previous research such as handling a family problem on your own, keeping family business private and utilizing family, friends, and/or God for help in times of need as part of their perceptions and barriers experienced on their path to family therapy (Boyd-Franklin, 2006; Conner et al., 2010; Thompson, Bazile & Akbar, 2004). These well documented macrosystem influences or cultural beliefs within the African American culture appear to have influenced the hesitancy in seeking family therapy among many of the study's participants. However, of those who

had positive perceptions of family therapy before attending, most participants, potentially due to the sample's higher level of education, cited a general belief in therapy and its effectiveness which increased their likelihood of using it.

The microsystem also appeared to play a significant role in the experiences of the participants seeking family therapy in the present study. Of those who did cite encouraging influences that led them to therapy, a small group described a previous personal experience in therapy and an interaction with a friend who attended therapy as affecting their positive perceptions of therapy. In addition, a participant specifically reported their church's encouragement of marriage counseling influenced their decision to attend family therapy. All of the aforementioned experiences at the microsystem level helped shape the participants' confidence in the efficacy of therapy. Similarly, within the present study the fundamental microsystem experience of going to family therapy appears to have solidified participants' already positive beliefs about the therapeutic process. Likewise, the change in many participants' beliefs about family therapy, from negative before therapy to positive after attending, indicates a shift in macrosystem beliefs that was facilitated by their microsystem experience in therapy. Fundamentally, most participants indicated that their microsystem experiences in therapy shaped or cemented an internal belief about the usefulness and effectiveness of family therapy.

In addition, Billingsley (1968) described general functions of the Black family as *instrumental* or economic function and maintenance of boundaries (i.e. preserving inclusion of members in the family), *expressive*, which encompasses attributes such as

family cohesion, belonging and love, and *expressive-instrumental* or the functions of propagation and parenting of children. The instrumental function of the family or the process of insuring family members remain in the family was cited in the current research as one of the leading reasons for pursuing family therapy. Participants described wanting to prevent divorce or preserve their marriage as well as ensuring children in the family be they young or adult children remain cohesive and connected with their parents as motivating events to attending family therapy.

Lastly, several of negative perceptions and initial challenges to engaging in family therapy reported by the participants in this research potentially reflect the family racial socialization process as described by Billingsley (1968). Billingsley (1968) suggests that African American families must teach a fear of White society within the culture to help ensure individuals are cautious in engaging with its institutions since those structures have a history of oppressive and marginalizing behaviors. Participants fear of sharing personal information, stigma by the therapist, belief that they will not be understood and that they should be able to handle their problem on their own all could be seen as African American family processes to preserve their well-being in the midst of a White society that oppresses and marginalizes the group. In addition, the initial coping mechanism most identified by the subjects of this study was talking to family members about their problem. Again, Billingsley suggests that the political and economic isolation of African Americans from the dominant society has forced their families to rely on themselves. The participants in this study citing relying on family in their time of distress before attending

family therapy as a dominant coping mechanism falls in line with Billingsley's (1968) research that suggest that the marginalization of African Americans has caused them to depend on the family for their needs.

Limitations

This qualitative study was limited to 39 participants recruited through a convenience sample of TWU affiliated individuals and through limited social media outlets; therefore, the sample is not a representation of all African Americans who attend family therapy. This researcher was unable to capture age and gender of the participants which affected her ability to completely describe the sample as is typically expected. The research study was limited to the reported experience of only one participant in each family after they attended therapy which reduces the description of the family's experience to one person's perspective.

In addition, because the research required the participants to recall how they felt before therapy, their recall of those experiences may have been influenced by their more recent positive therapy outcomes which could have caused an inaccurate recollection of events. Finally, data for this study was captured completely through an online survey; therefore, a small number of participants' answers that were vague or incorrect could not be explained in further detail.

Implications for Future Research

The current research study generated a number of implications for future research. Each implication will be described below:

1. Future research could include quantitative and qualitative studies with a larger more representative sample that encompasses the experiences of African Americans throughout the United States. The quantitative study could allow for the collection of data using a survey that is based on the experiences collected in this study and provide broader more generalizable findings concerning this population's experiences that led them to family therapy.
2. Further research that captures the experiences of the entire family that attended therapy immediately before and after they attended would provide a broader, timelier, and more accurate picture of the entire family's experiences in choosing to use family therapy.

Recommendations

This study provides some compelling evidence that the therapeutic experience can be transforming in terms of changing negative perceptions of therapy to positive among African Americans, thus increasing the utilization of family therapy. This research provides some evidence that if African Americans can experience family therapy they will include it in their repertoire of coping mechanisms for future times of distress. In order, to overcome barriers to initially engaging in therapy, negative perceptions of stigma and judgement must be eradicated. Robert B. Hill (2003) suggests that two of the Black community's strengths are their strong family bonds and religious affiliation. In fact, Billingsley (1992) proposes that the African American church has been not only a spiritual refuge, but a place for communal support and the cornerstone of any major

reform in the African American community. The current researcher discovered these two cultural characteristic were also cited as significant to the study's sample as indicated by their high frequency use of family and religion/spirituality in times of distress. The significance of these African American family strengths should set the framework for encouraging the use of family therapy when culturally prevalent resources alone are no longer effective. Therefore, churches pastors and clergy as well as African Americans who have attended therapy can be influential in helping to reduce stigma and misinformation about therapists and the therapy process.

By involving African American institutions, such as the church and family in dispelling negative and inaccurate perceptions of therapy, many more African Americans may utilize family therapy when they are in need of support. This researcher suggests the creation of a family therapy advocacy campaign utilizing the strengths of African American families would be effective in encouraging their use of mental health providers. This campaign would strive to transform African Americans perceptions of therapy and would be established in their community featuring African Americans with positive past experiences in therapy and community religious figures. These efforts involving church and individuals from the community may help to reduce stigma and increase belief in the efficacy of family therapy. In addition to the campaign, a free initial family therapy session for African American families may be provided by therapist and community mental health clinics to circumvent concerns about cost and increase the likelihood of engagement in therapy. By implementing the aforementioned

recommendations, the researcher believes the process of changing negative beliefs about family therapy will begin and the likelihood of more African Americans engaging in family therapy will increase.

The current study also provides implications for educators preparing students for the field of family therapy. It is imperative that therapist are trained to understand the cultural characteristics typically associated with the African American community, so they can ensure Black families in therapy have a positive experience. For instance, therapist should understand the potential fear of the judgement and stigma associated with attending family therapy among some African Americans. To address the concern of judgement, the therapist can work to become skilled in taking a non-judgmental stance when serving African American families. In addition, negative perceptions many participants reported in the current study were stigma related to counseling and feeling therapy is a sign of weakness. Family therapists should be trained to normalize the use of therapy and highlight the strengths found in the family, so African American families feel empowered versus diminished by the therapy process.

Summary

The present study examined the experiences that led a group of 39 African Americans to family therapy. The African Americans in this study described intense major life stressors and an ongoing pile up of daily stressor experiences as well as a failure of their traditional coping mechanisms as the events that led them to choose family therapy. Over half of the participants overcame negative beliefs and barriers about

therapy often rooted in macrosystem influences, such as cultural beliefs prevalent in the African American community: like they should handle their problem on their own and using therapy is a sign of weakness, to attend family therapy (Conner et al., 2010; Williams, Domanico, Marques, Leblanc & Turkheimer, 2012).

Before attending therapy, many of the African Americans in this study initially felt that family therapy would be ineffective and described stigma related to therapy and mental illness as two of the main contributors to their negative perceptions of therapy; which was consistent with previous research on mental health treatment (Conner et al., 2010; Hall & Sandberg, 2012; Thompson, Bazile & Akbar, 2004; Williams, Domanico, Marques, Leblanc & Turkheimer, 2012). Despite the challenges indicated by the bulk of the participants, they overcame barriers, such as a strong desire for privacy, and the beliefs that therapy would not work and they should handle their problems on their own, and engaged in family therapy. The participants' engagement in family therapy ultimately provided a positive experience that encouraged a strong willingness to pursue family therapy in the future. Similarly, participants with positive perceptions of therapy prior to attending therapy also felt their affirmative beliefs about therapy were solidified after attending family therapy. Through this phenomenological study, the researcher gained insight into the unique experiences of African Americans who attended family therapy. It is the researchers hope that this study will serve as a catalyst for future research that will contribute to the increased utilization of family therapy among African Americans.

REFERENCES

African American. (2013). In *Merriam-Webster.com*. Retrieved November 20, 2013 from http://www.merriam-webster.com/dictionary/hacker

Akutsu, P. D., Snowden, L. R., & Organista, K. C. (1996). Referral patterns in ethnic-specific and mainstream programs for ethnic minorities and whites. *Journal of Counseling Psychology, 43*(1), 56-64.

Awosan, C. I., Sandberg, J. G., & Hall, C. A. (2011). Understanding the experience of Black clients in marriage and family therapy. *Journal of Marital and Family Therapy, 37*(2), 153-168.

Ayalon, L., & Young, M. A. (2005). Racial group differences in help-seeking behaviors. *The Journal of Social Psychology, 145*(4), 391-403.

Billingsley, A. (1992). *Climbing Jacob's ladder: The enduring legacy of Africa-American families*. New York: Touchstone.

Boyd-Franklin, N. (2006). *Black families in therapy.* New York: The Guilford Press.

Bronfenbrenner, U., & Morris, P. A. (2007). The bioecological model of human development. In W. Damon & R.M. Lerner (Series Eds.), R.M. Lerner (Vol. Ed.), *Handbook of Child Psychology, Vol.1. Theoretical models of human development* (6th ed., pp. 793-828). New York: Wiley.

Retrieved from http://www.cdc.gov/nchs/data/series/sr_10/sr10_252.pdf

Conner, K. O., Copeland, V. C., Grote, N. K., Rosen, D., Albert, S., McMurray, M. L., Reynolds, C. F., Brown, C., & Loeske, G. (2010). Barriers to treatment and culturally endorsed coping strategies among depressed African-American older adults. *Aging and Mental Health, 14*(8), 971-983.

Conner, K.O., Koeske, G., & Brown, C. (2009). Racial differences in attitudes toward professional mental health treatment: The mediating effect of stigma. *Journal of Gerontological Social Work, 52*, 695-712.

Cooper-Patrick, L., Gallo, J. J., Powe, N. R., Steinwachs, D. M., Eaton, W. E., & Ford, D. E. (1999). Mental health service utilization by African Americans and Whites: The Baltimore epidemiologic catchment area follow-up area follow-up. *Medical Care, 37*(10), 1034-1045.

Copeland, V. C., & Snyder, K. (2011). Barriers to mental health treatment services for low-income African American women whose children receive behavioral health services: An ethnographic investigation. *Social Work in Public Health, 26*, 78-95.

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). Thousand Oaks, CA: Sage.

Diala, C. C., Muntaner, C., Walrath, C., Nickerson, K., LaViest, T., & Leaf, P. (2001). Racial/ethnic differences in attitudes toward seeking professional mental health services. *American Journal of Public Health, 91*(5), 805-807.

Franklin, J.H. & Moss, A.A. (2010), From slavery to freedom: A history of African Americans (8th ed.). New York: Random House.

Grant, K., Poindexter, L., Davis T., Cho, M. H., C., McCormick, A., & Smith, K. (2000). Economic stress and psychological distress among urban African American adolescents: The mediating role of parents. *Journal of Prevention & Intervention in the Community, 20*(1/2), 25-37.

Gutman, L. M., McLoyd, V. C., & Tokoyawa, T. (2005). Financial strain, neighborhood stress, parenting behaviors, and adolescent adjustment in urban African American families. *Journal of Research on Adolescence, 15*(4), 425-449.

Hall, C. D., & Sandberg, J. G. (2012). "We shall overcome": A qualitative exploratory study of the experiences of African Americans who overcame barriers to engage in family therapy. *The American Journal of Family Therapy, 40*, 445-458.

Hill, R. B. (2003). *The strengths of Black families* (2nd ed.). Lanham, Maryland: University Press of America.

Keating, F., & Robertson, D. (2004). Fear, Black people and mental illness: A vicious circle? *Health and Social Care in the Community, 12*(5), 439-447.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Lindsey, M. A., Korr, W. S., Broitman, M., Bone, L. Green, A., & Leaf, P. J. (2006). Help-seeking behaviors and depression among African American adolescent boys. *Social Work, 51*(1), 49-58.

McCubbin, H. I., & Patterson, J. M. (1982). Family adaptation to crisis. In H.I. McCubbin, A. E. Cauble, & J. M. Patterson (Eds.), *Family stress, coping, and social support* (pp. 26-47). Springfield, IL: Charles C. Thomas.

McKenry, P.C., & Price, S.J. (2005). Families coping with problems and change: A conceptual overview. In P.C. McKenry & S.J. Price (Eds.), *Families and change: Coping with stressful events and transitions* (3rd ed., pp. 1-24). Thousand Oaks, CA: Sage.

Murray, V. M., Heflinger, C. A., Suiter, S. V., & Brody, G. H. (2011). Examining perceptions about mental health care and help-seeking among rural African American families of adolescents. *Center for Family Research, 40,* 1118-1131.

National Alliance on Mental Illness. (2009). *African American Community Mental Health: Fact sheet.* Retrieved October 28, 2013 from http://www2.nami.org/Template.cfm?Section=Fact_Sheets1&Template=/ContentManagement/ContentDisplay.cfm&ContentID=53812

National Center for Health Statistics. (2012). *Health, United States, 2011: With Special Feature on Socioeconomic Status and Health*. Hyattsville, MD.

Nichols, M. P. (2012). *Family therapy: Concepts and methods* (10th ed.). Thousand Oaks, CA: Pearson.

Obasi, E. M., & Leong, F. T. L. (2009). Psychological distress, acculturation, and mental health-seeking attitudes among people of African descent in the United States: A preliminary investigation. *Journal of Counseling Psychology, 56*(2), 227-238.

Price, S. J., Price, C. A., & McKenry, P. A. (Eds.) (2010). *Families and change: Coping with stressful events and transitions* (4th ed.). Thousand Oaks, CA: Sage.

Richman, L. S., Kohn-Wood, L. P., & Williams, D. R. (2007). The role of discrimination and racial identity for mental health service utilization. *Journal of Social and Clinical Psychology, 26*(8), 960-981.

Saldana, J. (2009). *The coding manual for qualitative researchers.* Los Angeles: Sage.

Schiller, J. S., Lucas, J. W., Ward, B. W., & Peregoy, J. A. (2012). *Summary health statistics for U.S. adults: National health interview survey, 2010*. Washington, DC: Government Printing Office. Retrieved from Center for Disease Control and Prevention website: http://www.cdc.gov/nchs/data/series/sr_10/sr10_252.pdf

Solantaus, T., Leinonen, J., & Punamaki, R. L. (2004). Children's mental health in times of economic recession: Replication and extension of the Family Economic Stress Model in Finland. *Developmental Psychology, 40*(3), 412-429.

Takeuchi, D. T., & Cheung, M. K. (1998) Coercive and voluntary referrals: How ethnic minority adults get into mental health treatment. *Ethnicity & Health*, *3*(3), 1355-7858.

Thompson, V. L. S., Bazile, A., & Akbar, M. (2004). African Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice, 35*(1), 19-26.

Thurston, I. B., & Phares, V. (2008). Mental health service utilization among African American and Caucasian mothers and fathers. *Journal of Consulting and Clinical Psychology, 76*(6), 1058-1067.

U.S. Census Bureau. (2011). *Income, poverty, health insurance coverage in the United States: 2011*. Washington, DC: U.S. Department of Commerce.

U.S. Department of Health and Human Services. (2010). *2010 National Healthcare Quality and Disparities Reports*. Rockville, MD: Agency for Healthcare Research and Quality.

Vetere, A. (2001). Structural family therapy. *Child & Adolescent Mental Health, 6*(3), 133-139.

Williams, M. T., Domanico, J., Marques, L., Leblanc, N. J., & Turkheimer, E. (2012). Barriers to treatment among African Americans with obsessive-compulsive disorder. *Journal of Anxiety Disorders, 26*, 555-563.

Zimmerman, F. J. (2005). Social and economic determinants of disparities in professional help-seeking for child mental health problems: Evidence from a national sample. *Health Research and Educational Trust, 40*(5), 1514-1533.

APPENDIX A

Participant Social Media Recruitment Post

Hello Everyone,
I am recruiting participants for my dissertation research concerning the experiences that led African American adults to choose family/couples therapy.

If you meet the criteria below, please feel free to complete the survey at the following websitewww.aafamilytherapy.com.

If you are a therapist who has seen African American clients in the past, please feel free to forward this information to clients who you believe meet the criteria.
Please review the recruitment notification below:

Are you African American and have you ever gone to family/couple therapy or counseling to get help with an issue or problem?

If you answered "yes" to this question, you are invited to participate in a paid research study about your experiences that led you to participate in family therapy.

Criteria:

-Are you an African American adult over the age of 18, living in the United States?
-Are you able to use a computer and have access to the internet?
-Can you read and write at 5th grade level or above?
-Did you voluntarily go to therapy with a family member or significant other in the last 18 months, without any prompting by the legal system?
-Are you willing to share your experiences about what led you to therapy?
-Have you completed, left or terminated therapy?

If you meet the above criteria, I would like to hear about your experiences that led you to go to family/couples therapy or counseling. To participate in this study you will complete an online survey that will take about 20-30 minutes. Your identity will be kept confidential and your participation is voluntary. Participation in this study may include these risks: fatigue, loss of time while completing the survey, loss of privacy, uncomfortable feelings due to recounting stressful or emotional experiences.

All reasonable efforts will be made to keep your information confidential, but an online survey does have some risk of confidential information being observed by others. You may exit the survey at any time. If you choose to complete the survey, you will receive a $10 Target gift card for your participation.

Please go to the following website: www.aafamilytherapy.com
to complete the online survey.

If you have questions please feel free to contact me, Felicia J. Holloway, MA, LPC, LMFT at (214) xxx-xxxx or by email at fshelleyharoon@twu.edu. You can also contact my research advisor, Linda Ladd, PhD. at lladd@twu.edu.

This research study is being conducted by this researcher to fulfill the requirements for a PhD in Family Therapy from Texas Woman's University (TWU) in Denton, Texas. This research study has been approved by the TWU Institutional Review Board. This means that the study meets all standard of ethical requirements and it assures protection of each participant's rights, and the right to withdrawal at any time. There is potential risk of loss of confidentiality in all e-mail, downloading, and internet transactions as well as risk of fatigue and loss of time while completing the survey. Finally, by recounting emotional and or stressful times that led to therapy, participants may experience some uncomfortable feelings. This survey will take approximately 20-30 minutes to complete. Thank you for your participation.

APPENDIX B

Participant Recruitment E-mail

Are you African American and have you ever gone to family/couple therapy or counseling to get help with an issue or concern?

If you answered "yes" to this question, you are invited to participate in a paid research study about your experiences that led you to participate in family therapy.

Criteria:
- Are you an African American adult over the age of 18, living in the United States?
- Are you able to use a computer and have access to the internet?
- Can you read and write at 5th grade level or above?
- Did you voluntarily go to therapy/counseling with a family member or significant other in the last 18 months, without any prompting by the legal system?
- Are you willing to share your experiences about what led you to therapy/counseling?
- Have you completed, left or terminated therapy?

If you meet the above criteria, I would like to hear about your experiences that led you to go to family/couples therapy or counseling. To participate in this study you will complete an online survey that will take about 20-30 minutes. Your identity will be kept confidential and your participation is voluntary. Participation in this study may include these risks: fatigue, loss of time while completing the survey, loss of privacy, uncomfortable feelings due to recounting stressful or emotional experiences.

All reasonable efforts will be made to keep your information confidential, but an online survey does have some risk of confidential information being observed by others. You may exit the survey at any time. If you choose to complete the survey, **you will receive a $10 Target gift card for your participation**.

Please go to the following website: **www.aafamilytherapy.com** to complete the online survey.

If you have questions please feel free to contact me, Felicia J. Holloway, MA, LPC, LMFT at 940-xxx-xxxx or by email at fshelleyharoon@twu.edu. You can also contact my research advisor, Linda Ladd, PhD. at lladd@twu.edu.

This research study is being conducted by this researcher to fulfill the requirements for a PhD in Family Therapy from Texas Woman's University (TWU) in Denton, Texas. This research study has been approved by the TWU Institutional Review Board. This means that the study meets all standard of ethical requirements and it assures protection of each participant's rights, and the right to withdrawal at any time. There is potential risk of loss of confidentiality in all e-mail, downloading, and internet transactions as well as risk of fatigue and loss of time while completing the survey. Finally, by recounting emotional and or stressful times that led to therapy, participants may experience some

uncomfortable feelings. This survey will take approximately 20-30 minutes to complete. Thank you for your participation.

Sent by the advisor of Felicia Holloway, MA, LPC, LMFT

Linda D. Ladd, PhD, PsyD
Professor, Family Therapy
Texas Woman's University
940-898-2694
lladd@mail.twu.edu

APPENDIX C

Primary Online Survey

WHY CHOOSE FAMILY THERAPY? AFRICAN AMERICAN ADULT EXPERIENCES THAT LED TO THEIR ENGAGEMENT IN FAMILY OR COUPLES THERAPY/COUNSELING

WELCOME & INFORMED CONSENT

Welcome! Thank you for coming!

If you answer “yes” to all of the following questions, you are invited to participate in a paid research study about your experiences that led you to participate in family therapy.

PARTICIPATION CRITERIA:

1. Are you an African American adult over the age of 18?
2. Are you able to use a computer and have access to the internet?
3. Did you voluntarily go to therapy with a family member or significant other in the last 18 months, without being required to do so by the legal system?
4. Are you willing to share your experiences about what brought you to therapy?
5. Have you completed, left or terminated therapy?
6. Do you live within the United States?
7. Are you are able to read, write, and understand English at a 5th grade reading level or higher?

If you meet the criteria listed above and would like to complete the study, click "continue" below. From there, you will begin an confidential survey that will ask you basic demographic questions, and a few open-ended questions. Your identity will be kept confidential and your participation is voluntary. The survey will take about 20-30 minutes to complete. Instructions are provided throughout the survey to guide you through each section. All reasonable efforts will be made to keep your information confidential, but an online survey does have some risk of confidential information being observed by others. You may exit the survey at any time. If you choose to complete the survey, you will be able receive a $10 gift card to Target for your participation. At the end of the survey you will be given the option to provide mailing information to receive a $10 Target gift card for your participation as well as a summary of the results of the study upon its completion. You may only take the survey one time.

Note: The online submission of your completed questionnaire constitutes your informed consent to act as a participant in this research.

Research investigator*: Felicia Holloway, LPC, LMFT, 214-xxx-xxxx fshelleyharoon@twu.edu. This research study is conducted to fulfill the requirements for a PhD in Family Therapy from Texas Woman's University (TWU) in Denton, Texas. This research study has been approved by the TWU Institutional Review Board. This means that the study meets all standard of ethical requirements; assures protection of participant's rights, and the right to withdraw at anytime. There is potential risk of loss of confidentiality in all e-mail, downloading, and internet transactions as well as risk of fatigue and loss of time while completing the survey. Finally, by recounting emotional and or stressful times that led to therapy, participants may experience some uncomfortable feelings. This survey will take approximately 20-30 minutes to complete. Thank you for your participation.*

***1)** Do you understand and agree with the above statements and consent to voluntarily participate in this study?

● Yes ● No

Please answer the following questions about yourself and your last experience in family or couples therapy/counseling. Click on the answer that applies to you.

***2)** What is your ethnicity (choose one):

● African American/Black ● Asian ● Hispanic ● Non-Hispanic White ● Native American/Alaskan Native ● Native Hawaiian and other Pacific Islander ● White ● Other (please specify)

***3)** Are you 18 years of age or older?

● Yes ● No

***12)** What is your highest level of education (choose one):

● Less than high school ● Some high school ● High school graduate/GED ● Some College ● Associate's degree/Vocational Training ● Bachelor's Degree ● Graduate Degree

***13)** What is your household income level (choose one):

● Less than $15,000 ● $15,000 to $25,999 ● $26,000 to $35,999 ● $36,000 to $45,999 ● $46,000 to $55,999 ● 56,000 to $75,999 ● $76,000 to $99,999 ● $100,000 to $149,999 ● $150,000 or more

***14)** What is your marital status (choose one):

● Single, Never Married ● Married/ Domestic Partnership/ Cohabitation ● Separated ● Remarried ● Divorced ● Widowed

I am interested in how you decided to go to family or couples therapy/counseling within the last 18 months. The questions below are about couples or family therapy/counseling that has finished. Please answer the questions as completely as possible. Provide details about your experience by including specific circumstances, situations, and or thoughts you had at the time. This survey will take approximately 20-30 minutes to complete.

Before Therapy/Counseling *(Answer the following questions based on your thoughts and experiences before you entered therapy/counseling, within the last 18 months)*

***15)** What were your general thoughts about therapy/counseling before you ever attended a therapy/counseling appointment?

***16)** Within the last 18 months, what happened that led you to go to family or couples therapy/counseling?

***17)** Did anything in particular keep you from going to couples/family therapy, at first? If so, please describe what kept you from going, initially.

***18)** What other ways did you try to solve your challenges before you actually went to couples/family therapy?

After Therapy/Counseling *(Answer the following questions based on your thoughts and experiences after you stop attending family or couples therapy/counseling)*

***19)** Will you go to therapy/counseling again if you have another problem in the future? Why or why not?

***20)** Is there anything else you want to say about your experience in couples or family therapy? Please share your thoughts below.

WHY CHOOSE FAMILY THERAPY? AFRICAN AMERICAN ADULT EXPERIENCES THAT LED TO THEIR ENGAGEMENT IN FAMILY OR COUPLES THERAPY/COUNSELING

Thank you!

Thank you for participating in this study and assisting in the research of marriage and family counseling/therapy. Your time is greatly appreciated and the information you provided is extremely valuable to us! You may invite others to participate in this study by directing them to the following website www.aafamilytherapy.com .

Finally, if you would like to receive a summary of this study's findings and your $10 Target gift card as a token of our appreciation for completing the survey, click here to go to a separate site: https://www.psychdata.com/s.asp?SID=160226 to provide your name and mailing address.

If you would like more information about mental health, or desire support for you or your family members, you may contact any of the resources listed below:

Mental Health Information Websites:

The National Institute of Mental Health

www.nimh.nih.gov/

National Alliance on Mental Health

www.nami.org/

MentalHealth.gov

www.mentalhealth.gov/

Mental Health Provider Websites:

American Association of Marriage and Family Therapy

http://www.aamft.org/imis15/content/directories/locator_terms_of_use.aspx

American Counseling Association

http://www.counseling.org/learn-about-counseling/what-is-counseling/find-a-counselor

Local Mental Health Clinic:

Texas Woman's University

Counseling and Family Therapy Clinic

Human Development Building, Room 114

Denton, TX

940-898-2600

http://www.twu.edu/family-sciences/counseling-family-therapy-clinic.asp

Research investigator: Felicia J. Holloway, MA, LPC, LMFT

fshelleyharoon@twu.edu

APPENDIX D

Secondary Online Survey

WHY CHOOSE FAMILY THERAPY? AFRICAN AMERICAN ADULT EXPERIENCES THAT LED TO THEIR ENGAGEMENT IN FAMILY OR COUPLES THERAPY/COUNSELING SURVEY SUMMARY AND GIFT CARD

***1)** Would you like to receive a brief summary of the study upon its completion?

● Yes ● No

***2)** Please enter you e-mail address below:

***3)** Would you like to receive a $10 Target Gift Card as a token of our appreciation for participating in the study?

● Yes ● No

***4)** Please enter your first and last name:

***5)** Please enter your complete mailing address below (i.e. Street Number, Street Name, City, State, & Zip Code):

WHY CHOOSE FAMILY THERAPY? AFRICAN AMERICAN ADULT EXPERIENCES THAT LED TO THEIR ENGAGEMENT IN FAMILY OR COUPLES THERAPY/COUNSELING SURVEY SUMMARY AND GIFT CARD

Thank you for you participation in this study!

If you chose to receive either the gift card or the summary and you provided the appropriate information, please read below. Otherwise, thank you again for your time

If you provided the requested contact information, you will receive your $10 Target gift card with in 6-8 weeks and you will receive a summary of the results of the study upon the completion of the study.

APPENDIX E

IRB Approval Letter

TWU
TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Institutional Review Board
Office of Research and Sponsored Programs
P.O. Box 425619, Denton, TX 76204-5619
940-898-3378 FAX 940-898-4416
e-mail: IRB@twu.edu

January 27, 2014

Ms. Felicia J. Holloway

Dear Ms. Holloway:

Re: Why Choose Family Therapy? African American Adult Experiences That Led to Their Engagement in Family (Protocol #: 17587)

The above referenced study has been reviewed by the TWU Institutional Review Board (IRB) and was determined to be exempt from further review.

If applicable, agency approval letters must be submitted to the IRB upon receipt PRIOR to any data collection at that agency. Because a signed consent form is not required for exempt studies, the filing of signatures of participants with the TWU IRB is not necessary.

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 unanticipated incidents. If you have any questions, please contact the TWU IRB.

Sincerely,

Rhonda R Buckley

Dr. Rhonda Buckley, Chair
Institutional Review Board - Denton

cc. Dr. Karen Petty, Department of Family Sciences
Dr. Linda Ladd, Department of Family Sciences
Graduate School

APPENDIX F

Research Questions, Central Questions and Interview Questions

Research Questions	Central Questions	Interview Questions
1. How did adult African Americans decide to go to family therapy?	1. What experiences led adult members of African American families to choose family therapy?	16. Within the last 18 months, what happened that led you to go to family or couples therapy/counseling?
2. How did adult African Americans perceive family therapy before they entered therapy?	2. What perceptions about therapy did African Americans hold prior to going to therapy?	15. What were your general thoughts about therapy/counseling before you ever attended a therapy/counseling appointment?
3. What were the motivating factors and/or challenges, if any, that they experienced in their efforts to utilize family therapy?	3. What challenges did African American experience when initially considering engaging in family therapy?	17. Did anything in particular keep you from going to couples/family therapy, at first? If so, please describe what kept you from going, initially.
3. What were the motivating factors and/or challenges, if any, they experienced in their efforts to utilize family therapy?	4. What positive experiences encouraged African American families to initially engage in therapy?	15. What were your general thoughts about therapy/counseling before you ever attended a therapy/counseling appointment?
1. How did adult African Americans decide to go to family therapy?	5. What experiences did African Americans families have with other resources/ coping skills to address their issue prior to pursing family therapy?	18. What other ways did you try to solve your challenges before you actually went to couples/family therapy?

(Continued)

4. How likely is it that African Americans who attended family therapy will return to family therapy in the future?	6. How did the experience of utilizing therapy increase or decrease the likelihood of African American families choosing therapy in the future?	19. Will you go to therapy/counseling again if you have another problem in the future? Why or why not?