African American Christians' Decision Making to Pursue or Not Pursue Professional Psychological Help: A Qualitative Study

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AFRICAN AMERICAN CHRISTIANS’ DECISION MAKING TO PURSUE OR NOT PURSUE PROFESSIONAL PSYCHOLOGICAL HELP: A QUALITATIVE STUDY

A DISSERTATION

Submitted to the Faculty of
Montclair State University in partial fulfillment
of the requirements
for the degree of Doctor of Philosophy

by

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Upper Montclair, NJ

2018

Dissertation Chair: Dr. Leslie Kooyman
MONTCLAIR STATE UNIVERSITY

THE GRADUATE SCHOOL

DISSERTATION APPROVAL

We hereby approve the Dissertation

AFRICAN AMERICAN CHRISTIANS' DECISION MAKING TO PURSUE OR NOT

PURSUE PROFESSIONAL PSYCHOLOGICAL HELP: A QUALITATIVE STUDY

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ABSTRACT

AFRICAN AMERICAN CHRISTIANS’ DECISION MAKING TO PURSUE OR NOT PURSUE PROFESSIONAL PSYCHOLOGICAL HELP: A QUALITATIVE STUDY

by Dawn Y. Norman

The aim of this study was to explore how African American Christians’ have experienced decision making related to seeking counseling and other mental health treatment outside of the church. To this end, this study asked the following research question: What influences African American Christians’ decisions to pursue or not pursue professional psychological help? The impact of culturally related influences on the help seeking decision making of African American Christians was explored and discussed throughout this research study. The research question for this study was addressed through a qualitative interview design. This qualitative design included interviewing a total of 12 African American men and women who identified as Christian and either Baptist or African Methodist Episcopal (AME). For optimal analysis, data were stratified by participants’ age, gender, and denomination. Analysis of the data collected produced several emergent themes. From this study’s emergent themes, it is suggested that the professional psychological help seeking decisions of African American Christians are influenced by their diverse life experiences and cultural influences. Prior research has examined patterns and barriers related to the mental health treatment of African Americans. However, this study is more specific in its exploration of the impact of cultural influences the mental health help seeking decisions of African American Christians.
ACKNOWLEDGEMENTS

I am eternally grateful for the many people who have traveled with me along this doctoral journey. Although this process ends without the two most important people who began with me, I feel their pride and presence now more than ever. Rev. Dr. Clarence Norman Sr. and Ellen Norman, as my mom and dad, the love and support that you poured over me became the foundation that held me up throughout this process when my entire world shook. As you continue to smile down upon me, I will forever look up to Heaven and say, thank you.

I am thankful for the love and support of my family and friends. I wish to express endless gratitude to my children, Tara Norman and Joshua Norman. Thank you for encouraging me to begin this journey and allowing me to complete it. This could not have happened without your cooperation and sacrifice. Thank you for sharing your mom with a PhD program. I am forever appreciative of my siblings, my loves, Clarence Norman Jr., Charles Thomas, Kimberly Fortune, Beverly Norman-Thomas, and Kendra Norman. We did this together. Thank you for being my steadfast support, always. To my soulmate, Orvelle Lawson, I found motivation in the joy you brought into my life. Thank you for your love and support, just in the nick of time. I also have significant gratitude for my First Baptist Church of Crown Heights family. Thank you for being my village.

I humbly thank my mentors, colleagues, and friends at Montclair State University. I am grateful for an outstanding dissertation committee, led by Dr. Leslie Kooymans. Les, thank you for the guidance you have given me since the first day we met. Words could never capture the admiration I have for who you are and what your dedication has meant
to me. I wholeheartedly thank Dr. Catherine Roland for continually pushing me beyond my comfort zone. I appreciate every nudge that she gave me to get me to this point. As well, I am grateful for the patience and kindness of Dr. Kathryn Herr, who often encouraged me to “unpack more”. Now, I understand why. Sincere thanks to Dr. Larry Burlew, whose input was reliable and invaluable, even beyond his time at MSU. I appreciate the guidance of Dr. Kathy Gainor, who taught my first counseling course and has been teaching me ever since. I thank her for challenging me and serving as an example of what I could achieve, while doing all she could to help me achieve it. I am forever impacted by cohort number one. Thank you for the laughs and tears we shared together. Those experiences sustained me and provided me with the support I needed to finish this work. The journey would not have been the same without you. I give special acknowledgement and thanks to my Passaic County Community College family. Thank you for the support you have given me throughout this journey.

Lastly, the most important acknowledgement of all…To God be the glory.
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CHAPTER ONE

INTRODUCTION

There is no precise equivalent in human history to the psychological experience of African Americans. Due to discrimination, exposure to 300 years of slavery, and the continual concern of unfair treatment, African Americans may have developed a unique psychology that requires a particular sensitivity and approach in a counseling relationship (Vontress & Epp, 1997). While African Americans experience similar rates of mental health issues as other Americans, they have a tendency to underutilize counseling services (Constantine, Myers, & Kindaichi, 2004; Buser, 2009).

This qualitative study explored the lived experiences of African American Christians and how those experiences may have influenced their decisions to pursue or not pursue professional psychological help. Research (e.g., Chandler 2010; Vontress & Epp, 1997; Whaley, 2001) has documented how the experiences of religiosity, cultural mistrust, historical hostility, and resilience may affect African Americans’ views and behaviors regarding professional psychological help; therefore background information on these topics has been provided and considered throughout this study. Additional themes and influences that emerged were considered, analyzed, and conveyed.

The relationship between religion and mental illness has not always been positive, particularly in Western cultures. However, religious traditions have historically provided humane treatment to the emotionally vulnerable or mentally ill (Koenig, 2005). While obstacles to the mental health treatment of African American Christians may involve
several causes, in this study I explored what influenced their decisions to pursue or not pursue professional psychological help.

My exploration of these influences included the consideration of African American Christians’ religiosity. Religiosity is identified as the level of connectedness to a particular religion and its rituals and practices (Chaney, 2008). Crabtree and Pelham (2009) reported that among developed countries, the extent to which the members of a population state that religion is important to them is distinct in the United States. The Crabtree and Pelham (2009) study showed 65% of Americans state that religion is important, as compared to an overall median of 38% among other developed nations. Additionally, sub-group differences such as race, age, and gender also exist in public, private, and attitudinal indicators of religiosity within the U.S. populace. For example, African Americans consistently demonstrated higher rates of religious involvement (e.g., prayer service attendance) than their White counterparts (Chatters, Taylor, Bullard, & Jackson, 2009).

Historical research exists that documents the important role of religion and religious institutions in the lives of African Americans (Billingsley, 1999; Lincoln & Mamiya, 1990). Black churches have an extensive tradition of developing educational, social, and health services for their congregation and surrounding community. Post emancipation, Black churches were involved in founding and supporting secondary schools and colleges (Jones, 1979). These programming efforts reflect a particular worldview of African American religious traditions that prioritize the communal nature of worship, the collectivity of the church, and the role of the Black Church in reconciling
the broader social environment (Grayman-Simpson & Mattis, 2012; Lincoln & Mamiya, 1990).

Although the historical and current significance of religiosity and spirituality in the lives of many African American people has been clearly identified by researchers, psychotherapists, and counselors, the research related to the relationship between the psychotherapeutic process, particularly the decision to pursue professional psychological help or not, and religiosity and spirituality is limited (Ennis Jr., Ennis III., Ennis-Cole, & Bolden, 2004).

Additional mental health research related to ethnicity, culture, and race (Chandler, 2010; Kennedy, Mathis, & Woods, 2007; Whaley, 2001) examines the disparities in the health care treatment between African Americans and their White counterparts that continue to exist. While some of the barriers to treatment have been decreased for African Americans, many persist. Chandler (2010) examines religiosity, as well as cultural mistrust as possible contributors to African Americans’ underutilization of health services.

Cultural mistrust has been defined as the inclination some African Americans may have toward distrusting Whites (Whaley, 2001). Distrust of the health care system continues to be among the noted barriers that exist between African Americans and the health care system (Kennedy, Mathis, & Woods, 2007). Kennedy et al. (2007) cited the Tuskegee Syphilis Study as a classic and historical case of blatant governmental racism against African Americans. The infamous Tuskegee Syphilis Study is responsible for some of the distrust that many African Americans have for the health care system. While
it has been noted that there are several contributors to the distrust that persists between African Americans and the health care system, which includes professional helping relationships. Baer and Singer (2002) postulated that the distrust that many African Americans have toward professional helping relationships has often been reinforced by their religious affiliations.

An additional facilitator of some African Americans’ distrust of systems and professional psychological helping relationships is historical hostility. Historical hostility is a term coined by Vontress and Epp (1997); they noted, “Historical hostility carries the emotional charge and historical consciousness of oppression that many African Americans carry in their psyche” (p. 226). The Black church has been a primary source of fulfillment for African Americans who have often experienced hostility from the dominant society (McRae, Thompson, & Cooper, 1999). While the concepts of historical hostility and cultural mistrust may sometimes be perceived as negative byproducts of an oppressive history, researchers of these concepts (Vontress & Epp, 1997; Whaley, 2001) convey that they also foster resilience by providing judicious and discerning adaptation to oppressive environments.

**Background Research**

In this chapter I will briefly present some of the background research available related to a model of mental health help-seeking, religion and spirituality, denominational distinctions, and African Americans and mental health. More in-depth coverage of these concepts will be explored in chapter two.
Theoretical Framework

In this study I utilized *The Model of Mental Health Help-Seeking* developed by Cauce, Domenech-Rodriquez, Paradise, Cochran, Shea, Srebnik, & Bayder (2002). Although this particular model was developed for use with adolescents, it was adapted from previous versions which were developed for use with adults (Cauce et al., 2002; Srebnik, Cauce, & Baydar 1996).

The model chosen for this study is most relevant due to its emphasis on the importance of cultural factors as contributors to the help seeking attitudes and decisions of individuals (Cauce et al., 2002). This conceptual framework assisted in the examination of influences on the professional psychological help seeking decisions of African American Christians. This model was most appropriate for the study because of its emphasis on culture and context. The model indicates that cultural and contextual considerations must be examined for a comprehensive evaluation of help seeking beliefs and behaviors. *The Model of Mental Health Help-Seeking* is composed of three steps. While the order can fluctuate, the model’s steps include problem recognition, the decision to seek help, and service selection.

Religion and Spirituality

Some research (e.g., Colbert, Jefferson, Gallo, & Davis, 2008; Lewis, 2007; Tabak & Mickelson, 2009) exists that examines spirituality, religion, and mental health. However, there is limited research addressing religious and spiritual issues in counseling. According to Lewis (2007), the available research is inadequate because it is limited and narrowly focused due to a lack of diversity in the populations studied.
The confusion between religiosity and spirituality is one reason for a current lack of research regarding religiosity (Colbert, et al., 2008). Searches for the term spirituality return much more information than searches for the term religiosity. Religion is connected with identifiable organizations and faiths, while the focus of spirituality is more personal, experiential, and existential (Moberg, 2009). The concept of religiosity is described as the degree of connectedness to the practices and rituals of a particular religion (Chaney, 2008). According to Holmes and Lochman (2012), although the two constructs are separate, both religiosity and spirituality are strengths among African Americans. The terms spirituality and religiosity have been used reciprocally throughout social science research (e.g., see Mattis, 2000). Using these two terms synonymously implies that they represent the same group of values, beliefs, and experiences.

Although a noteworthy intersection of the religious and spiritual experience may exist, there is empirical confirmation (Mattis, 2000; Reed & Neville, 2013) that people make essential distinctions between these two concepts. With respect to African Americans, religion and spirituality are often essential in structuring their thoughts about social obligations, interpersonal relationships, choice of partners, and definition of community (Mattis, 2000). Socially disadvantaged groups such as African Americans may find religion helpful in providing necessities, which can include coping and support resources (Tabak & Mickelson, 2009). Religion may also serve as an integral aspect of particular cultures meeting spiritual and worldly needs (Krause, 2003).
Denominational Distinctions

Additionally, religion is often associated with denominational distinctions. According to a study conducted by the Pew Research Center’s Forum on Religion & Public Life entitled, *A Religious Portrait of African Americans* (2009), “While the U.S. is generally considered a highly religious nation, African Americans are markedly more religious on a variety of measures than the U.S. population as a whole, including level of affiliation with religion, attendance at religious services, frequency of prayer and religion’s importance in life” (p.1). The most likely group to report organized religious association was African Americans. This is in comparison to other racial and ethnic groups, with 87% of African Americans reporting belonging to one of several religious groups. Comparatively, 83% of the general public are affiliated with a religion (Pew Research Center’s Forum on Religious & Public Life, 2009).

According to *A Religious Portrait of African Americans* (2009), “The vast majority of African Americans (78%) are Protestant (‘Christian denominations that do not accept the primacy of the pope’) (True Church, 2007), compared with only 51% of the U.S. adult population as a whole” (p.1). In the U.S. and in the African American community, Protestantism is divided into three distinct traditions, which traditions include evangelical Protestant churches, mainline Protestant churches, and historically Black Protestant churches. *A Religious Portrait of African Americans* (2009) reported that 59% of African Americans belong to one of the historically Black Protestant denominations, which include the National Baptist Convention and the African American Methodist Episcopal (AME) Church.
African Americans and Mental Health

Constantine, Myers, and Kindaichi (2004) postulated that African Americans experience the same number of mental health concerns as other Americans. Yet, African Americans tend to underutilize counseling services (Buser, 2009). Treatment utilization patterns have been examined, as well as potential causes for poor treatment adherence among many members of the African American population (Jackson, Neighbors, Torres, Martin, Williams, & Baser, 2007). Additionally, research has shown that compared to Whites, the treatment outcomes of African American clients are less favorable (Bae, Brekke, & Bola, 2004).

Some of the potential obstacles to successful treatment include cultural mistrust (Whaley, 2001), racism within the counseling relationship (Parham, 2002), and treatment conditions that are inadequate in addressing the cultural values and worldviews of diverse clients (Duran, Firehammer, & Gonzalez, 2008). The issue for many African Americans and their distrust of White medical professionals was addressed by several clergy at a conference on AIDS which hosted more than 300 church leaders (AIDS Conference for Black Churches, 2000). Many of the church leaders referenced the Tuskegee Syphilis Study as a significant historical occurrence that promoted a proliferated distrust among many African Americans toward White medical professionals (The Christian Century, 2000; Head, 2007).

Additionally, many African Americans do not have equal access to formal mental health professionals. Even though African Americans are not more likely to be mentally ill, there are many factors that lead to lower rates of seeking and receiving needed mental
health care services (Lo, Cheng & Howell, 2013). The U.S. Department of Health and Human Services (2001) reported that the mental health care services received by some members of the African American community may be inadequate or the services may be received later than would be ideal. Therefore, compared to Whites, African Americans are less likely to engage in outpatient mental health treatment, and it is more common that an African American will engage in emergency mental health treatment. African Americans are also more likely to end treatment prematurely (Ayalon & Alvidrez, 2007).

The incorporation of religion and spirituality into clinical work has been an area of importance and increasing interest related to the competence needed to address diversity in clients (Parker, 2011). According to Boyd-Franklin (2003), African Americans may depend upon indigenous African spirituality as opposed to Western forms of counseling. As a result, African-centered therapy models that view spirituality as an important element to human development have been established.

To that end, one notable collaboration between psychologists and other mental health workers with the Black church was found by Ennis Jr., Ennis III, Durodoye, Ennis-Cole, and Bolden (2004) in the counseling ministry at Mt. Pilgrim Baptist Church in Scotlandville, Louisiana. This is noteworthy because the African American church and African American clergy have long served as mental health resources for the African American community (Chandler, 2010; Cook, 1993).

**Problem Statement**

Most people seem hesitant to utilize professional mental health services, and it seems that numerous individuals experiencing psychological difficulties do not seek
professional psychological help (Head, 2007; Rickwood & Braithwait, 1994). This disinclination may be accounted for by various personality or psychological characteristics, as well as inhibitors to seeking professional psychological help that are grounded in culture, and include stigma (Sue, 1994; Tata & Leong, 1994).

African Americans in the U.S. have lower rates of seeking and receiving professional psychological help than their White counterparts. Religiosity, spirituality, and trepidation of Eurocentric establishments have been discussed as possible reasons for the underutilization of health services by Blacks (Chandler, 2010). Several barriers to the mental health treatment seeking behaviors of some African Americans have caused disparities in their mental health treatment utilization (Hatcher, 2012). Some of the barriers cited include stigma, poverty, insufficient resources, transportation, childcare, as well as institutional racism, discrimination, and cultural mistrust (Hatcher, 2012; Obasi & Leong, 2009). There are also times that many African Americans trust that only God will correct issues of mental health and that difficulties will go away if ignored, or that the need to seek mental health treatment is a sign of faultiness and reduced pride (Thompson, Bazile, & Akbar, 2004).

According to Constantine, Robinson, Wilton, and Caldwell (2002), researchers have highlighted the value of assessing the critical role that religion plays in the lives of African Americans, however, studies that examine the influence of various effects of religiosity and spirituality on the psychological health of African Americans have frequently been inadequate and superficial. However, what is not as clear is how religiosity and other cultural influences may impact their decisions to pursue or not
pursue professional psychological help. Therefore, in this study, I explored and described some of the lived experiences of African American Christians who have considered pursuing professional psychological help, and delineated common culturally influential themes that emerged.

**Research Question**

The major research question for this study was: What influences African American Christians’ decisions to pursue or not pursue professional psychological help?

**Purpose of the Study**

The purpose of this study was to explore the experiences of African American Christians and make meaning of those experiences and how they may have influenced their professional psychological help-seeking decisions. This was done as an effort to illustrate perceptions not yet recognized regarding how African Americans’ lived experiences may contribute to their underutilization of professional psychological help. Uncovering these influences may assist in identifying practices or beliefs that serve as potential barriers to, or facilitators of, professional psychological treatment services for African American people in the United States. Themes that emerged were considered and explored throughout this research study.

This qualitative study was necessary because it will add to the limited research available that specifically addresses the cultural influences on African American Christians’ decisions to seek professional psychological help. Previous research (e.g., Ennis Jr., Ennis III., Ennis-Cole, & Bolden, 2004; June, 2008) has indicated that African Americans’ attitudes toward help seeking may be impacted by religiosity, cultural
mistrust (Scott, McCoy, Munson, Snowden, & McMillen, 2011; Whaley, 2001),
historical hostility, and resilience (Vontress & Epps, 1997). Therefore, in this study, I
provided background information on these concepts as a contextual framework.

One salient characteristic of much of the literature related to African Americans
and help-seeking is that they utilize a predominately college student sample population.
The principal use of college students assumes that they are an accurate representation of
the broader African American population (Brown & Stayman, 1992). To establish
increased generalizability, Peterson (2001) suggests more studies involving non-college
African Americans be conducted to explore cultural influences on help-seeking
behaviors.

A goal of this qualitative study was to contribute to the current research by
considering the lived experiences of African American Christians who may or may not
have attended college and had varied ranges of educational backgrounds, as well as
diverse life histories. During this study, I attempted to gain understanding of the
participants’ experiences and what, if any, current and historical circumstances may have
influenced their decisions to pursue or not pursue professional psychological help. Doing
so, could potentially help identify facilitators of, and barriers to, the mental health
treatment of African Americans.

**Significance of the Study**

This study extends the existing literature regarding African Americans and mental
health treatment, while the findings can potentially identify cultural barriers to and
facilitators of mental health treatment of African Americans. The utilization of mental
health services by African Americans is disproportionately lower than their White counterparts (Chandler, 2010; Hatcher, 2012; Obasi & Leong, 2009), and several possible barriers to treatment have been identified (Sue, 1994; Tata & Leong, 1994; Thompson, Bazile, & Akbar, 2004).

While some researchers (Thompson, Bazile, & Akbar 2004; Vontress & Epp, 1997; Whaley, 2001) have reported issues with religion, cultural mistrust, or historical hostility as possible barriers, until African American Christians tell their own stories about seeking professional psychological help or not, it is difficult to fully understand the attitudes they hold toward such behavior. My ultimate goal in this study was to facilitate more understanding of the experiences that may influence African Americans and their attitudes and behaviors related to seeking mental health treatment.

This study probed how the lived experiences of African American Christians may influence their decisions to pursue or not pursue professional psychological help. Exploring these experiences in a qualitative study provides a voice for the impact historical and current societal conditions may have on a population of people who could benefit from, yet underutilize, professional psychological help services. In this study I identified the influences that emerged and explored their benefits and consequences in regard to the professional psychological help seeking of African American Christians.

African American Christians were selected to participate in this study because a large part of the African American experience includes being Christian (Blaine & Crocker, 1995; Krause, 2003). The majority of African Americans (78%) are Protestant, which is a form of Christianity according to The Pew Forum on Religion & Public Life
(2009). One goal of this qualitative enquiry into the experiences of African American Christians was to use their voice to ascertain information that will assist in increasing the availability of research with diverse populations, specifically designed to examine ethnic, cultural, and religious attributes related to help seeking behaviors.

Koenig (2005) emphasized the importance of the development of more research with diverse populations for training purposes. He proposes short research training courses where researchers could receive intensive instruction on religion, as well as other cultural variables, and mental health concerns. In addition, the understanding gained through this research may assist church leaders in understanding the influence their teachings, attitude, and beliefs may have on their parishioners’ decisions to pursue or not pursue professional psychological help.

This study’s use of Christians and discussion of religiosity is critical because some people may believe religious service attendance and other ritualistic practices are the only interventions needed to combat issues of mental health. African Americans in the US experience various conditions that may be addressed effectively in a therapeutic setting. One example of this is the experience of childhood sexual abuse. Estimates of childhood sexual abuse histories among Black women range from 34% to 40% (Amodeo, Griffin, Fassler, Clay, & Ellis, 2006; Boynton-Jarrett, Rosenberg, Palmer, Boggs, & Wise, 2012). Sexual abuse is a vigorous forecaster of reduced psychological functioning (Molnar, Buka, & Kessler, 2001). Therapeutic intervention may help those effected avoid dysfunctional behavioral patterns (e.g., substance abuse) that may result.
The mass incarceration of African Americans in the US is another condition that may lend itself to the benefits of the therapeutic process. According to author Michelle Alexander (2012), “In major cities across the United States, the majority of young African American men are under the control of the criminal justice system or saddled with criminal records” (p. 169). African American individuals and families affected by mass incarceration could possibly benefit from therapeutic interventions related to separation, guilt, shame, transition, etc.

In addition, the condition of many African American families is another concern to be considered when examining the need for more therapeutic relationships among African Americans. According to Manning and Brown (2010) of the National Center for Family and Marriage Research (NCFMR), there is a significant difference in the first-time divorce rate when race is examined. African American women have divorce rates of 30.4 divorces per 1,000 women, considerably higher than their White counterparts, at 16.3 per 1,000 women. Utilization of professional marriage and family counseling services could possibly help sustain the marriages and families of African Americans.

In this study, I sought to understand how the decisions to pursue or not pursue professional psychological help may have been influenced by the lived experiences of African American Christians. While African Americans are experiencing societal and psychological conditions that may benefit from therapeutic intervention, they continue to underutilize professional psychological help services (Dobalian & Rivers, 2008). In addition, because a higher proportion of African Americans consider themselves religious (A Religious Portrait of African Americans (2009), understanding what role religion
plays in their decisions to seek professional psychological help could provide useful data to religious leaders, counselors, and mental health professionals. Also, more descriptive research that examines African Americans’ experiences may better prepare mental health professionals to provide culturally responsive treatment and establish a more therapeutic connection with African Americans.

**Definitions of Terms**

To provide clarity, definitions of various terms commonly used in the literature are provided.

**African American**

African Americans may also be referred to as Black Americans (West, 1985). African Americans have been described as an American ethnic group which includes residents or citizens of the United States. This diverse population may include people with partial or complete ancestry from any of the Black racial groups of Africa (United States Census, 2010).

**Black**

For the purpose of this study, this term refers to a person who identifies racially as Black; this includes Black people with nationalities other than American.

**Black or African American Christian**

For the purpose of this study, these terms refer to any people who identify as Black and/or African American and Christian. This includes Black people with nationalities other than American.
The Black Church

Term used by scholars as a sociological and theological reference to the pluralism of America’s predominately African American Christian churches. While there are predominately African American churches that belong to White denominations, the term often refers to those that belong to denominations that are historic and entirely controlled by African American people. Almost 60% of all African American Christians belong to one of the historic seven denominations that traditionally make up the Black Church. The seven historic denominations are: the African Methodist Episcopal (AME) Church; the African Methodist Episcopal Zion (AMEZ) Church; the Christian Methodist Episcopal (CME) Church; the National Baptist Convention, USA., Incorporated (NBC); the National Baptist Convention of America, Unincorporated (NBCA); the Progressive National Baptist Convention (PNBC); and the Church of God in Christ (COGIC) (Lincoln & Mamiya, 1990).

Christianity

“The religion derived from Jesus Christ, based on the Bible as sacred scripture, and professed by Eastern, Roman Catholic, and Protestant bodies” (Merriam Webster Online, 2013).

Church Leader

For the purposes of this study, the term church leader refers to any person in a position of leadership in the church. A church leader includes, but is not limited to, Pastor, Assistant Pastor, Lay Minister, Deacon, Trustee, First Lady (Pastor’s wife), etc.
Cultural Mistrust

Term created by Terrell and Terrell (1981), refers to African American peoples’ distrust and suspiciousness toward White systems (medical, justice, educational, political, social, etc.).

Historical Hostility

Coined by Vontress and Epps (1997), this term refers to seemingly negative responses shown by some African Americans, possibly caused by persistent marginalization and inferior treatment.

Mental Illnesses

Described by the National Alliance on Mental Illness (2013) as “Medical conditions that disrupt a person’s thinking, feeling, mood, ability to relate to others and daily functioning…Mental illnesses are medical conditions that often result in diminished capacity for coping with the ordinary demands of life” (p.1). Some of the mental illnesses included in this description are major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), and panic disorder (NAMI, 2013).

Religious denomination

“A group or branch of any religion” (Oxford Dictionaries Online, 2013).

Resilience

Exhibition of positive adaptation regardless of negative and significant experiences of trauma (Luthar & Cicchetti, 2007).
Professional psychological help

For the purpose of this study, the term professional psychological help refers to the non-religious mental health treatment services of professional counselors, psychologists, psychiatrists, and social workers.

Protestant

Denominations of Christianity that do not recognize the primacy of the pope (True Church, 2007).

Religiosity

The level of connectedness to a particular religion and its rituals and practices (Chaney, 2008).

Spirituality

Gall, Malette and Guirguis-Younger (2011) described spirituality as a fundamental part of one's identity and the individual understanding of the transcendent whether it is defined conventionally as God or a higher power, or in more nonspiritual terms as unity with the enigmatic or the greater world. Similarly, Moreia-Almeida, Koenig, and Lucchetti (2014) describe spirituality as “the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community” (p. 176).

Organization of the Dissertation

This dissertation is presented in five chapters. Chapter one includes an introduction and background literature on the concepts explored in the study, including
religiosity, cultural mistrust, historical hostility, and resilience. In addition, chapter one also provides a brief overview of information regarding differences between religion and spirituality, African Americans and mental health, a problem statement, a statement of purpose of the study, a statement of significance of the study, definitions of key terms, and possible significance of the findings.

Chapter two contains an extensive review of the literature related to the critical concepts being explored. In chapter three, I have described the: methodology used for the study, population of participants, stratification methods, data collection methods and process. Chapter four presents the data analysis results. Finally, in chapter five, I have discussed and interpreted the study results and their implications to the mental health treatment of African Americans. Chapter five also includes a discussion that addresses some of the limitations to this study.
CHAPTER TWO
REVIEW OF THE LITERATURE

In this study, I explored what influenced African American Christians’ decisions to pursue or not pursue professional psychological help. A disproportionate number of health problems do exist among African Americans. However, some researchers (McGuire & Miranda, 2008) state that while African Americans have equal or better mental health than their White counterparts, they continue to suffer from mental health care disparities. Once African Americans become mentally ill, they are also more susceptible to chronic and persistent conditions (Lo, Cheng & Howell, 2013; McGuire & Miranda, 2008). This study explored several components of the African American experience in America and examined their possible influence on the professional psychological help seeking decisions of African American Christians.

A comprehensive review of the literature regarding the experiences of African Americans and how those experiences may influence their decisions to pursue or not pursue professional psychological help has informed this study. This chapter is a review of the related literature.

The history of African American people in America began with slavery and has been constructed on a foundation of racism and discrimination. According to Randall Robinson (as cited in Leary, 2005), much of the wealth and power that exists today was built on the economic cornerstone of slavery. Robinson adds that the psycho-social consequences of slavery in America also continue to exist as well. Therefore, I assert that matters regarding the mental health of African American people in America are most
effectively examined within this broader historical context. This broader historical context is particularly important because researchers (e.g., Chandler, 2010; McGuire & Miranda, 2008) have reported that African Americans utilize mental health services less than Whites and terminate treatment prematurely more often than Whites. Early termination of mental health treatment among racial minority populations is a persistent challenge (Fortuna, Alegria, & Gao, 2010). In addition, even though minorities generally have equivalent mental health issues to Whites, they suffer from disparities in mental health treatment (McGuire & Miranda, 2008).

Clearly, slavery and religion have played a critical role with respect to the African American culture today. These historical factors may even influence the psychological help seeking decisions of African American Christians or the psychological distress that many African Americans experience. An example of this is an ailment known as Post Traumatic Slave Syndrome (PTSS) (Leary, 2005).

Post Traumatic Slave Syndrome is a condition existing when multigenerational trauma ensues within a population as a result of its experience of centuries of slavery, sustained oppression, and persistent institutionalized racism. Prevalent among those who experience PTSS is a worldview that the advantages of society are not attainable (Leary, 2005). In a counseling context, the advantages African Americans consider unattainable may include fair, quality, trustworthy, culturally competent professional psychological help. While some African Americans may experience trauma as severe as PTSS, there will be varying degrees of how individuals’ experiences are informed by a historically racist and oppressive society. Therefore, in this qualitative study, I explored how African
American Christians’ decisions to pursue or not pursue professional psychological help may have been influenced by sociopolitical history, as well as other personal experiences. Some of the historical and personal experiences considered in this study will include religiosity, cultural mistrust, historical hostility, and resilience.

Participants’ personal experiences of being an African American Christian will also be an intricate component for exploration in this research study. I have chosen to study African American Christians because of my personal experience being an African American Christian and because 59% of African Americans belong to one of the historically African American Protestant denominations (A Religious Portrait of African Americans, 2009). In numerous studies (e.g., Chatters, Taylor, & Lincoln, 1999; Constantine, Lewis, Conner, & Sanchez, 2000; Levin, Taylor, & Chatters, 1994; Smith, 1997) African Americans reported levels of religious and church participation that are higher than the general U.S. population. Chandler (2010) described the church as having served as African American peoples’ primary physical and psychological health facility, for those of Christian faith.

**African Americans and Mental Health**

Differences in the use of mental health services by ethnic and racial minority groups have been well recognized. Members of ethnic and racial minority groups are less likely to visit mental health specialists or receive outpatient care (Jimenez, Cook, Bartels, & Alegria 2012; Lo, Cheng & Howell, 2013; McGuire & Miranda, 2008). Jimenez et al. (2012) report that mental health care generally occurs less often for members of ethnic
and racial minority groups. Researchers have compared mental health service utilization by different ethnic groups and found that African Americans received less care than White Americans; and that most African Americans experiencing anxiety or mood disorders did not receive care (Chandler, 2010; McGuire & Miranda, 2008; National Center for Biotechnology Information [NCBI], 2015).

Disparities remain between African Americans and Whites even after initial contact has been made with mental health systems. African Americans tend to terminate treatment prematurely more often than Whites (Chandler, 2010; Sue, Zane, & Young, 1994). African Americans also tend to receive emergency or mandated care more often (Carpenter-Song, Whitley, Lawson, Quimby & Drake, 2011; Cook, Zuvekas, Carson, Wayne, Vesper, McGuire, 2014; Hu, Snowden, Jerrell, & Nguyen, 1991).

Some of the barriers most often identified as causing such disparities in the mental health treatment of many African Americans include poverty and lack of resources, insufficient insurance coverage, childcare, and transportation (Brown, Ojeda, Wyn, & Levan, 2000). Additional barriers noted by researchers consist of discrimination, institutional racism, inadequate understanding of the mental health profession, religious or spiritual codependence, and cultural mistrust of medical systems and mental health care professionals (Chandler, 2010; Obasi & Leong, 2009).

Hatcher (2012) opines that African Americans may also be disinclined to seek mental health treatment if the only options for service are the same people who have added to their stress and oppression. Statistics from the National Alliance on Mental Illness (NAMI) (2009) show that only 2% of psychiatrists, 2% of psychologists, and 4%
of social workers in America are African American. Additional statistics from Towns et al. (2009) report that only 3.8 percent of counseling professionals identify as Black. While it has been established that more racial and ethnic minorities are necessary in the mental health workforce, there is also a prevalent need for an increased level of cultural competency among all mental and behavioral health care providers irrespective of their race.

The 2007 Annapolis Coalition reports that new health care providers are insufficiently prepared to meet the mental health needs of a progressively diverse population. The coalition notes this as a crisis for communities of color. In her 2006 book, *Black Families in Therapy*, Nancy Boyd-Franklin acknowledges that it has been necessary for numerous training programs to specifically recruit African Americans and other ethnic minority clinical staff and trainees.

According to Thompson, Bazile, and Akbar (2004), many African American people are often under the impression that God alone can remedy issues of mental health. Frequently, it is believed that utilizing mental health agents is a sign of weakness, and if disregarded, these problems will diminish. People often deny necessary mental health treatment because of this perceived stigma. Even at times when the conceivable consequences for not seeking help are severe, stigma has become the most prominent reason for people’s unwillingness to do so (Vogel, Wade, & Hackler, 2007). Not only could stigma affect access to mental health treatment, it could affect treatment efficacy as well (Sadow & Ryder, 2008).
It is believed that African Americans make tremendous use of alternative treatment for health and mental health difficulties. In a seminal article written by Smith Fahie (1998), the author postulated that this is a reflection of cultural customs established by African Americans when they were methodically omitted from mainstream healthcare institutions. Notably there is a dearth of empirical data that has examined the use of alternate or complimentary treatment among African Americans faced with mental health or other health challenges (Koss-Chioino, 2000; Ojelade, McCray, Ashby, & Meyers, 2011).

One nationally representative survey showed that African Americans held more positive opinions regarding the use of home remedies than White Americans (National Institute of Mental Health, [NIMH] 2001; Snowden, Libby, & Thomas, 1997). However, people who use home remedies and alternative treatments may not understand that if the use of these methods is not reported to their clinicians, it could interfere with clinical mental health treatment. These practices could inadvertently act as barriers to mental health treatment (NIMH, 2001).

Ayalon and Alvidrez (2007) discussed some of the barriers to and facilitators of the mental health treatment of African Americans for whom the need for mental health treatment was documented. They interviewed over 30 African American mental health treatment consumers. Interviewees suggested that some of the barriers to seeking treatment were family privacy, denial of mental health problems, and concern about stigma.
While most of the research regarding African Americans and mental health treatment has focused on the barriers to treatment, Ayalon and Alvidrez (2007) also examined the facilitators of mental health treatment for African Americans. The researchers noted that some of the facilitators of African Americans’ mental health treatment consumption were: perceived need, receiving a referral from a health care provider or friend/family member, and ignoring negative opinion of others regarding mental health and treatment.

Mental Health Concerns

In her 2004 book, *Post Traumatic Slave Syndrome*, Dr. Joy Leary examined the long-lasting effects of slavery on African Americans. She often asks the question, “What effect has our history had on our culture and our soul?” (p. 112). Leary compares the stress and trauma yielded from slavery to a wound on the psyche of African Americans that still suppurates. Leary (2004) describes African Americans of having experienced a “legacy of trauma” (p. 117). She explains that included in this legacy is many of the beliefs and behaviors of African Americans. Although some of those beliefs and behaviors were once needed for survival, they now undermine many African Americans’ capability to be successful. Leary contends that beliefs and behaviors are informed by life experiences. She explains that experiences are passed down through generations and that those experiences inform the way parents raise children, as well as the way their children raise children.

Leary (2004) also notes that while the direct relationship between slavery and modern major social issues facing African Americans is a challenge to prove empirically,
research has shown that survivor syndrome is prevalent among the second and third
generations of other groups who have been traumatized and oppressed (Danieli, 1998). According to Danieli (1998), survivor syndrome includes problems with aggression,
stress, self-doubt, and several psychological and interpersonal relationship problems.

Some of the social issues faced by African Americans have been examined in the
National Alliance on Mental Illness (NAMI) (2009) report. The report stated that social circumstances frequently function as indicators for the chances of developing a mental illness. NAMI (2009) references some of these social circumstances that African Americans experience at a disproportionate rate. For example, African Americans comprise only 12% of the U.S. population yet 40% of the homeless population. People who experience homelessness have increased risks of developing a mental illness. African American children encompass 45% of the public foster care population. Children in foster care and the child welfare system have an increased likelihood of developing mental illness. Exposure to violence also increases the risk of developing mental illness. The criteria for posttraumatic stress disorder are met by over 25% of African American children exposed to violence (NAMI, 2009).

The mass incarceration of African Americans in the U.S. is another social condition that affects the mental health of many African Americans. In her 2012 book *The New Jim Crow*, Michelle Alexander reports that in 2011 there were more African-Americans in prison or “under the watch” of the justice system than were enslaved in the United States in 1850. Alexander compares America’s mass incarceration of African
Americans to the legalized discrimination of Jim Crow, in which state and local laws enforced racial segregation in the Southern United States.

Through mass incarceration, large segments of society are segregated physically and discriminated against in voting, employment, education, jury service, and public benefits. From 1980 to 2008, the number of people incarcerated in America quadrupled from about 500,000 to 2.3 million people. African Americans now constitute nearly 1 million of the total 2.3 million incarcerated populations. African Americans are incarcerated at almost six times the rate of Whites (Alexander, 2010; National Association for the Advancement of Colored People [NAACP], 2014).

Approximately 650,000 people are released from prison per year. Mental illness is 2-4 times higher among prisoners than it is in the general population. In addition, three out of four of those released have a history of substance use disorders (Council of State Governments [CSG], 2014). The aforementioned conditions affect African Americans at disproportionate rates. African Americans are noted as being excessively more probable to experience social circumstances that worsen their chances of developing a mental illness (Chandler, 2010; Lo et al, 2014; NAMI, 2015). Hays and Erford (2010) noted some additional challenges common among African Americans that may manifest as presenting issues in a counseling setting. Those concerns include multigenerational role conflict, the experiences of the school to prison pipeline, the negative impact of colorism, absent father figures, and unemployment. For many, these conditions have been a part of their experience and has impacted their mental health and their decisions to pursue or not
pursue mental health treatment. This study describes participants’ interpretation of their experiences that relate to professional psychological help treatment decisions.

In this study I have offered historical information that may increase understanding of the mental health treatment consumption of African Americans. Historical information provides a framework and sociopolitical context of the experience of many African American people in America.

**The Historical Experience of African Americans in the United States**

In the early 1500s, the first slaves arrived in the Americas from Africa. Although the transatlantic slave trade became illegal in the United States in 1808, it continued until 1870 in other parts of the Americas. Although numbers vary, it has been estimated that between 20 and 30 million people were captured and transported during that period (Leary, 2005). The practice of slavery continued in the United States for centuries, with African American slaves helping to build America’s economic foundation and provide the foundation for the wealth of America (Horton & Horton, 2005).

The population of slaves practically tripled between 1790 and 1830. Slave families were often broken apart and sold as individuals. Occasionally, Whites recognized the inhumanity of separating families but continued the practice due to the large profits that resulted from the sale of separated slave families (Horton & Horton, 2005). Menard (2013) notes that some historians believe that slavery was driven by such profits and was sustained by political and cultural necessities.

The institution of slavery grew to approximately four million people held captive by the beginning of the Civil War in 1861. The labor of at least 12 generations of African
American people held in bondage created extreme wealth and political power for
slaveholders (Horton & Horton, 2005). Slavery has been referred to as the “American
crucible” (Blackburn, 2011), and its impact continued throughout American history.
According to Alexander (2012), “Slavery may have died, but for thousands of Blacks, the
badge of slavery lived on” (p. 141).

With respect to understanding the impact of slavery, one man, Ulrich Bonnell
Phillips, dominated the thinking of many people for almost fifty years after World War I.
Phillips taught at institutions such as the University of Michigan and Yale. He was a
Southerner with a widely publicized belief in the inferiority of African Americans.
Phillips’s imperious book, *American Negro Slavery*, written in 1918 was long regarded as
a commanding work in its field. Phillips’s writing described the treatment of slaves on
large plantations as kind paternalism, orderly, with a concern for good health (Davis,
2001).

Davis (2001) noted that in Phillip’s lengthy book, no section is devoted to the
topic of slave families. The topic of slavery and family was later covered by E. Franklin
contended that American Blacks had been detached from their African cultural heritage
by the Atlantic slave trade and by depriving husbands and fathers of responsibility and
authority; slavery “had led to families headed by mothers, weak marital and parental ties,
and a lack of restraint on individual impulses—marks of social disorganization which
racism and poverty had perpetuated far into the twentieth century” (Davis, 2001, p. 282).
Another groundbreaking book, *The Peculiar Institution*, written by Kenneth Stampp in 1956 discredited Ulrich Bonnell Phillips’s portrayal of munificent paternalism and pronounced the extensive horrors of the ownership of human beings in a permissive society. Like Frazier, Stampp reported the damaging effects that slavery and Southern laws (which did not recognize slave marriages and gave owners complete power) had on slave families and slave marriages.

Stampp insists that those effects caused slaves to live “in a kind of cultural chaos” (Davis, 2001, p. 282).

Stampp’s (1956) work is known for discrediting the theory that had been perpetuated by Southern historians during the Jim Crow era that slavery was a benevolent, protective institution that was better for slaves than their lives in “savage” Africa. Stampp’s belief that “both races had approximately the same potentialities” separated *The Peculiar Institution* from the majority of previous studies of slavery (Brundage, 1997, p. 119). In his original writing on the topic, Stampp (1956) asserted that natural and social science was revealing that race was inconsequential to the potential of human beings and that slaves were human beings with the same capabilities and potential as Whites. Stampp unambiguously linked his study of slavery to contemporary issues. He maintained it was not possible to comprehend the “recent tribulations” of Blacks without a comprehension of slavery.

Information provided in this chapter regarding slavery and other historical events that significantly impacted African Americans is intended to provide a framework for how past experiences may influence their choices years after the occurrences have taken place.
A comprehension of the past and present sociopolitical perspective of African Americans may assist in understanding the current influences on their decisions to pursue or not pursue professional psychological help.

**A History of Scientific Racism and Medical Experimentation**

Historical incidents of medical experimentation in the United States may also contribute to African Americans’ decisions to pursue or not pursue professional psychological help. The medical experimental exploitation of African Americans has been well documented by Harriet Washington in her 2006 book *Medical Apartheid*. Washington describes medical experimentation performed on slave women and continues to describe unethical medical policies and practices that have taken place throughout the course of American history; with some of these events being fairly recent (e.g., The Tuskegee Syphilis Study of 1972). While this book is one source of documentation, many African Americans have been exposed to some version of these events through a rich oral storytelling tradition (Rommel-Ruiz, 2006).

These prejudicial and damaging historic medical practices and diagnoses were physically and psychologically harmful to African Americans. Several injurious practices will be discussed in this chapter. These documented events, along with numerous others, may contribute to African Americans’ cultural mistrust and suspicion of medical systems, as well anything professing to be scientific, such as psychology and counseling. By acknowledging cultural influences on the professional psychological help seeking decisions of African American Christians, this study recognizes the importance of
examining this decision-making process through the lens of a cultural and historical context.

Research suggests that African American peoples’ decision making is influenced by current societal situations, as well as history (Washington, 2006; Whaley, 2001). The following information on medical experimentation is provided for the purpose of framing the possible historical and current contributors to religiosity, cultural mistrust, historical hostility, and resilience, which are cultural experiences that may influence African American Christians decisions to pursue or not pursue professional psychological help.

**During Slavery**

During slavery Southern doctors were significantly involved in the medical treatment of slave women. The pre-emancipation care these doctors provided has been described by some as offensive, exploitive and cruel (Haller, 2007). The doctors identified with the slave owners, not the slave women they were treating, which facilitated a despotic relationship between the doctor and the patient (Haller, 2007).

Gamble (1997) and Washington (2006) discussed Dr. J. Marion Simms, known as the father of gynecology. Dr. Simms performed experimental surgical procedures on slave women. Three of the women that Dr. Simms reported operating on underwent up to 30 surgeries each between 1845 and 1849. These painful surgeries were performed on slave women using no anesthesia. Once Dr. Simms perfected his surgical technique to repair vesicovaginal fistulas by experimenting on slave women, he attempted the procedure on White women who volunteered for the surgery. The surgery on the White
volunteers was done while the patient was anesthetized (Gamble, 1997; Washington, 2006).

Slave women attempted to maintain control of their health and reproductive functions by utilizing alternative lay healers within the slave communities. If at all possible, slave women depended on each other when it came to health matters. They reached out to elderly slave women and mid-wives who were prepared to treat them with folk medicine and ancient customs when they were sick or in labor. Even though this option offered restricted medical knowledge, it was the preferred choice of the slave women (Haller, 2007). This type of reliance on one’s own community for treatment, when the threat of an outsider is perceived (i.e. cultural mistrust and historical hostility), may prove relevant in the lives of the participants in this study.

Another acclaimed doctor during slavery was Dr. Samuel Cartwright. Dr. Cartwright was a well-known doctor in Louisiana in 1851. He was considered a primary authority on the medical treatment of African Americans (Jackson, 2003). Dr. Cartwright was appointed chairman of a Louisiana State Medical Convention Committee and assigned to examine the diseases specific to Black slaves in the South (Bynum, 2000). In his work, he identified two mental disorders that he said were specific to slaves, *Dysaethesia Aethiopica*, also known as *Rascality*, and *Drapetomania* (Washington, 2006).

According to Dr. Cartwright, the skin lesions and other physical marks that accompanied Dysaethesia Aethiopica made it different from other mental diseases. He explained this disease as a dullness of the mind and laziness. He proclaimed that the cure
for this particular mental illness was whipping. As a principal thinker on the institution of slavery, Dr. Cartwright wrote an article titled *Diseases and Physical Peculiarities of the Negro Race*. As a supplement to his scholarly work, Dr. Cartwright regularly wrote pro-slavery letters to newspapers and magazine publications where he pronounced Black inferiority using the bible and science as his foundation. (Washington, 2006).

Along with Dysaethesia Aethiopica, Drapetomania was also branded by Dr. Cartwright as a disease that was peculiar to slaves and also cured by whipping. Drapetomania according to Dr. Cartwright was a condition that caused slaves to attempt to escape capture and flee from “service.” Drapetomania was marked as a disorder characterized by absconding from service. Dr. Cartwright contended that the slave owner had an obligation to keep slaves from escaping for the slaves own safety because freedom would create insanity in the slave (Washington, 2006).

**Post-Slavery**

In 1895, the Superintendent of the Georgia Lunatic Asylum, Dr. T. O. Powell, noted a large growth in tuberculosis and insanity among Blacks in Georgia. A contrast of census records between 1860 and 1890 displayed that insanity among Blacks had risen from 1 in 10,584 to 1 in 943. Dr. Powell purported that the sanitary and controlled lives lived by Blacks when they were slaves protected them against tuberculosis and insanity. Dr. Powell postulated that freedom removed restraints and that Blacks were no longer compliant to the inescapable laws of health and began to engage in various immoralities and had no control of their passions. It is noted that Dr. Powell failed to mention the
former slaves’ destitution, disruption of family, racism, and terrorism as causes of the elevated rates of so called insanity (Jackson, 2003).

When slaves were freed, most were penurious and still regarded by many as less than human. They received health care treatment by Southern medical schools. These teaching hospitals and free clinics had a disproportionately Black patient population, and many institutions in the South only treated Blacks. The intention at these institutions was to use these patients for practice, not healing (Cohen, 2009). Washington (2006) contended that studying a population over represented by African American patients created a sampling bias that promoted untrue beliefs regarding racial differences in intelligence and philosophy. Unusual conditions of Black people were racialized and assigned to all Black people or only to Black people (Washington, 2006).

Post-Civil Rights Era

Washington (2006) recognized “Black iatrophobia” (an abnormal or irrational fear of doctors) and explained that there are several experiences in the history of African Americans that contribute to its existence. Washington described the Tuskegee Syphilis Study (TSS) as a major contributor to the iatrophobia of many Blacks, but cautioned that it is not the only factor. Washington (2006) referenced the TSS and credited “a rich oral tradition” to “the sustained remembrances of pain, abuse, and humiliation” (p. 179). Stories of oppression and racism are as essential as stories of strength and hope, so as not to forget the past. Collective memories can be kept alive through these stories being told and retold (Sharma, 2009).

The following excerpt describes the TSS in detail, as told by Sharma (2009):
The Tuskegee Syphilis Experiment, or the study on The Effects of Untreated Syphilis in Negro Male, as it was officially titled, was a research project conducted in Macon County in the state of Alabama between 1932 and 1972, with 600 black men as the subjects, of which 399 had been identified as syphilitic and 201 were part of the non-syphilitic control group (Baker et al.; 2005 Jones, 1993). Macon County was chosen because of the high rate of syphilis among the black population there (Baker et al. 2005). Funded by the United States Public Health Services (USPHS) and led by a team of physicians and other health care providers, the experiment was aimed at understanding the effects of syphilis among black men, if left untreated. While the study was originally meant to last only a few months, it eventually became a longitudinal study that examined the effects of untreated syphilis over a lifetime, and ended up as a 40-year long project that terminated only when the matter was picked up and publicized by the media in 1972 (Brandt, 1978; Jones, 1993).

The major focus of this experiment was the interest in racial differences between black and white men, based on the observed effects of syphilis, which at the time was often attributed to the differences in the biological makeup of the two races (Brandt, 1978). The premise of the Tuskegee study was that the “treatment for venereal disease among blacks was impossible, particularly because in its latent stage the symptoms of syphilis [became] quiescent” (Brandt, 1978). So, their justification was that when treatment was not going to have any positive bearing
on the health outcomes for these black men, then why not study them in order to understand better how syphilis influences them, and thereby study the disease better. Moreover, they opined, that even if treatment was available, health services for black men were few and far in between in the rural South, and therefore many of these men would go untreated anyway. Therefore, as they saw it, this was an experiment on the subjects in their natural environment, without any external interference. These arguments helped them rationalize and defend the need for starting the experiment, and continuing it for four decades.

Men subjected to the experiment were typically poor and illiterate (Jones, 1993). This made it easier to deceive and exploit them. When they recruited the sample of syphilitic and non-syphilitic black men, they told many of these men that they were being treated for “bad blood” (Jones, 1993). Some subjects believed they were being treated for rheumatism or bad stomachs (Jones, 1993). They were also offered various incentives such as “free physical examinations, free rides to and from the clinics, hot meals on examination days, free treatment for minor ailments, and a guarantee that burial stipends would be paid to their survivors” (Jones, 1993). However, at no point during the study did they have any intention of providing treatment for the venereal disease, even when they knew that these men had such a disease (Jones, 1993).

They used different tactics, often with the assistance and participation of African American health care personnel, in order to continue deceiving the research subjects and making them undergo a variety of medical tests, many of which were
excruciatingly painful. Even when the use of penicillin for such bacterial infections had gained popularity in the 1940s, the subjects of the Tuskegee study were denied this treatment although the patients could have potentially benefited from it (Jones, 1993). The experiment came to an unplanned end in 1972 when a journalist broke the story in the media, and the USPHS was forced to terminate the study due to the shock and outrage generated by media reports (Brandt, 1982; Jones, 1993). Twenty-five years later, at a ceremony in the White House in 1997, President Clinton would apologize to the African American people affected by the study on behalf of the citizens and government of the US (Sharma, 2009, p. 5).

Reverby (2011) postulated that the story of the Tuskegee Syphilis Study sometimes becomes mythical when it circulates; this refers to assertions that the doctors went beyond the acknowledged neglect and secretly infected the men with syphilis. Tuskegee Syphilis Study historians have spent over twenty years attempting to rectify and correct this misinformation and inform the public and scholars of as many of the facts as possible. Reverby (2011) contended that the facts of the story are horrendous enough without propagating misunderstanding over the true events.

This story has impacted Black peoples’ trust of mental health services as well as physical health services. John Head (2007), author of *Standing in the Shadows: Understanding and Overcoming Depression in Black Men*, noted that when he speaks to people regarding mental illness in the Black community, lack of trust in the healthcare system always arises. The most common reason Black people give Head for not seeking treatment for mental health issues is the stigma associated with mental illness, but the
second most common reason is the distrust of the healthcare system. Head reported that the Tuskegee Syphilis Study is often provided as an explanation of why many Blacks fear seeking help from the health care system.

Because of America’s history of engaging in egregious unethical medical procedures and practices with African Americans, cultural mistrust may be a thriving experience for African Americans across generations. For those affected, this factor may then, in fact influence thinking about any health care system for treatment of any kind and whether or not it can be trusted. Therefore, I considered the concept of cultural mistrust when I explored the influences on Black Christians’ decisions to pursue or not pursue professional psychological help.

Cultural Mistrust

A major barrier to the use of mental health services by racial minorities has been identified as mistrust (Scott, McCoy, Munson, Snowden, & McMillen, 2011). In their 1968 seminal book, *Black Rage*, authors Grier and Cobbs contended that a “cultural paranoia” was important for Blacks, whereby they viewed Whites and systems of formal service as untrustworthy until those Whites and systems were proven to be trustworthy. The necessity for an increased level of cultural sensitivity in psychological interactions with African Americans sometimes involves a dilemma in communication for mental health care providers. While acknowledging cultural differences, mental health care providers are advised to demonstrate competence and authenticity and not rely on stereotypes and oversimplifications when engaging in therapeutic relationships with African American clients (Scott et al., 2011; Whaley, 2001).
The construct of *cultural mistrust* was generated by Terrell and Terrell (1981). This construct defines the theoretical level of distrust and suspiciousness Black people displayed toward White political activities, educational systems, business interactions, and interpersonal and social contexts. The Cultural Mistrust Inventory (CMI) is a seminal tool created by Terrell and Terrell in 1981 based on the assumption that due to past and present oppressive and racist experiences, Blacks retain a cultural paranoia in the form of mistrust of Whites (Terrell, Taylor, Menzise, & Barrett, 2009).

The CMI examines Black people’s cultural mistrust within the four domains of Education and Training, Interpersonal Relations, Business and Work, and Politics and Law (Terrell & Terrell, 1981; Townes, Chavez-Korell, & Cunningham, 2009). A meta-analysis was conducted by Whaley (2001) examining cultural mistrust and how it relates to the use of mental health services verses the domains addressed by Terrell and Terrell (1981). Whaley (2001) found that African Americans’ mistrust of White people in the domains listed in the CMI were consistent with their mistrust of White people in counseling settings.

Most of the related research has addressed the association between attitudes toward counseling and cultural mistrust among Blacks, particularly in an interracial context. Generally, African Americans who possess high levels of cultural mistrust tend to possess more negative views and expectations of White counselors (Chandler, 2010; Grant-Thompson & Atkinson, 1997; Nickerson, Helms, & Terrell, 1994; Poston, Craine, & Atkinson, 1991; Terrell & Terrell, 1984; Thompson, Worthington, & Atkinson, 1994; Watkins & Terrell, 1988; Watkins, Terrell, Miller, & Terrell, 1989). One pioneering
study by Terrell and Terrell (1984) examined Black clients’ premature termination rates at a community mental health center and found that those rates were positively associated with cultural mistrust. At times, the dubious interactions between Black and non-Blacks are duplicated in counseling and therapy sessions (Scott et al., 2011).

In therapeutic situations that replicate the power relationships and cultural principles of society at-large, cultural mistrust might be reinforced and create a barrier to health promotion in African Americans (Chandler, 2010; Maultsby, 1982; Ridley, 1984). Low self-disclosure in a therapeutic context has conventionally been interpreted as a manifestation of psychopathology. However, cultural mistrust or adaptive paranoia could cause Black clients to limit self-disclosure in an interracial therapeutic setting.

Cultural mistrust could also impact the outcomes of neuropsychological testing and evaluations. In turn, a Black client’s healthy reaction to a racist society may be mistakenly pathologized by mental health care providers (Ridley, 1984; Whaley, 2012). For example, numerous historical and current studies (e.g., Barnes, 2013; Collins, Rickman & Mathura, 1980; Mukherjee, Shukla, Woodle, Rosen & Olarte, 1983; Toch, Adams & Greene, 1987; Whaley & Hall, 2009) indicate that schizophrenia is over-diagnosed among African Americans. One explanation for the over-diagnosis of schizophrenia for African Americans is that mental health care providers may be insensitive to dissimilar cultural norms for paranoid ideation in the Black population (Adebimpe, 1981; Barnes, 2013; Grier & Cobbs, 1968; Jones & Gray, 1986; Ridley, 1984; Whaley & Hall, 2009).
Additionally, some research (Brown, Vinson, Abdullah, 2015; Castro, Gordon, Brown, Anestis, Joiner, 2008) examining racial identity and the Minnesota Multiphasic Personality Inventory (MMPI) has also noted the misdiagnosis of African Americans who generally scored higher on scales 8 and 9, which assess schizophrenia and hypomania. These researchers have voiced concern that “the MMPI may pathologize normal racial identity processes for African Americans” (Brown et al., p. 13). When using instrumentation created by and standardized with European Americans to assess African Americans, various cultural issues and differences should be considered (Brown et al., 2015).

Some of the psychiatric misdiagnosis of Blacks can be explained by the construct of cultural mistrust (Barnes, 2013; Whaley, 1997; Whaley & Hall, 2009). In a seminal study, Ridley (1984) noted that the essential hypothesis is that mental health care providers’ misinterpretation of cultural mistrust as clinical paranoia contributes to the misdiagnosis of African American mental health treatment consumers as schizophrenic. According to McGuire and Miranda (2008), evidence indicates that clinicians under-diagnose mood disorders and over-diagnose schizophrenia in African Americans.

In this study, I explored African American Christians’ familiarity with these types of experiences and considered the impact of cultural mistrust and examined its possible influence on their decisions to pursue or not pursue professional psychological help. In a classic study, Vontress and Epp (1997) explain that this cultural mistrust is sometimes displayed as a paranoia and can effect African Americans’ actions toward counseling and during the counseling session. The authors report that in some cases this mistrust is
accompanied by historical hostility, which can also have a critical impact on African Americans’ decisions regarding mental health treatment. Therefore, my study also examined the influence of historical hostility on African American Christians’ decisions to pursue or not pursue professional psychological help.

**Historical Hostility**

As a result of the historical experience of African Americans in the United States, some African Americans may have developed what Vontress and Epp (1997) have described as a unique psychology that maintains an emotional connection with a historical consciousness of oppression. According to Vontress and Epp (1997), historical hostility constitutes a normal response to the traumatic historical events experienced by Black people in America. The researchers contend that historical hostility could manifest in various ways. It may manifest as a combination of anger, contempt, frustration, or hopelessness.

Vontress and Epp (1997) acknowledge that while they may have coined the term “historical hostility” the concept of this condition has been discussed by several African American scholars in the past. Willis and Gilbert (1993) observed this aspect of the African American experience and called it “programmed self and other destruction.” In their writing, Willis and Gilbert (1993) described this condition as an endurable and unconscious anger, resentment, and self-hatred, evolving from a history of subjugation and oppression. The scholars predicted that many African Americans would continue to experience this condition regardless of success. Vontress and Epp (1997) note that while the concept of “Black rage” captures the intensity and passion of the collective
experience referenced by the term “historical hostility”, the term “historical hostility” more accurately describes the source and more subdued quality of this condition.

While Vontress and Epp (1997) acknowledge that historical hostility does infer that numerous African Americans retain a suppressed anger against the majority culture, they also note that that this anger may manifest in a destructive or prosocial manner. They postulate that acknowledging and navigating the hopelessness and frustration of historical hostility may be an essential element of the effective mental health treatment of African Americans. This supposition is significant to my study since I included historical hostility as part of the framework and cultural context to be considered throughout this exploration of Africa American Christians’ lived experiences, and the influences on their decisions to pursue or not pursue professional psychological help.

**Religiosity**

Along with historical hostility, religiosity is another cultural factor to be considered as part of the framework for my study. Holmes and Lochmand (2012) proposed that there are several important cultural factors to be aware of when exploring resilience, particularly among African Americans. Although religiosity and spirituality are related, they are distinct concepts in many ways. Religiosity is defined as the level of connectedness to a particular religion and its rituals and practices (Chaney, 2008), while spirituality is viewed as a fundamental part of one's identity and the individual understanding of the transcendent whether it is defined conventionally as God or a higher power, or in more nonspiritual terms as unity with the enigmatic or the greater world (Gall, Malette, & Guirguis-Younger, 2011). Boyd-Franklin (2006) listed these two
concepts separately because not all African Americans are involved with organized religions or churches, although many have an internalized sense of spirituality. In this study, I included religiosity (service attendance and ritualistic practices) as a cultural concept to be considered while exploring the experiences of African American Christians and their decisions to pursue or not pursue professional psychological help.

One example of a ritualistic practice in the Christian religion is the altar call (also called prayer of comfort). During the altar call, congregants walk to the altar for special prayer. The altar call is considered by some participants as a mind cleansing experience where all problems, including mental illness can be taken away by God at the altar. To many, this is the cornerstone of the Christian religious experience and a changing moment in their lives (Newman, 2005). This type of ritualistic experience of religiosity may influence the participants’ decisions to pursue or not pursue professional psychological help. Researchers (e.g., Ennis Jr., Ennis III, Durodoye, Ennis-Cole, & Bolden, 2004; Helms & Cook, 1999; Ojelade, McCray, Ashby, & Myers, 2011) have shown that the emotional and psychological well-being of many African Americans is impacted by church services, religious orientation, pastoral counseling, and community outreach.

Boyd-Franklin (2006) found that during therapeutic treatment many African Americans have discussed their use of prayer to deal with challenges they may face, which includes issues of physical and mental health. This type of reliance on prayer is significant to my study, particularly since I explored the influence of religiosity on African American Christians’ decisions to pursue or not pursue professional
psychological help. This study will add to the dearth of literature related to African Americans and cultural influences on mental health and mental health treatment.

Researchers, counselors, and psychotherapists acknowledge the importance of spirituality and religiosity in the lives of many African Americans. However, the empirical research regarding African Americans and relationships between religiosity, help-seeking behaviors, the psychotherapeutic processes, and outcomes remains limited (Faiver, Ingersoll, O’Brien, & McNally, 2001).

**African Americans, Christianity, and the Black Church**

“Christianity in Africa is so old that it can rightly be described as an indigenous, traditional and African religion” (Mbiti, 1970, p. 300). According to researchers Usry and Keener (1996), Christianity was practiced across North Africa, Egypt, Ethiopia, and parts of Sudan in the third and fourth centuries. Usry and Keener (1996) noted that after the fall of Rome, the northern European barbarians came into North Africa and devastated its civilization. Eventually most of North Africa, which had been predominately Christian, succumbed to Islam.

According to Albert J. Raboteau (1999) in his book *Canaan Land*, “Although Muslim and Christian Africans were swept up in the Atlantic slave trade, the vast majority of those enslaved in the Americas practiced the traditional religions of their ancestors” (p. 8). For Africans, the traditional religious practices (e.g., drumming, physical movements) clarified reality, and provided them with rituals to express joy surrounding life’s significant events. Through their related rituals, Africans endeavored to foresee and control hardships like illness, flood, or drought. Eventually, Christianity
became the principal religious practice amongst enslaved African Americans due to slave owners’ beliefs of Christianity as validation of slavery and the state-sanctioned suppression of Africans’ varied religious practices, which diminished diverse religious forms among Blacks (Ross, 2012).

Historically, significant research (i.e., Frazier, 1964; Lincoln, 1974; Raboteau, 1999) states that forced adherence to Protestantism, and various additional efforts to eliminate African culture prevailed. Laws forbade unsupervised assembly of the African slaves. These laws forced slaves to gather secretly and develop what became known as the “invisible church.” Late in the evening slaves would gather in remote areas beyond the inquiry of the overseer and freely practice their religion. This invisible church created unity and resistance among the slaves. During these secret meetings, the slaves shared their suffering and celebrated their survival. In this invisible church slaves created their own religious culture.

This history was critical to my study because it illuminates the foundation of African Americans dependence on religion for comfort and survival, as well as the development of their own place to gather for celebration, expression, and wellbeing. This type of historical reliance on religion and church may be a continued practice of African Americans and should not be over-looked when exploring their lived experiences, as well as their decisions to pursue or not pursue professional psychological help.

The impact of religion in African Americans’ significant efforts to endorse human and civil acknowledgement has been tremendous. The early religious gatherings of Africans in America aimed to preserve roles of cultural systems interrupted by
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colonization and slavery. During slavery, Black religions and para-religious groups structured Black civil society (Ross, 2012).

Simms (1998) noted Christianity as one of the earliest methods of African American resistance to European domination. Simms claimed that while White slave owners justified their enslavement of Africans through biblical and scientific arguments, African Christians gained solace in the belief that God would help them prevail against the mental and emotional distress of slavery. This study explored if its participants shared similar beliefs regarding mental and emotional distress and if those beliefs have influenced their decisions to pursue or not pursue professional psychological help.

The system of slavery was somewhat challenged by the growth of the Baptist and Methodist denominations in the late eighteenth-century. In 1783 and 1784 the governing body of Methodist clergy condemned slavery and prohibited ministers and members from buying, owning, and selling slaves. Several Baptist leaders freed their slaves, and in 1789 the General Committee of Virginia Baptists spoke out against slavery. However, these rulings met fierce opposition in the South and were suspended shortly after being instituted. The majority of these two groups decided to pursue better treatment of slaves rather than their freedom (Raboteau, 1999).

Baptists and Methodists began licensing Black men to preach; therefore a large group of Black preachers began to pastor Blacks during the 1770s and 1780s. These newly licensed preachers were men who were slaves and men who were free. During that time, African Christian institutions began to formally organize in the United States. Those institutions included, the Free African Society organized in Philadelphia by
Richard Allen in 1786, and The First African Baptist Church of Savannah organized by a freed men named George Liele and Andrew Bryan in 1788 (Ross, 2012). According to Lincoln and Mamiya (1990) this church was also organized by slaves, namely Jessie Peters (also called Jessie Galphin).

At the end of the eighteenth-century these Black pastors began the development of an independent Black church through the formation of Christian communities amongst slaves and free Blacks. Raboteau (1999) declared “The growth of Baptist and Methodist churches between 1770 and 1820 changed the religious complexion of the South by bringing large numbers of slaves into membership in the church and by introducing even more to the basics of Christian belief and practice. The Black Church had been born” (p. 20).

The term "the Black Church" evolved from the phrase "the Negro Church," which was the name of a study of African American Protestant churches at the turn of the century conducted by W.E.B. Du Bois (Mellowes, 2014). During the colonial era, these institutions were not only places for religious practice. These were also places where rebellions were organized, runaways were housed, social and political information was dispersed, people were educated, and much more (Ross, 2012).

In their seminal theological writing, *The Black Church in the African American Experience*, Eric Lincoln and Lawrence Mamiya (1990) noted that the sermon in the Black Church has been a critical component and serves several purposes. The sermon has served as theological education, ritual drama, encouragement and political advice, as well as therapy. Although some scholastic conversation has highlighted a diminishing
importance of religion in the life of Americans, more recent evaluation shows that African American religious institutions remain significant in modern day actions for social justice and in meeting the economic, social, educational, and health needs of people and communities (Barnes, 2005; Hall-Russell & Kasberg 1997; Hunt & Maurrasse, 2004). African American religious establishments are perhaps the most active and essential institutional curators of the African American helping tradition (Grayman-Simpson & Mattis, 2012).

**The Role of Clergy and Church Leaders**

Currently, there is a limited amount of literature recognizing the varied roles that clergy play in identifying and addressing the mental health needs of their congregants (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000). Parham (2002) stated that instead of making referrals to professional mental health resources, some African American pastors many times explore religious solutions to their congregants’ mental health concerns.

In her research, Jennifer Payne (2008) reported that an analysis of the sermons of ten African American Pentecostal ministers showed they viewed depressive symptoms negatively, and that this was true of feelings of sadness and grief as well. These ministers also spoke unfeelingly about mental health treatment, use of psychotropic medication, and psychiatrists. While some African Americans do seek mental health services (Ayalon & Alvidrez, 2007; U.S. Department of Health and Human Services, 2001), the impact of statements like those made by ministers in the Payne study is not clear with respect to religious African Americans and their decisions to pursue professional psychological help or not.
From her analysis of the sermons of ten African American Pentecostal ministers, Payne (2008) concluded that mental illness and non-religious mental health treatment was looked upon deleteriously and portrayed as a sign of weakness within the sermons analyzed. Payne did not report a positive opinion of mental health services by the pastors, and hers was one of few studies found that directly examined this occurrence in the Black community.

Church leaders are an important factor in the lives of many Black Christians. A cross-sectional study conducted by Allen, Davey, and Davey (2010) examined the attitudes and beliefs of several layers of church leadership regarding seeking professional psychological help. These researchers examined a Black Baptist mega-church (a church with more than 2000 congregants at a Sunday or Saturday worship service). The layers of church leadership consisted of the senior pastor, the associate pastors, deacons, and congregation aids. Their examination of different layers of church leadership is significant because the attitudes and beliefs of the church leaders can be examined for consistency with each other and the senior pastor. The researchers found that the further away from the senior pastor the church leader was, the less similar their views around mental-health treatment were with his (Allen, Davey, & Davey, 2010).

Although Allen et al. (2010) did note that the senior pastor said that he supported and encouraged professional psychological help services, they did not mention an examination of his specific attitudes and beliefs regarding professional psychological help. However, they do report that the senior pastor of a mega-church could possibly have no personal contact with parishioners at all (Allen et al., 2010). This could imply
that the beliefs of the church leaders who interact with congregants more than the senior pastor are critical in the communication of opinions about seeking professional psychological help.

The *National Alliance on Mental Illness (NAMI) 2009 African American Community Mental Health Fact Sheet* reported that increased programming regarding mental health issues within churches and other respected institutions can help decrease the stigma related to treatment. The organization also encourages more collaboration between mental health service providers and these organizations (NAMI, 2009). One reason for the limited amount of collaboration between mental health resources and the Black church may be that many mental health workers possess the worldview of traditional theoretical orientations that lack the room for inclusion of religion and spirituality (Queener & Martin, 2001). Throughout history, religion has been associated with psychological disturbance and denounced by renowned practitioners and theoreticians in the field of psychology (Hays & Erford, 2010; McRae, Thompson, and Cooper 1999).

Lack of collaboration between counselors, psychologists and mental health workers and the Black church may also be perpetuated because the former may not have an understanding of how to become involved with the church system and may feel discomfort in consultation with a leader of a Black church. Mental health workers with little or no formal or informal exposure to religion may believe they need theological training to address issues of spirituality, therefore they may deem their preparation inadequate to work on religious or spiritual topics (Queener & Martin, 2001).
The Resilience of African Americans

My review of the literature and presentation of information regarding African Americans would be incomplete without the provision of information that speaks to the resilience and pliancy of African Americans in spite of a history of oppression, degradation, and disproportionate utilization of mental health services. Resilience will be included as one of the cultural concepts that provide a more comprehensive framework for this study.

One study reported that African Americans who are connected with a faith-based organization are more resilient, likely to live longer, and reap psychological and physical health advantages (Marks, Nesteruk, Swanson, Garrison, & Davis, 2005). Also, as noted by Young, Griffith, and Williams (2003), participating in the Black church is often a source of surviving and managing while experiencing stressful situations.

Vontress and Epp (1997) credit religion with assisting in encouraging African Americans to manage their hostility in a positive manner. The researchers also recognize that the fellowship and interaction with other spiritual individuals also help some African Americans manage the negative effects of discrimination. According to researchers, cultural mistrust (Whaley, 2001) and historical hostility (Vontress and Epp, 1997) also contribute to African Americans’ resilience, and provide self-protective measures that can function as cogent and rational coping mechanisms within an oppressive society. However, the authors caution that these concepts can become self-destructive in excess.

Cultural factors are a critical component to consider when examining resilience. Holmes and Lochmand (2012) proposed that this is particularly true with African
Americans. In the 1963 edition of his seminal book, *Man’s Search for Meaning*, Viktor Frankl credits maintaining hope as the critical element possessed by concentration camp survivors during the Holocaust. Dr. Lee June has written extensively regarding the exploration of the Black church through a psychological and biblical lens. Like Frankl, Dr. June also discussed the concept of hope in his 2008 book, *Yet with a Steady Beat*. Dr. June examined hope specifically among African Americans in the Black church, and credits it with the resilience of African Americans. According to June (2008), hope is described psychologically as “A belief that leads one to strive for a certain outcome with the expectation that the outcome will occur” (p. 119).

Since its formation in America, even as an “invisible institution” during slavery, the Black church has taught and encouraged hope as a necessary element for enduring the circumstances of life (June, 2008). June describes a very popular song sung in the Black church that emphasizes the importance of hope for survival. The words explain “My hope is built on nothing less than Jesus’ blood and righteousness” (p. 119).

The historical information and concepts explored in this research study should not be misconstrued as inferring that all of the experiences and worldview of African Americans are immersed in disgruntlement and discontent. Such a characterization would be far too simplistic and one-dimensional for a culture of people who are extremely complex and resilient, possessing strength beyond that of any oppressive policies or systems they have encountered throughout their history in these United States.
The Model of Mental Health Help-Seeking

To assist in understanding participants’ experiences and analyze the data collected more effectively, the Model of Mental Health Help-Seeking developed by Cauce, Domenech-Rodriquez, Paradise, Cochran, Shea & Srebnik, and Bayder (2002) was the conceptual framework used in this study.

Cauce et al. (2002) utilized this model to explore the help-seeking channels of minority adolescents (even though it appears appropriate for minority adults), as well as the adults who were the caregivers of those minority adolescents. This model consists of three interrelated steps, the order of which may vary. The presented order begins with problem recognition as the first step. Problem recognition is precipitated by epidemiologically assessed need and perceived need. Epidemiological need and perceived need are important elements that lead to problem recognition, and they are affected by culture and context. The next step, the decision to seek help, refers to a coercive process or a voluntary process, and is also influenced by culture and context.

The final step in the help-seeking model is the service selection process. Cauce et al. (2002) explained that because this step involves who is enlisted for help, culture and context are large determinants of this stage in the help-seeking model. At this final stage, those enlisted for help could include formal mental health services (e.g., counselors, psychologists, social workers), informal network members (e.g., family, friends, clergy, folk healers), or collateral services (e.g., school counselors, juvenile justice system).

The constructs in this model encompass culture and context. People react to concerns of mental health within the context of society and their environment. Social
environment may be a facilitator or barrier to various types of services. White individuals with social and emotional disorders are not as likely to end up in the justice system as African American individuals with the same disorders (Comer & Hill, 1985; Kaplan & Busner, 1992). African American individuals are also more likely to access mental health treatment through involuntary commitment, law enforcement, or under urgent conditions (Carpenter-Song, Whitley, Lawson, Quimby & Drake, 2011; Fabrega, Ulrich, & Mezzich, 1993; McGuire, 2014; Snowden & Cheun, 1990; Takeuchi, Bui, & Kim, 1993). By exploring participants’ lived experiences, this study demonstrated how those experiences may have influenced some African American Christians’ decisions to pursue or not pursue professional psychological help.

According to Cauce et al. (2002), these disparities result from an interaction between individual and family choice, cultural values and beliefs related to mental health and help-seeking, as well as contextual and systematic factors like the community services available and the social networks that can offer referrals. This three step model of help-seeking has served as an investigative tool that examines cultural and contextual influences and the impact they may have on how individuals may come to receive mental health services. While this model was originally applied to African American adolescents, it can straightforwardly be applied to adults as well. Particularly since adults usually have control over their help seeking choices, as well as the help seeking choices of the adolescents for which they are caring. The concerns of caregivers for the lives of their loved ones will often initiate a desire for professional psychological help (Thompson, Marriot, Telford, Law, McLaughlin, & Sayal, 2014).
Problem Recognition

Until a need or issue with mental health is acknowledged, help-seeking cannot begin. This help-seeking model defines need as an epidemiologically defined need or as a subjective or perceived need. Epidemiologically defined need is usually evaluated using the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (Cauce et al., 2002). The DSM’s emphasis on diagnosis and disease as opposed to the experience of the individual may perhaps illuminate the Western bias toward “scientific objectivism” (Parron, 1997, p. 157). This scientific objectivism is the idea that personal experience, bias, and emotional involvement must not exist when uncovering truths about the natural world (Green, 2016). One of the significant strengths of this help-seeking model is that the family or individual’s perception of need is a critical component (Cauce et al., 2002).

The recognition of an individual's mental health issues and service selection decisions are sometimes determined by the family in discussion with the individual and others (Burns, Angold, & Costello, 1992; Combs-Orme, Chernoff, & Kager, 1991; Thompson et al., 2014). While not methodically examined, there has been significant supposition that ethnic and cultural groups differ on the perception of what is considered a mental health problem (Fabrega et al., 1993; Sue, 1994). It can be expected that the variations between epidemiologically assessed need and perceived need across ethnic groups is somewhat influenced by contextual and cultural factors (Cauce et al., 2002).

Tolerance for certain psychiatric symptoms may also vary across cultures, with Blacks showing higher tolerance for psychological and emotional distress (Alegria, Robles, Freeman, Vera, Jimenez, Rios, & Rios, 1991; Blank, Mahmood, Fox, &
Intercultural variations have been found in parents’ “distress thresholds” in regard to the mental health problems of their children (Blank et al., 2002; Weisz & Weiss, 1991). At this juncture, culture may perhaps influence whether a problem is understood as mental health related or not. Some cultures may offer many alternative explanations for undesirable or strange behavior. Spiritual, supernatural, or religious theories of emotion and behavior may be prominent with African American and Native American families with substantial ethnic identities (Cheung & Snowden, 1990; Wright, 2014). This is significant because utilizing this model, I examined the influence religiosity and other cultural factors may have had on participants’ recognition of a problem, which may have influenced their decisions to seek help.

When discussing adolescents with mental health issues such as eating disorders, Thompson et al. (2014) emphasizes the importance of parental problem recognition in the help seeking process for treatment of the adolescent’s disorder. In this study, I utilized the stages from the Model of Mental Health Help-Seeking to explore the lived experiences of Black Christians’ and interpret the related data.

The Decision to Seek Help

Many studies indicate that problem recognition and service utilization are closely related (Leaf, Livingston, Tischler, Weissman, Holzer, & Myers, 1985; Thompson et al., 2014). When a mental health problem is acknowledged as unwanted and assumed not to spontaneously stop, help-seeking is more likely to happen. Families and individuals can assess that a mental health problem is undesirable moderately easily, even though they may differ on the severity and nature of the problem. However, it is more challenging to
assess whether or not the problem will cease without seeking intervention, particularly with adolescents because some emotional instability and antisocial behavior may perhaps be considered normal (Moffit, Caspi, Dickinson, Silva, & Stanton, 1996; Thompson et al., 2014). Although the utilization of service is closely associated with problem recognition (Leaf et al., 1985; Thompson et al., 2014), in their dated, yet relevant article, Saunders, Resnick, Hoberman, and Blum (1994) stated that the relationship between need and action is not dependable or direct.

When a problem is understood as unwanted, even with the individual’s or family’s desire to change it, the resolution regarding whether and how to seek help will differ by culture and context. Some cultures believe that psychological problems are best managed by avoiding thoughts of them. For instance, African Americans are sometimes encouraged to overcome difficult situations by using willpower, strength, and God (Broman, 1996; Chandler, 2010). Some African American adolescent males refer to “chilling” or fading down on negative affect as a coping mechanism for anger or stress (Poulin, Cillessen, Hubbard, Coie, Dodge, & Schwartz, 1997).

Help-seeking and problem recognition may occur through somewhat forced or urgent processes. For instance, a family might be instructed by a school to enlist an individual into mental health treatment or she/he will be expelled from school. Similarly, an individual may possibly be mandated by the courts to engage in mental health treatment as an alternative to sentencing, or as part of probation (Carpenter-Song et al., 2011; Cauce et al., 2002).
An increasing amount of research (i.e., Cauce et al., 2002; Raviv, Sharvit, Raviv, & Rosenblat-Stein, 2009) suggests that individuals are tremendously hesitant to seek help, even when they recognize their problems. This finding is concerning and is important to consider when exploring service selection, or what types of treatment people are more likely to receive (Cauce et al., 2002). My study’s examination of the influences on decisions to seek professional psychological help also provided input relevant to the decision to seek help, as well as service selection. The participants’ decisions regarding professional psychological help may also involve making a choice between seeking treatment from their pastor and/or mental health services outside of the church.

Service Selection

The current help-seeking model defines service selection as “Where or to whom individuals and their families turn after identifying a problem and deciding to seek help” (Cauce et al., 2002, p. 12). Although finding help seems like it would sensibly flow from problem recognition and the decision to seek help, it is not usually straightforward. Burns, Costello, Angold, Tweed, Stangl, and Farmer (1995) reported that less than half (40%) of all individuals who both met criteria for a psychiatric diagnosis and demonstrated functional impairment received mental health sector services. Many (70%) of these adolescents received some type of services from the school system. Additional locations where adolescents obtained services consist of primary health care settings (11%), the welfare system (16%), and the juvenile justice system (4%). Apparently, educational networks like schools and other directly and indirectly related services not necessarily meant to be the primary providers of treatment for individuals with mental
health problems have become just that (Hoagwood & Jensen, 1997; Rossen & Cowan, 2015).

Cauce and Srebnik (1989) postulates that many attempts to get help for behavioral and social problems occur within more informal networks of the domain of friends and family. Ethnic minorities will often consult their family and community regarding these challenges. This network may include extended family, friends, and religious healers. Some evidence has showed that African Americans only have a small amount of faith in the helpfulness of psychotherapeutic interventions and do have some concerns that their family member will be institutionalized if they have any contact with a mental health provider (Takeuchi, Bui, & Kim 1993; Whaley, 2004).

This three-part model of help-seeking assists in the presentation of evidence that demonstrates the cultural and contextual influences on how minority individuals may begin to receive mental health treatment. Notably, the three stages of this model are not necessarily consecutive or discrete. This help-seeking model has been developed to operationalize the process of help-seeking, which is the foundation of my study regarding African American Christians. This model is significant to my study because it was developed with consideration of cultural influences on the help-seeking process.

Since my study examined the influence of religiosity, cultural mistrust, historical hostility, resilience, and other emerging themes; the Model of Mental Health Help-Seeking helped demonstrate how these culturally related concepts have influenced African American Christians’ decisions to pursue or not pursue professional
psychological help and also explored the influence of these concepts across the three interrelated stages.

**Summary**

This chapter provided a historical overview of the experience of African Americans in the United States and addressed various reasons why that experience may contribute to their underutilization of mental health services and attitudes toward seeking professional psychological help. A theoretical framework for understanding help-seeking behavior has been presented for consideration. The Model of Mental Health Help-seeking developed by Cauce, Domenech-Rodriquez, Paradise, Cochran, Shea, & Srebnik, and Bayder (2002) was utilized throughout my study.

Historic background about African Americans and Christianity, and the Black church has been presented to provide foundational knowledge, as well as enhance understanding of the importance and connectedness of these institutions in the lives of some African Americans. This unique relationship between the Black church and African Americans has the potential to serve as a facilitator of, or a barrier to, their mental health treatment. The concepts of religiosity, cultural mistrust, historical hostility, and resilience have been discussed relative to African Americans and mental health treatment. This chapter has also offered information regarding African Americans and mental health, as well as the Black experience in America, in an attempt to provide exposure to literature related to those concepts.

While studies exist that examine the cultural concepts of religiosity, cultural mistrust, historical hostility, and resilience, few have been found that specifically explore
these concepts with African American Christians and how they may relate to psychological distress, mental health treatment consumption, or decisions to pursue or not pursue professional psychological help. By exploring the lived experiences of African American Christians, as well as the aforementioned cultural concepts, I have attempted to improve the availability of research specifically related to the influences (cultural and other) on African Americans’ decisions to pursue or not pursue professional psychological help.
CHAPTER THREE
RESEARCH METHODS

In this chapter I will describe the research methodology utilized and incorporate discussions around the following areas: (a) identification of the primary research question, (b) rationale for the research design, (c) information regarding the research sample, (d) methods of data collection, (e) data analysis format and theme development, (f) information concerning validity and trustworthiness, (g) ethical considerations, and (h) researcher’s positionality. This chapter will conclude with a brief summarization of my data collection methods and the acknowledgement of various strengths of the proposed method and analysis.

Research Question

The major research question for this study was: What influences African American Christians’ decisions to pursue or not pursue professional psychological help?

Research Design

This study has utilized a qualitative design. Merriam’s (2009) description of a basic interpretive study read “Qualitative researchers conducting a basic qualitative study would be interested in (1) how people interpret their experiences, (2) how they construct their worlds, and (3) what meaning they attribute to their experiences. The overall purpose is to understand how people make sense of their lives and their experiences” (p. 23). Merriam’s description was consistent with the goals of this study, to make meaning of African American Christians’ experiences and narratives and explore how they may influence their decisions to pursue or not pursue professional psychological help.
A qualitative study permitted participants to be interviewed and have their experiences analyzed through their own words. This approach has allowed me to provide a descriptive interpretation of those experiences. By conducting in depth interviews, I have served as the instrument seeking to comprehend the participants’ perspectives.

By utilizing a qualitative methodology, I have sought to explore and understand the meaning of the lived experiences of the human participants. This was done by conducting in depth interviews, which is most commonly the primary method of data collection in qualitative research (Bloomberg & Volpe, 2012). Additionally, my role has been to incorporate openness to change and flexibility into the research process. As the sole researcher, I remained active and involved with every aspect of my research study, while maintaining some level of objectivity.

An inductive collection and analysis of the data collected helped identify common themes or patterns that emerged. The inductive nature of a qualitative study has enhanced my ability to hear the participants’ lived experience in an unfamiliar way, which has allowed for more opportunity to uncover influences on African American Christians’ decisions to pursue or not pursue professional psychological help that a quantitative survey study would not.

According to Morrow, Rakhsha, and Castaneda (2001), qualitative methodology is a valuable approach to conducting research related to cultural issues. They propose several reasons that support the benefit of qualitative research related to multicultural counseling. The reasons that related most to my study were:
1. It has a distinct ability to capture the meanings participants convey of their experiences.

2. Qualitative studies offer the opportunity for experiences and lives that were marginalized to be highlighted and voices that were previously silenced to be heard.

3. Context is a vital element of the inquiry.

4. The researcher’s process of self-reflection and self-awareness is addressed in a qualitative approach.

Research Sample

The selection of a purposive sample has allowed me to interview participants who were from a culture which may have provided unique experiences related to being an African American Christian in America, and is documented as underutilizing mental health treatment services (Buser, 2009). I sought to locate African American Christian participants from various educational, church attending, and socioeconomic backgrounds. In order to achieve this variation, I solicited participants from the northeast region via personal recruitment and snowball sampling.

A snowball sampling strategy, sometimes referred to as chain or network sampling (Miles & Huberman, 1994; Patton, 2001), was employed, in an attempt to achieve more variation among participants. This study sought to include participants with various levels of religiosity, therefore, participants were chosen not withstanding their amount of church attendance or participation.

Each participant was required to be over 18 years old, able to read and write English, and identify as an African American Christian. Because this study sought to
explore lived experiences, each participant must have also acknowledged having been faced with the decision to pursue or not pursue professional psychological help at some point in their lifetime.

Twelve participants were selected and strategized into 2 sub-groups based on participants’ age. The participants in the study could have belonged to any gender. However, one goal of this study was to also stratify by gender, if possible. This goal was achieved. Six male and six female participants were included. All contributors in this study were over 18 years old, identified racially as Black or African American, and religiously as Christian.

As stated, this purposive sample was stratified. In this stratification the sampling frame was divided into two age groups. The sub-group ages were 18-50, and 51 and over. Each sub-group contained 6 participants. The selected age ranges were based on the possible exposure to societal conditions and historical events participants may have experienced in their lifetime, as well as possible generational commonalities amongst sub-group members.

For example, participants in the 18-50-year-old sub-group may have been born and raised between 1964 and 1997, which is after the Civil Rights Act of 1964 was passed, which may have affected their experience with discrimination, legalized segregation, and various other marginalizing conditions. However, those participants in the sub-group over 51 years old may have been born before 1964 when Jim Crow Laws were pervasive and overt violence, discrimination, segregation, and humiliation were common experiences of African Americans in America.
Participants were also stratified by gender. This gender stratification was done to examine any differences that may have emerged between male and female participants. Hunt and Tyrrell (2001) stated that stratified sampling guarantees better coverage of the population, rather than purposive sampling without any stratification. According to Merriam (2009), purposive sampling is the chosen method for most qualitative research.

Sample Selection Sites

The churches visited for the purpose of this research were of the Baptist and African Methodist Episcopal (AME) denominations. The Baptist and AME denominations were selected for this study because 59% of African Americans belong to one of these historically Black Protestant (a form of Christianity) denominations, which include the National Baptist Convention and the African American Methodist Episcopal (AME) Church (Pew Research Center’s Forum on Religious & Public Life 2009).

The church sites utilized for this study were located in northeast urban communities. Two churches were identified and willing to participate in this study as selection sites. One church was Baptist and the other church was AME. Both churches are predominately African American and were organized over 20 years ago. They are both considered traditional Black churches. These mid-size churches have over 300 members each. Due to successful snowball sampling, more than half of the study participants did not come from either of these two churches. This allowed for even more variety in participants’ background.

Research participants were solicited with a clear explanation of the purpose of the study and the data collection process. The edification of the purpose and process of the
study to potential participants was important to ensure to the greatest extent possible that they understood the importance of their involvement and what they should expect if they agreed to participate.

**Denominations**

In their 1990 pioneering book, *The Black Church in the African American Experience*, Lincoln and Mamiya explained the historical make-up of the Black Church as including seven major Black Protestant denominations. The seven denominations are: the National Baptist Convention, the National Baptist Convention of America, the Progressive National Convention, the African Methodist Episcopal Church, the African Methodist Episcopal Zion Church, the Christian Methodist Episcopal Church, and the Church of God in Christ.

According to the Pew Forum on Religious & Public Life (2009), 59% of African Americans belong to one of the historically Black Protestant denominations. Although their research included African American people who identified with any Christian denomination, or even no particular denomination, the churches visited for the purpose of my research were of the Baptist and African Methodist Episcopal (AME) denomination.

I selected Baptist and AME denominations for this study because these are the two denominations with which I am most familiar. Based on my upbringing, I have always had an interest in exploring help-seeking behaviors, attitudes, etc. within these two denominations. These two denominations hold historical significance in the African American community and have often been compared to each other throughout my life experience.
Baptist

In the last half of the eighteenth century, the first Black Baptist congregations were developing. Unlike the AME denomination, the Black Baptists’ origins are in the South rather than the North. Black Baptist churches continue to be characterized by distinct Southern environments which emphasize fervid and expressive worship. One of the hallmarks of the Baptist organization is the complete independence of each local church, as opposed to the complex connectional structure of the Methodists (Lincoln & Mamiya, 1990).

African Methodist Episcopal (AME)

The AME church grew from the Free African Society which was founded by Richard Allen. In 1794 Allen, a Black Methodist preacher and former slave, founded Bethel African Methodist Episcopal Church in Philadelphia in response to the pervasive racial discrimination Blacks were experiencing at White churches (Raboteau, 1999). The AME denomination has proclaimed:

“‘African’ and ‘Christian’ in the names of our denominations denote that we are always concerned for the well-being of economically and politically exploited persons, for gaining or regaining a sense of our own worth, and for determining our own future. We must never invest with institutions that perpetuate racism. Our churches work for the change of all processes which prevent our members who are victims of racism from participating fully in civic and governmental structures. (Lincoln & Mamiya, 1990, p.47)
Data Collection

To recruit participants from the selected churches, I printed a brief advertisement in the churches’ bulletin and newsletter publicizing an interest in research study participants (see Appendix A). Each church introduced me to the congregation and announced that I had been given permission to work with its congregants. After the initial introduction, I begin individually soliciting participants with an in-person recruitment statement (see Appendix B). I attend various church events during the week, as well as Sunday morning service. I asked people to participate in the research study before and after each event.

Although each church leader agreed to allow the participation of their parishioners, I evaded any appearance of being connected with each particular church or its leaders, so as not to possibly influence people’s participation or responses. While soliciting participants, I provided information about the study and the requirements for participation. Once people agreed to participate, we exchanged contact information and arranged a time to communicate via telephone. During our next conversation I reiterated information regarding the study and what their commitment would involve. Once they reaffirmed their verbal consent, I arranged the first interview. A location comfortable for each participant was selected for the interview.

All of my requested contact was outlined in a consent form to provide participants with a clear understanding of their expected participation. Participants agreed to all of my requested contact, and were selected for participation in the study. The consent form was read and signed by each participant at the beginning of the first interview. The consent
form included my commitment to confidentiality and respect throughout this research process. The consent form also requested consent for the initial interview, a follow up interview, and email and/or telephone conversations, if necessary (see Appendix C). The consent form concluded with an expression of my appreciation for each person’s participation in the study.

Each participant was also asked to complete a demographic information sheet at the beginning of the first interview (see Appendix D). The demographic information sheet was designed to collect participants’ personal information, such as their level of education, income, age, gender, racial identification, and religious denomination affiliation. The summary of sources used to collect data were: interviews, key informants, and when necessary, telephone and/or email communication.

Twelve participants consented to one initial 60-90 minute audio recorded semi-structured interview conducted at a time and place of their convenience. Although 5-10 interview questions were formulated, rather than hold these questions constant, my ongoing data analysis informed the use of particular questions (see Appendix E). In order to gather data most effectively, I reviewed and recalibrated questions as necessary throughout the data collection process. Each interview was transcribed, and the responses were analyzed.

After analyzing all initial interviews, various follow-up interviews were conducted. Each follow-up interview provided an opportunity for member check and further information gathering. Key informant interviews were conducted with three participants to obtain additional information about the African American Christian
experience. Key informant interviews are in-depth qualitative interviews with people who are knowledgeable about a particular subject or community. These key informants can include professionals, community leaders, or residents and can possibly provide information that enhances the awareness of the experiences of particular groups (DiCicco-Bloom & Crabtree, 2006).

Follow-up interviews and interviews with key informants enhanced the triangulation of data collection and increased the trustworthiness and validity of this study. These follow-up conversations and key informant interviews were also audio recorded. This process also allowed me to cross-check data from the initial interviews. Data collected during the follow-up and key informant interviews was coded and observed for emerging themes similar to the data from the initial interviews. All interviews were conducted in a quiet and private environment. Written data is being kept in a locked file cabinet in my home. Electronic data is stored on my password and virus protected computer.

I also maintained a research journal to document my experiences and feelings throughout the research process. Journaling produces a reflective position which allows the opportunity to develop a record of my research experiences, insights, and methodological and analytical concerns (Bloomberg & Volpe, 2012). A critical friend was also enlisted to assist me during the research process through inquiry, reflection, and independent analysis, nurturing productive critique (Storey & Taylor, 2011). This critical friend challenged my assumptions and made inquiries regarding my conclusions.
In accordance with Patton (2002), data for this study was collected under the criterion of maximum variation. This variation related to the study’s participants and the sample sites chosen for the study. The participants varied in age, education level, gender, denominational affiliation, and income level. The setting of this study also involved dissimilarity since it included churches of different denominations.

Data Analysis and Theme Development

This study included the constant comparative method of data analysis developed by Glaser and Strauss (1967). This method compares one section of information to another and examines the differences and similarities. The constant comparative method of data analysis is an inductive way of making comparisons that is often used in various types of qualitative studies. Although it is most often associated with grounded theory studies (Merriam, 2009), the constant comparative method has been widely appropriated for other types of qualitative studies as well.

The Nvivo Qualitative Data Analysis Computer Software was used to assist the data analysis process of this study. The first step of my data analysis process was to create a manageable classification system through the process of coding (Patton, 2002). The coding entailed evaluating the central content of the information collected through interviews and deciding which material is important. Preliminary reading of the transcripts was done in order to develop the coding categories and classification system, as suggested by Patton (2002). Additional readings were done in order to systematically begin the formal coding. Different ideas and concepts were color coded using colored highlighters and colored labels. Coding was also done electronically via Nvivo. The data
analysis for this research project explored repeated patterns that characterized the data. Data analysis was conducted simultaneously with data collection. Merriam (2009) states this simultaneous process makes data “parsimonious and illuminating” (p.17).

While coding data from the transcribed interviews, emergent themes were identified and explored. Key informants provided further clarification and member checking to confirm my understanding of the participants’ words and meanings. Throughout the process of data analysis, the primary research question was continually revisited in order to ensure that I remained focused on the question: What influences African American Christians’ decisions to pursue or not pursue professional psychological help? The emergent themes and patterns discovered and evaluated during the coding process informed the answer to my research question.

This research study also included two sub-group analysis, which allowed me to compare two age groups (18-50 and 51 and over), as well as gender. These sub-group analysis were intended to reveal and explore any possible differences, trends, or themes that may exist based on the participants’ age range or gender.

The development of themes and data analysis for this study was guided by Johnny Saldana’s Coding Manual for Qualitative Researchers (2013). Conversational exchanges and responses from the interviews are presented as representative of each of the four themes. The four themes that emerged from the interviews are: trust and mistrust from a sociohistorical context, anger and hostility toward White people, resilience, religiosity, and the Black church, and getting help.
Identifying these themes involved a coding process that was both intricate and illuminating. The data was explored and navigated in its entirety with the primary research question prominently displayed on every page. This research question display was recommended by Auerbach and Silverstein (2003) to help the researcher maintain focus and decrease worries when making coding decisions. This study’s themes were born out of a process of descriptive coding, categorizing, and analytic memo writing. The descriptive coding process began with pre-coding, which was done by underlining, highlighting, and identifying phrases and quotes that appeared relevant to my central research question.

During the descriptive coding process, topics were extracted from the qualitative data and summarized with a one to five-word title. Similar topics were then categorized together into an inventory for further analysis. Analytic memo writing supported my coding process by allowing me to document my choices of codes and identify patterns, questions, and interesting findings that emerged.

In addition to descriptive coding, some In Vivo Coding was also used to honor the voices of the participants. Honoring the voices of African Americans was critical to this study, particularly due to our American history of government sanctioned marginalization and voice silencing.

Coding was conducted in hand-written form and with the Nvivo Qualitative Data Analysis Software. While the Nvivo software allowed coding to be done by categorizing data electronically in nodes, and run searches and queries, the hand-
written coding process facilitated my closeness with the data. This closeness enhanced my understanding of the data and the experiences of the study’s participants.

**Validity and Trustworthiness**

Ultimately the information obtained is my perception of the participants’ understanding of the phenomenon being studied (Merriam, 2009). “To reduce the likelihood of misinterpretation, we employ various procedures, including redundancy of data gathering and procedural challenges to explanation. These procedures called triangulation are considered a process of using multiple perceptions to clarify meaning” (Bloomberg & Volpe, 2012, p. 107). Triangulation has been essential to my acquisition of an accurate understanding of the participants’ experiences with the themes that emerged, and how those experiences may have influenced their decisions to pursue or not pursue professional psychological help.

I engaged in triangulation through multiple sources of data collection, such as interviews and the utilization of key informants. The data obtained from these methods was compared and cross-checked at different times. Audio recordings were reviewed and transcribed. After transcription, each recording was reviewed and matched with the written transcription to insure the accuracy of the transcription. According to Anderson (2010), “Validity relates to the honesty and genuineness of the research data” (p. 141). Validity and trustworthiness are addressed in the design of this study. In an attempt to further ensure validity and trustworthiness, I conducted this study as proposed. I also addressed any concerns of validity and reliability through what Merriam (2009) regards as “careful attention to a study’s conceptualization and the way in which the data was
collected, analyzed, and interpreted, and the way in which the findings were presented” (p. 210). Therefore, the importance of validity and trustworthiness informed this study from its inception and continued throughout its conclusion.

I engaged in four known strategies for ensuring internal validity and credibility in qualitative research. Those strategies were triangulation, member checks, adequate engagement in data collection, and reflexivity (Merriam, 2009). As previously mentioned, triangulation took place in this study through the use of multiple sources of data collection, which included interviews and the utilization of key informants.

Member checks took place during follow-up interviews with key informants. This helped me clarify some of the information received, verify what was said (or meant), and also ask additional questions, if needed. Maxwell (2005) acknowledges member checks as the most significant way a researcher can eliminate the chances of misunderstanding what participants say and do, as well as their perspective of what is happening. Member checks are also critical to researchers identifying their own biases and misunderstandings of what was observed.

Adequate engagement in data collection was imperative throughout this research process. During this research study, I adhered to what Merriam (2009) described as the best rule of thumb “The data and emerging findings must feel saturated, that is, you begin to see or hear the same things over and over again, and no new information surfaces as you collect more data”
(p. 219). Therefore, while collecting and analyzing data, I remained mindful of this concept of saturation. Saturation was reached when I was no longer hearing new information from the data being collected.

The data collected in the interviews was coded and evaluated to explore emergent themes. This process was important because one goal of this study was to consider if the current and historical experiences and knowledge of African American Christians influences their decisions to seek professional psychological help. Therefore, throughout the process of this study, I explored any emergent influences on African American Christians’ decisions to pursue or not pursue professional psychological help. Some of those influences included religiosity, cultural mistrust, and historical hostility.

In an increased effort to ensure validity and trustworthiness to the greatest extent possible, I engaged in the continual process of reflexivity. Also referred to as the researcher’s position, Lincoln and Guba (2000) consider this “the process of reflecting critically on the self as the researcher, the ‘human as the instrument’” (p. 183). Clarifying my own assumptions, experiences, and worldview was important during this study due to my life-long connection with the Black church and my professional commitment to counseling, as well as my personal devotion to both. This clarification will help the reader gain a more accurate understanding of how I may have reached my interpretations of the data (Merriam, 2009).

Another invaluable tool for trustworthiness was my critical friend, who challenged my assumptions and requested clarification as needed. My critical friend was a person with experience in qualitative studies who was interested in the successful
completion of this study, yet challenged my biases while looking at the data from another perspective (Costa & Kallick, 1993). My relationship with my critical friend was what has been referred to as “true friendship, a successful marrying of unconditional support and unconditional critique” (MacBeath, 1996). I met with my critical friend at least once a month while collecting and analyzing the data for this study. Documentation of my critical friend’s input was kept in my journal notes.

Transferability was another goal of this study and was made conceivable through my provision of what Lincoln and Guba (1985) describe as “sufficient descriptive data” (p. 298). This data was rich and thick, detailing the study’s participants, setting, and findings (Merriam, 2009). Transferability of the study’s findings was enriched by attaining maximum variation in the research sample. To that end, sample variation for this research included participants’ gender, age, education, income, and denominational affiliation. Merriam (2009) describes maximum variation as allowing for the prospect of a larger scope of application by those who read or consume the research.

**Ethical Considerations**

This research study was conducted with a focus on a high standard of ethical behavior. “…Part of ensuring for the trustworthiness of a study (i.e., its credibility) is that the researcher himself or herself is trustworthy in carrying out the study in as ethical a manner as possible” (Merriam, p. 234). The trustworthiness of this study relied on my trustworthiness as a researcher, as well as the methodological design of the study. During this research process I remained committed to continuous engagement in ethical conduct. Patton (2002) presented an “Ethical Issues Checklist” which was a useful tool throughout
the extent of this research project. Patton’s checklist included, but was not limited to, confidentiality, ethical verses legal conduct, informed consent, and interviewer mental health.

I remained cognizant of these areas while conducting this research study. The confidentiality of all participants was protected; pseudonyms were given at the beginning of each interview and used to identify participants throughout the research process. Participants were told that they could even identify themselves to me using a pseudonym if they choose. Interviews were conducted in private areas.

Ethical and legal conduct and informed consent are areas that are critical to any discussion regarding research studies and human subjects. These two concepts were significantly critical to this study because they are closely related to one of the major historic events mentioned several times within this proposal’s first three chapters, the Tuskegee Syphilis Experiment. As a result of the Tuskegee Syphilis Experiment (as well as other ethically problematic experiments), the concept of informed consent, participants’ right to be informed about the nature of a research study and its risks and benefits to them prior to agreeing to involvement was developed (Hesse-Biber & Leavy, 2011).

According to Patton’s (2002) ethical checklist, the mental health of the interviewer is an ethical consideration for all qualitative research. I pledge that I have conducted this study being of sound mind and good mental health. I further pledge that I have consulted my dissertation Chairperson for advice on any ethical questions that developed during this research process.
Researcher’s Positionality

My position in this research study had the potential to appear complex due to my personal experience. I could never fully elucidate my position without providing background information on the person who has had the most significant impact on my current research interests, my father, Rev. Dr. Clarence Norman Sr. My father was born in Goldsboro, NC on April 30, 1930 and died on July 8, 2015. He was an 85-year-old African American pastor of a mid-size (2000 members) Black Baptist church in Brooklyn, NY. My dad founded the First Baptist Church of Crown Heights and served as pastor for 62 years, until his death.

My dad was raised in the South during the Jim Crow era when racism was legally sanctioned and educational and employment opportunities for African Americans were limited. He moved to New York when he was a teenager in order to escape pervasive racially motivated mistreatment and educational disadvantage. In New York, he attended school, worked hard, and eventually earned his Doctor of Ministry (D.Min.) degree from Howard University in 1971.

I have attended the church pastored by my father throughout my entire life; therefore, he was not only my father, but my pastor as well. I attend church every Sunday and am involved in church activities. Through my father’s experience, and the African American experience as well, I have been exposed to a narrative history of religion, cultural mistrust, historical hostility, and resilience. I have also had my own personal experiences with these concepts and observed the experiences of other African Americans with them as well.
Much of my worldview has been influenced by the teachings of my father and the Black church. I was taught to be kind and love others, and that prayer and God were the answers to all problems. However, the potential benefits of receiving professional psychological help were never mentioned as part of these teachings. In actuality, the messages regarding help-seeking usually encouraged conversations with God and church leaders, and discouraged divulging personal business to outsiders, particularly White people. Such limited disclosure and protection of privacy have been methods of survival for some African Americans and are rooted in the history of the Black experience in America.

While my father’s teaching was virtuous and beneficent, it was also informed by his personal familiarities with the segregated South, lynching, medical experimentation on Blacks, systematic racism, and various other concepts that promoted religiosity, cultural mistrust, historical hostility, and resilience within him and within our family. Hence, I had long wondered if similar experiences and upbringings among other African American Christians have influenced their decisions to pursue or not pursue professional psychological help.

My identity as an African American Christian woman is primary, however, my identity as a professional psychological help agent and future counselor educator informed this research study tremendously. Therefore, I acknowledged multiple positionalities within this research study and remained cognizant of how the dimensions of race, religion, professional background, etc. may have informed the perspective that I brought to this research in terms of ideological or political beliefs and cultural
assumptions (Herr & Anderson, 2005). However, I was also uniquely situated to conduct this study by being inside of the culture of the Black church and its belief system.

My insider positionality assisted in trust-building and creating a more authentic and empathic interview process. I endeavored to make the familiar strange by hearing acquainted and similar experiences in new ways. While my position in this study did vary, the information and understanding produced was valid because I remained thoughtful, reflective, and honest about those varied and/or multiple positions (Herr & Anderson, 2005). This process was assisted by the use of a critical friend, triangulation of data, and journaling.

I acknowledged that the potential for participants to identify with me may have existed due to my familiarity with the subject matters and obvious affiliation with the Black race. I addressed the prospect of participant reactivity by continually reflecting on my position and how it might influence participants, as well as the research process. Furthermore, my creation of an environment that promoted an honest and authentic discourse also contributed to reducing the chances of the study being affected by participant reactivity (Bloomberg & Volpe, 2012).

Any potential biases, assumptions, or expectations held by me were addressed within the context of the study. According to Herr and Anderson (2005), it was imperative for me to recognize that I embarked upon this study with a viewpoint developed from my own distinctive experiences. Critical reflexivity was also incorporated into the process of this research. Through critical reflexivity, I suspended the obvious and heard the lived experiences of each participant without taking any of
those experiences for granted. Journaling and recording field notes assisted in communicating my perspective, as well as any potential biases, expectations, and assumptions that may have existed. The utilization of my critical friend also enhanced this part of the research process.

Summary

A detailed description of this study’s research methodology was presented in this chapter. A basic qualitative methodology has been described and was used to explore the research question: What influences African American Christians’ decisions to pursue or not pursue professional psychological help? The target participant sample size was 12; however saturation was also identified as the goal related to sample size.

Participants were purposively selected and stratified by age and gender, which permitted me to interview members who may have had certain cultural and generational experiences that may have influenced their decisions to pursue or not pursue professional psychological help. Triangulation consisted of several data collection methods that were engaged, initial interviews, some follow-up interviews, and the utilization of key informants. This process was followed in an effort to increase the study’s trustworthiness, validity, and credibility.

Some of the strengths to this study were that its design and analysis was developed after an extensive review of the literature. The literature review assisted the research process by exposing me to the various ways this topic and similar topics have been previously explored. This study was also enhanced by a qualitative methodological approach, which was carefully selected to provide information that would inform the
existing body of research and effectively address the research question: What influences African American Christians’ decisions to pursue or not pursue professional psychological help?
The purpose of this study was to explore the experiences of Black Christians. In this study, I aim to make meaning of these experiences and examine how they have influenced the professional psychological help-seeking decisions of African American Christian participants. A basic qualitative inquiry was conducted, using an interview method to understand the experiences of 12 African American Christians and the influences on their decisions to pursue professional psychological help.

While some researchers (e.g., Ennis Jr., Ennis III., Ennis-Cole, & Bolden, 2004; June, 2008) have examined a connection between African Americans’ attitudes toward help seeking and religiosity, cultural mistrust (Scott, McCoy, Munson, Snowden, & McMillen, 2011; Whaley, 2001), historical hostility, and resilience (Vontress & Epps, 1997) as psychological constructs, this qualitative study, explored the more personal experiences of Black Christians seeking psychological help while considering these broader constructs as well. This approach yielded a deeper sociohistorical context for understanding their personal experiences. The transcriptions of interviews were analyzed utilizing Nvivo Qualitative Data Analysis computer software which helped in creating a manageable classification system that enabled me then to perform my data analysis.

Data management was done through a manual and electronic coding and categorizing process. The data analysis for this research project examined recurring patterns that characterized participants’ shared experiences. The research question explored throughout this study was: What influences African American Christians’
decisions to pursue or not pursue professional psychological help? The theoretical conceptual framework to be considered was the Model of Mental Health Help-Seeking developed by Cauce, et al. (2002).

Chapter four will begin by providing participants’ demographic information, as well as information about each participant that may be relevant to this study. This chapter will then focus on the four broad themes that I identified through a careful analysis and review of the interviews.

**Description of the Participants**

Each participant was interviewed individually and asked about her/his viewpoints and experiences related to professional psychological help and the influences on their decisions to pursue or not pursue that help. The participants are identified by pseudonyms which are not related to their real names. Table 1 provides a summary of the demographic data of the participants interviewed.
Table 1

**Participant Demographic Data**

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>AME/Baptist</th>
<th>Age</th>
<th>Gender</th>
<th>Education</th>
<th>SES</th>
<th>Church Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>April</td>
<td>AME</td>
<td>40</td>
<td>F</td>
<td>HS</td>
<td>25-45k</td>
<td>2 x month</td>
</tr>
<tr>
<td>2</td>
<td>Bernice</td>
<td>AME</td>
<td>78</td>
<td>F</td>
<td>HS</td>
<td>25-45k</td>
<td>Every Sunday +</td>
</tr>
<tr>
<td>3</td>
<td>Carl</td>
<td>AME</td>
<td>42</td>
<td>M</td>
<td>BA</td>
<td>45-65k</td>
<td>Every Sunday +</td>
</tr>
<tr>
<td>4</td>
<td>Donna</td>
<td>Baptist</td>
<td>46</td>
<td>F</td>
<td>Grad</td>
<td>45-65</td>
<td>Every Sunday +</td>
</tr>
<tr>
<td>5</td>
<td>Junnie</td>
<td>Baptist</td>
<td>76</td>
<td>F</td>
<td>HS</td>
<td>under 10k</td>
<td>2 x month</td>
</tr>
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<td>M</td>
<td>BA</td>
<td>45-65k</td>
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</tr>
<tr>
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<td>52</td>
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<td>Every Sunday +</td>
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<tr>
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<td>AME</td>
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**Participant Profiles**

The information included in this section reflects data collected during interviews with the participants for this study. A brief, narrative overview of the participants is included to provide context to some of the statements that they offer in the presentation of findings.

**April**

April is a 40-year-old female with a high school diploma who earns 25-45k per year. She is AME and attends church for Sunday service or bible study about 2 times a month. April describes herself as a person who loves her culture and loves herself. She is a single mom of a six-year-old daughter. April says her life was a struggle because due to her mom’s drug use; she has been on her own since she was 14 years old. She says she...
wants to be a better mother to her daughter than her mother could be for her. April had a lively and pleasant personality during the interview. However, when we discussed certain topics, April displayed some amount of displeasure through her comments and facial expressions. Some of the topics that lead to a displeased reaction from April included discussions about her brother being medicated for behavioral issues, and the recent police shootings of unarmed Black men.

**Miss Bernice**

Miss Bernice is a 78-year-old widow whose husband of 50 years died about 5 years ago. She has a high school diploma, is retired, and earns 10-25k per year. She is AME and attends church services every Sunday, as well as throughout the week for various church activities. Miss Bernice is active in the senior community where she lives. She jokes and laughs often and moves around effortlessly throughout the interview. Miss Bernice says that she has an active social life and emphasizes with a hearty laugh that she even has a new boyfriend. Miss Bernice has a leadership position in the church and is considered a *church mother*.

**Carl**

Carl is a 42-year-old gay male with a BA degree who earns 45-65k per year. He is AME and attends church every Sunday, as well as throughout the week for various church activities. Carl was raised in the South by his mom and dad who are both medical professionals. He says he is grateful that his parents have always loved him unconditionally. Although Carl shared his past counseling experience in the early-stages of the interview, he seemed slightly protected for the first few minutes of our
conversation. As the interview progressed, Carl appeared to relax and became less
guarded. Until then, Carl kept his arms and legs tightly crossed. As we talked more, his
body language became open and less shielded. After about 20 minutes, Carl even began
to smile and give a slight laugh.

**Donna**

Donna is a 46-year-old female with a MA degree who earns 45-65k per year. She
is Baptist and attends church every Sunday, as well as throughout the week for various
church activities. Donna has been married for 15 years and has two sons. She described
her marriage as “having some problems at times.” Donna has a leadership role in the
church and in her community. While her initial demeanor was reserved, Donna showed
eagerness to be a part of this study and seemed to relax more as the interview progressed.

**Junnie**

Junnie is a 76-year-old female with a high school diploma who is retired and
earns less than 10k per year. She is Baptist and attends church approximately 2 times per
month and reads the bible and other spiritual readings often. Junnie is soft spoken and
moves slowly. Junnie shares with me that her 47-year-old son died of a heart attack about
8 months ago. I was immediately aware of the pride and strength in Junnie’s voice when
she mentioned her deceased son. In that moment, I also noticed that Junnie had been
sitting comfortably in her chair with her beautiful, tiny dog sitting still in her lap ever
since we began our conversation. Our entire interview was conducted while her beloved
pet remained in place.
Mitch

Mitch is a 39-year-old male with a BA degree who earns 45-65k per year. He is AME and attends church every Sunday, as well as throughout the week for various church activities. Mitch has a leadership role in the church, which includes assistant to the pastor. Mitch seemed confident yet slightly reserved for most of the interview. Mitch talked about his desire to apply to graduate school but says he is afraid that he would not have time to commit to graduate studies because of the work he has been doing in his church. He says that he is torn between church and some of the other things he wants in life, but that church is his priority for now.

Oz

Oz is a 52-year-old male with some high school education who is unemployed and earns less than 10k per year. He is Baptist but does not attend church. Oz describes himself as “doing the drug thing for a little while.” Oz dropped out of high school in 12th grade and has worked odd jobs most of his life. Some of these odd jobs included selling DVDs, clothing, stolen goods, and much more. Oz describes some of his jobs as “my hustle.” Oz attends 12-step meetings and has been in recovery for 10 years. He stated that he was nervous about our interview and surprised that anybody wanted to hear his story. Oz said he “wanted to help.” During the first interview, Oz appeared nervous. At the start of the interview he fidgeted in his seat and sweated. After about 20 minutes, Oz sat still, and the sweating stopped. He appeared calm and relaxed. During the follow-up interview, Oz seemed relaxed the entire time. Because of his experience, Oz was selected as a key informant in this study.
Ralph

Ralph is a 54-year-old male with a Doctor of Ministry degree. He is the pastor of a 200 congregant Baptist church and earns over 105k per year. Ralph attends church every Sunday and throughout the week conducting various church activities. He has been married for 20 years and has 3 children. Ralph referenced Bible scriptures several times throughout our interviews. He shared with me that it was hard for him not to use biblical references in his responses or descriptions of his life experiences. At times during the interview process, Ralph seemed to show a small amount of defensiveness. I appreciated Ralph’s perspective and thought it would be a useful point of information in this study. Because of his experience and expertise, Ralph was selected as a key informant in this study.

Regina

Regina is a 54-year-old female with an MA degree who earns 45-65k a year. She is AME and attends church services every Sunday, as well as throughout the week for various church activities. Regina is married to the pastor of her church; therefore, she is considered the first lady and has a leadership position in the church. She discussed how her role as first lady can sometimes be “too much pressure.” Regina came to the interview impeccably dressed, with a very formal presentation. Regina stated that she was nervous about the interview but wanted to “help people.” She seemed to become less formal once we were about half-way through the interview.
Roger

Roger is a 49-year-old male with BA degree who earns 45-65k per year. He is Baptist and attends church 2 times per month. Roger has a presence that is both commanding and welcoming. He is a former basketball player who stands 6’5 inches tall and speaks with a loud voice. Roger smiled often and immediately seemed comfortable once we started talking. Roger is a cancer survivor who is now concerned because he has recently been feeling pain in the area where his original cancer was located 10 years ago. Roger said “I have a doctor’s appointment to get things checked out. But don’t worry, I’m good.” His words seemed to be aimed at comforting me.

Roy

Roy is a 72-year-old male with a MA degree who earns 45-65k per year. He is AME and attends church approximately 2 times per month. Roy had a distinguished presence and a welcoming disposition. He appeared forthcoming in his responses which encouraged me to seek information from him regarding his unique historical perspective on segregation. Roy was personally impacted by the 1954 Brown vs Board of Education decision. At times during our interviews, Roy showed both anger and pride related to his culture and his experience being a Black man in America, particularly in the 1960s. Because of his historic personal experience, Roy was selected as a key informant in this study.

Sandy

Sandy is a 48-year-old female with a BA degree who earns 10-25k per year. She is Baptist and attended church frequently for much of her life. Although she no longer
attends church services or activities, she reads the bible and prays often. Sandy has been diagnosed with bipolar disorder and has been in mental health treatment for 10 years. Sandy lives in a community living environment for senior citizens and people with disabilities. She says this is the best type of living environment for her because of her life experiences. Sandy was pleased to participate in this study. She smiles often and shows interest in sharing her story. Throughout the interview, Sandy shared information regarding her mental health crisis and treatment process.

**Themes and Findings of Data Analysis**

The central research question for this study asked: What influences Black Christians’ decisions to pursue or not pursue professional psychological help? To answer this question, I conducted an analysis of the findings from the participant interviews and document review. I identified 4 themes from the qualitative data analysis of the interview data of 12 African American Christians. During the data collection process, I engaged in active listening and reflective journaling to fully capture participants’ experiences. Data transcriptions and data collection were conducted simultaneously, and a critical friend was utilized to help assure clarity in the information being collected and presented.

The four identified themes from the interviews are: (1) trust and mistrust from a sociohistorical context; (2) anger and hostility toward White people; (3) resilience, religiosity, and the influence of the Black church; and, (4) getting help. These themes describe how participants’ professional psychological help seeking decisions have been influenced by various components. Each theme will be discussed in the context of the
interviewees’ responses and the reiterative process of reflection. The themes are highlighted in the following discussion.

**Theme 1: Trust and Mistrust from a Sociohistorical Context**

Theme 1 explores trust and mistrust as it relates to participants’ experiences and decisions to seek professional psychological help. Due to its prominence in the conversations, this experience of trust was the first category I classified during the coding process. This theme was developed from the coding process of reviewing repeated or similar phrases and words that indicated trust as a salient topic. First cycle coding of this topic produced substantial amounts of phrases. Some of these phrases included: *They teach Black people not to trust them*, *Not trusting. Just some straight up misdiagnosis*, and *Yeh, can’t trust them*. Once I examined these phrases closer, second cycle coding allowed me to uncover nuance and develop two subthemes: mistrust of White people and their systems, and race and compatibility.

The interview question most related to trust was, *Black Americans often decide not to seek professional mental health help. Why do you think that is?* However, it was not surprising to me that no probing was necessary for trust to be mentioned by the participants. The distrust some African Americans have toward some White people is not unfamiliar to most African Americans. Nevertheless, this theme will reveal how several participants have negotiated and managed this distrust to survive.

A review of my field notes showed consistency with the participants’ words, particularly the use of the word “trust”. In the margin of my notes I recorded several words participants seemed to emphasize. For most participant interviews, I had written
the word “trust” in the margin of the notebook page. This is in line with an analysis of the interview data which revealed that within set parameters, the word “trust” was fourth of the ten most frequently used words in this entire study. Also, of the ten most frequently used words, “trust” was the number one word used that directly relates to counseling. A word query was conducted using Nvivo, and is presented in the table below. The ten words are displayed in different font sizes. Frequently used words are in larger font according to usage. Therefore, the word “trust” is displayed in the fourth largest font since it was the fourth most frequently used word in the study. Table 2 captures the utilization of the word “trust” throughout this study.

Table 2

*Utilization of the Word “Trust” Within Study*

Most participants related the sense of mistrust specifically to White mental health professionals, which then seemed to equate to institutional systems of caregiving. Therefore, in this theme, trust is recognized as participants’ belief that they could receive mental health treatment from a White mental health professional that is unbiased and effective. Mistrust is recognized as participants’ feelings of suspicion and skepticism that
facilitates a lack of confidence in professional counseling experiences with White mental health professionals.

Since trust is a foundational element of any therapeutic relationship, it was no surprise when participants’ distrust became a consistent theme across all the interviews. However, as I explored the interview data, I recognized that this theme of trust required more distinction. This recognition came as I read through the transcripts and began to realize the language regarding trust was consistently producing information regarding systemic racism and historical events. As I explored the data with more depth, I came to understand that participants distrust was even more nuanced than it originally appeared during the interviews.

Therefore, two subthemes were developed to more effectively report the data related to trust. These two subthemes highlight participants’ feelings about White people and the systems they control, and the influence of race on their trust and past counseling experiences. Through the participants’ shared experiences, I now understand that while some aspect of mistrust has influenced their decisions to seek professional psychological help, for many, the source of this mistrust is rooted in historical narratives of racism and mistreatment. It is important to understand that for some participants, the mistrust was reaffirmed when they were exposed to negative interactions with a White mental health professional. Closer examination of participants’ remarks indicated that mistrust was often reiterated in other interactions participants described throughout the interviews. This theme also explores the influence of race on participants’ past professional counseling experiences.
Mistrust of White People and Their Systems

The concepts of trust and mistrust in relation to influences on interviewees’ decisions to pursue professional psychological help were discussed in each interview conducted for this study. The topic of trust was central to every interview and evolved organically. It was continually mentioned by participants regarding White people. Mistrust manifested in the findings in a variety of ways. Most of the participants appeared to fuse their mistrust of White people with their mistrust of medical systems, and other systems historically and currently dominated by White people. For many, this fusion is reasonable due to America’s history of discrimination and marginalization practiced and sanctioned by these same predominately White systems.

The data in this subtheme demonstrates that some of the participants’ distrust of medical systems was validated by the Tuskegee Syphilis Study (TSS). Comments presented here will reveal participants’ practical fusion of distrust of White People and their systems. This fusion is apparent in a statement made by Miss Bernice when she referenced the TSS in explaining her mistrust:

Tuskegee is why I don’t even let them give me a flu shot. Not letting them shoot nothing in me. I don’t trust them. I don’t trust them. No thank you. A lot of my senior friends too, they won’t take the flu shot. Maybe the pneumonia shot, that's the only one they'll take. They won't touch anything else, because we don't trust it. It could be a test. They're testing to see what could be done. That's what happened at Tuskegee. It was a test, not to help them. It was a test. We shy away from that,
and we’ll stay away from that…White people. Doctors, psychiatrists, all of them. They did too much stuff to us. Still doing it.

This statement demonstrates that Miss Bernice and possibly some of her senior citizen friends share a mistrust of medical systems and White people. This is salient in her statement when she references “all of them.” Another interesting element to this statement was that Miss Bernice’s comment about her elderly friends maybe agreeing to the pneumonia shot but not the flu shot could suggest that even though a person has some mistrust, she/he may examine the risks and make a decision based on that risk assessment. Perhaps, the understanding that pneumonia can traditionally be more life threatening than the flu adds to some peoples’ decision to receive one vaccination but not the other. As an African American woman over 40, I have been exposed to the distrust of the Flu shot my entire life. I first decided to accept the flu shot when I was pregnant with my first child 21 years ago. My risk assessment at that time resulted in accepting the flu shot to protect my unborn child. Since then, I faithfully get a flu shot every year. Distrust of the flu vaccine has historically been commonly known within the African American community, although, like me, many African Americans do eventually choose to receive the influenza immunization.

For some African Americans, distrust of the flu shot is often connected with the TSS. This discussion about the flu shot and the TSS manifested during my first interview, which was with Miss. Bernice. It evolved from her response to the interview question that asked, *Black Americans often decide not to seek professional mental health help. Why do you think that is?* All 12 participants had varying degrees of knowledge about the TSS.
The TSS was usually mentioned in response to the same interview question or after additional probing. While some participants elaborated more than others on the TSS, everyone interviewed displayed concern and disappointment about the incident. Participants made similar references as Miss Bernice to the TSS and the flu shot to explain and justify their mistrust, which continued to illuminate the fusion of mistrust of White people and systems. Oz was clear in articulating his mistrust of medical systems and how that relates to the TSS. Oz contends:

Like that Tuskegee thing. It was crazy. That syphilis experiment. Man oh man. It was the nurse. She just sat there and let it happen. She even helped. That’s why I don’t play with none of them medical people. Even to this day, if you go to jail, they say, okay, we got to give you a TB shot. I’m like, oh, hell nah. Even today, flu shots, I wouldn't take the flu shot because I don't know what they're doing. Look, I’ve had the flu before. I’ll rock with the flu. I know what that is. I don’t know what that is you got right there (he points to an imaginary thing on the table) …Because of their trickery. We've been victimized to a point where you can't, it's hard to trust.

Participants’ apparent lack of distinction between mistrust of White people and mistrust of systems can possibly be attributed to the fact that the relevant systems have historically been dominated by White people. Currently, White mental health care providers remain the disproportionate majority of mental health care treatment providers. This perception and reality is illuminated in Roy’s statement about counseling. Roy
expresses, “Not to be racial, but I never thought that I could go seek counseling, because most of the counselors from my observation…were Caucasian.”

Other participants also spoke very directly about their mistrust of White people and how this mistrust is part of their experience as African Americans. Some of this mistrust can possibly be interpreted as a learned survival mechanism for Black people in America, born out of an unjust history of victimization through medical experimentation and abhorrent medical care. Roger’s explanation encapsulates this interpretation. Roger states, “A lot of this stems from experiences we went through with White people, and we’re just tired. We don't trust them at all. They teach Black people not to trust them.” This survival mechanism of mistrust may perpetuate the avoidance of systems, even if those systems are labeled as “helping” systems.

When faced with psychological challenges, most of the participants’ stories implied that they waited to see how far their own survival skills and resilience could take them, as opposed to early consideration of professional psychological help. Evidence from the data demonstrates that some of these tools of survival and resilience have included God, religiosity, education, family, and community. This experience was articulated clearly when Sandy says that she “tried to turn it over to God but it wasn't until all hell broke loose in my 40s that I finally got the help that I needed.”

Participants’ repeated references to words like *them, their, they’re,* and *most.* This implies that for most of the participants, the mistrust they have of White people and systems is interchangeable. Therefore, this mistrust is also assigned to professional psychological helping systems. In addition to systemic racism, participants discussed
their individual experiences of racism with White people and how those experiences continue to contribute to their distrust of White people and systems. Especially since many of these individual acts of racism are conducted by people who work within the very systems being discussed. This mistrust was consistently mentioned by participants as an influence on their decisions’ to not pursue professional psychological help.

**Race and Compatibility**

To delve into what participants thought was significant to their decisions to pursue professional psychological help, I queried the participants directly about their past professional psychological help seeking considerations and experiences. It became noticeable during the interviews and data analysis that the eight participants who had received professional counseling in the past were influenced in the future by their experience. I learned from some of these participants that because of the impact of an unfavorable counseling experience, they decided to never again pursue professional psychological help. While those with a favorable experience would seek professional help in the future. I also gleaned from the data that overall, most participants did not trust that they could have a positive compatible counseling experience with a White counselor.

During the coding process, patterns of data showed connections between compatibility, perception of compatibility, and counselor race. Past counselor compatibility was explored with participants who had previous professional psychological help experiences, while the perception of compatibility was explored with participants who had no past experiences.
The interview discussions explored the impact of race of provider on compatibility or the perception of compatibility with participants. This exploration of race and compatibility and the perception of compatibility is imperative because interviews revealed these elements influenced participants’ decisions to pursue or not pursue professional psychological help or to continue engaging in a professional psychological helping relationship.

Although eight of the participants had engaged in professional psychological help services in the past, all 12 participants had considered pursuing professional psychological help at some point in their life. For participants who had previous professional psychological help experiences, the unfavorable previous experiences reinforced their mistrust. Five of the eight participants who engaged in a professional psychological helping relationship reported their counseling experience as a favorable interaction. While three of the eight reported their experience as an unfavorable interaction. All participants who had unfavorable counseling experiences had White counselors; while all the participants who had favorable experiences had counselors of color.

Examination of the participants’ remarks about their previous counseling experiences indicated that participants believed the race of the counselor was the primary reason that the experience was either negative or positive. Participants who had negative past counseling experiences, described those interactions as lacking connection. I gleaned from the data that this lack of connection was often based on the perceived disinterest of the counselor, which all impacted participants believed was due to the racial difference.
On the contrary, those participants who had positive experiences, spoke about having a connection with the counselor. Data indicated participants attributed this connection to commonalities in interest and understandings based on race and experiences.

Close examination of participants’ remarks specified that virtually all the participants would not want a professional psychological service provider who was not Black. While this theme explores the connection of participants’ counselor race preference to the concepts of trust and compatibility, additional complexities may also be considered.

It is worthy to explore the qualities that participants felt were missing in the unfavorable counseling environment, as well as the components that were present in the favorable counseling environment. Although the identified qualities may be different based on individual preference, this type of exploration may facilitate a better understanding of the counseling needs of diverse populations. According to the following experiences of two participants, this need included more evidence that the counselor cared about their stories and had interest in their experiences.

The participants’ perception of the counselor’s disinterest and incompatibility may have assisted in the lack of trust development. This lack of trust development could have also been influenced by participants’ preconceived expectations of mistreatment and disregard.

Miss Bernice’s comments highlight the qualities that may have been absent in her counseling environment. She implied that her counselor did not show interest in the information that she was disclosing. In her experience, this interaction lacked concern
and connection. Miss Bernice indicated that she believed this was because the counselor was White. Miss Bernice explains:

He was White; it just didn’t work. There was no concern. When you tell somebody something that is really on your heart, you want them to be concerned about what you’re saying. You don’t want to just give out words, and they take it like, okay and that’s it. There’s no feeling coming back…No connection at all.

While some of the lack of connection between Miss Bernice and her counselor could have been related to gender differences, counselor skill, or various other variables, it is perceived by Miss Bernice as being caused by the fact that he was White, and she was Black. This could be an indication that for some clients and counselors, race is a starting point that should not be overlooked or ignored in the counseling environment. April gave a similar description. She referenced disclosing personal information to someone and not feeling understood due to their race difference. April describes her experience:

She was White and I believe that that had a lot to do with it to. Because even though some people, they try to seem like race is not an issue when it comes to certain things. It really is, because they don't know what we go through individually in different ethnicities. You know what I mean...It can be challenging, sitting in front of someone trying to pour out to them, and it's like they really don't understand.

It is significant to note that of the eight participants who had counseling experiences, the three who had unfavorable counseling experiences terminated those services after 1-2 sessions. They stated that even though they have had crisis situations
similar to what initially made them pursue professional psychological services, they have not considered counseling again because of their negative experience. According to participants, these negative experiences included lack of concern, connection, and familiarity with the African American experience.

Some of the previous participant statements referenced unfavorable counseling experiences and how they attributed their counselors’ Whiteness to their negative experiences. The following statements demonstrate feelings participants expressed about how having the same racial background as their counselor enhanced their counseling experience, which they reported as favorable.

Five of the eight participants who had engaged in past professional psychological help services had favorable experiences. These favorable experiences were with a counselor of color. These participants felt that the counselor’s similar racial background had a positive influence on the experience and said that race would influence their future professional psychological help seeking considerations.

Regina inferred that she could deal with a lot of issues because she and the counselor could relate because they were both Black. Regina shared her experience: “She was a true sista. I’ll never forget her…I was able to get a lot of junk out. Let me say that. I think it had a lot to do with the fact that she was able to relate.” Other participants also spoke about their favorable experience and attributed it to race. Carl said emphatically, “It was very, very good. She was a Black girl, Black lady I should say…I searched online first. I just saw it as a Black female, so I thought I can identify with something, because
she's a Black person instead of an older White person…It was a good connection with her.”

As participants reflected on their past professional psychological service considerations and experiences, many of them spoke directly and indirectly about the need to feel a connection with the provider. Their descriptions of connection essentially referenced being compatible. While feeling compatible is not always synonymous with racial similarity, it may be influenced by cultural components like the shared interests, experiences, and customs associated with race, history, and socioeconomic identity.

One of Roy’s responses eluded to the impact race may have on this compatibility and how compatibility may also be impacted by those cultural components. Roy said he didn’t want a White counselor because “What the hell can they tell me about my African American experience in this country?” Roy implies that a White counselor could not connect to his experience as an African American man. This experience includes sociopolitical and sociohistorical context and perspective.

Another noteworthy finding related to this theme is that the participants who reported having a favorable past counseling experience with a counselor who was a person of color were all college graduates (most held graduate degrees) and most earned over 45K per year. While those who had unfavorable past counseling experiences with White counselors were not educated beyond high school and earned less than 25K per year. This data could indicate that those participants who were satisfied with their past counseling experience may have had more resources related to finances, selection, access, insurance, or other socioeconomic variables.
Such resources may have given these participants greater access to providers of their choice. This was apparent when several of those participants who had favorable experiences talked about purposely choosing an African American counselor. Participants’ deliberate selection of an African American counselor was not a response to a negative experience with a White counselor, rather, a response to a history of racism that made them feel that they would be more comfortable with an African American counselor. Participants who had unfavorable counseling experiences with White counselors may have had less resources, therefore limited access and less choice.

The lack of connection in the past counseling experience was the reason participants who had unfavorable past experiences said they would not attend counseling again, regardless of counselor race. The participants who had favorable past counseling experiences said they would attend counseling again. The large majority prefer another African American counselor.

These findings establish that past counseling experiences have influenced participants’ future decisions to pursue or not pursue professional psychological help. Furthermore, it is significant that counselor race and compatibility influenced those past experiences. It is notable that participants’ future professional help seeking decisions will be determined by if their past professional help experience was favorable or unfavorable. My findings also reinforce the importance of the initial counseling sessions in the retention of a client. A study conducted by Fernandez and Eyberg (2009) found that discomfort with treatment approach was the most common reason the families studied did not return to treatment.
Table 3 provides a summary of the participants’ opinions of their past professional psychological help experiences and the race and gender of the care provider.

Table 3

*Participants’ Past Professional Psychological Help Experiences*

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<td>Ralph</td>
<td>M</td>
<td>54</td>
<td>Grad</td>
<td>105k Baptist</td>
<td>Every Sunday +</td>
<td>Marriage</td>
<td>Favorable</td>
<td>AA/M</td>
</tr>
<tr>
<td>9</td>
<td>Regina</td>
<td>F</td>
<td>54</td>
<td>Grad</td>
<td>45-65k AME</td>
<td>Every Sunday +</td>
<td>Personal</td>
<td>Favorable</td>
<td>AA/F</td>
</tr>
<tr>
<td>10</td>
<td>Roger</td>
<td>M</td>
<td>49</td>
<td>BA</td>
<td>45-65k Baptist</td>
<td>2x month</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>11</td>
<td>Roy</td>
<td>M</td>
<td>72</td>
<td>Grad</td>
<td>45-65 AME</td>
<td>2 x month</td>
<td>Marriage</td>
<td>Favorable</td>
<td>AA/F</td>
</tr>
<tr>
<td>12</td>
<td>Sandy</td>
<td>F</td>
<td>48</td>
<td>BA</td>
<td>10-25k Baptist</td>
<td>None</td>
<td>Personal</td>
<td>Favorable</td>
<td>Hispanic/F</td>
</tr>
</tbody>
</table>

The theme of trust and mistrust from a sociohistorical context reflects the experiences and feelings that participants had related to White people and the systems they dominate, and counselor race and compatibility were also a part of their decision making process.

Table 4 illustrates the aggregation of sub-themes.
Table 4

*Categorical Aggregation of Theme 1*

<table>
<thead>
<tr>
<th>Trust and Mistrust from a Sociohistorical Context</th>
<th>Mistrust of White People and their Systems Race and Compatibility</th>
</tr>
</thead>
</table>

**Theme 2: Anger and Hostility Toward White People**

Throughout the interview process, some participants’ experiences with anger or hostility toward White people became salient. This anger and hostility is mentioned by participants numerous times. Emotion coding was utilized to analyze the data included in this theme. During first cycle coding, data that reported participants’ words, expressions, body language, and inferences that communicated certain emotions was initially coded separately under labels like *anger, frustration, hostility, and disappointment*. Second cycle coding refined and reduced this information by checking for redundancy and frequency. After these coding cycles, information was placed into two categories, *anger* and *hostility*. Data from these categories inform this theme.

Participants’ experiences of anger and hostility were explored in the interviews and the findings are reported in this theme. Each participants’ expression of these feelings was unique and appropriate. April expressed anger when she discussed her early experiences with White counselors who medicated her brother. Roy displays anger when he describes his experience with school segregation and being a Black man in America. Carl’s anger becomes apparent when he talked about police brutality. When Roger voiced his anger, he referred to having “Angry Black Man Syndrome”. Roger goes on to discuss
a popular skit by an African American comedian, Chris Rock, about what he describes as “angry Black men”. Chris Rock refers to a male family member who he says is “always waiting for the revolution”.

The concepts behind the term “Angry Black Man Syndrome” can also refer to Black women. This informal term references hostility and anger similar to that described by Vontress and Epp (1997) as “historical hostility”. This hostility is described as African Americans’ responses to historic deleterious and unfair treatment in America. During some interviews, feelings of anger or hostility were displayed in diverse ways. At times, some participants were vocal and demonstrative regarding their feelings of anger and hostility toward White people, while others conveyed these feelings in a subtler manner.

From the examples mentioned, I found that participants did possess various levels of anger and hostility. Their responses showed that while some of the anger described by participants was from their individual interactions and experiences, some anger was also their response to situations that impacted them indirectly. Such as historic racism or the recent police shootings seen on television. A primary goal of this theme is to explore the data and examine if these experiences of anger or hostility influenced participants’ decisions to pursue or not pursue professional psychological help.

The impact these events have had on participants’ anger and hostility, is consistent with previous research that has examined the influence of anger on the overall health and well-being of Blacks in America. Two classic studies (Harburg, Blakelock, and Roeper, 1973, 1979) related to Blacks and health, support the contention that Blacks experience increased levels of anger as a consequence of social injustices and racism.
During numerous interviews, I detected participants’ feelings of anger and hostility toward White people and explored those feelings. Participants’ experiences of anger or hostility were communicated in many ways, even beyond words. Paralinguistics, body language, and posture were also significant indicators that those feelings were present. Once participants acknowledged those feelings, I explored how they may have influenced their decisions to pursue or not pursue professional psychological help.

Overall, I found that the feelings of anger and hostility experienced by these participants were diverse and multifaceted. Some participants were openly expressive of these feelings, and used language and physical actions to demonstrate them, while others were more discreet and less expressive, and used more subtle ways of communicating these feelings. It is evident from participants’ stories and the data analysis that these feelings are normal and rational responses to their direct and indirect exposure to historical and current individual and systemic practices of racism and discrimination. Furthermore, it is also apparent that these feelings of anger and hostility serve as protective factors and offer participants’ caution and discernment in their approaches to everyday life experiences, including the pursuit of professional psychological help.

Seven of the twelve participants directly or indirectly demonstrated feelings of anger or hostility towards White people. Inquiry into these expressions of anger was conducted as related participant’s decisions to pursue or not pursue professional psychological help.

April discusses her anger toward White mental health professionals because they prescribed medication for her younger brother when they were children. She says she felt
he was receiving inferior treatment because he was African American. April spoke through clinched teeth as she made a fist with her hand. Her posture prompted me to ask if this created anger in her. She quickly replied, “Yes, it does. You know maybe it's just a disappointment. You try to really... I can't even say really. You try to hope and think that White people are for the good, and it turns out in many cases that they're not.”

April’s anger and the anger and hostility of other participants communicated a common disappointment felt by some African Americans when lack of choice or options require that we trust White people for necessary services (counseling, policing, education) and those services are then perceived to be delivered in a biased manner.

Similarly, Carl expressed his feelings of hostility when our conversation about professional counseling led to African Americans and the police. In a very impassioned voice, Carl said:

We look at police officers as people who are supposed to protect us. We go to them for help, and this is the same type of figure we see counselors as. If I don’t trust a police officer, or if I’m pissed with a police officer, or whoever, do I trust a counselor? You weigh them both the same. (Carl sucks his teeth, waves his hands, and shakes his head dismissively). Please!

Carl’s body language, words, and the inflections in his voice indicated his anger and distrust regarding police officers. His last statement of “Please” helped emphasized his point, as well as his hostility. Carl’s words expressed disappointment similar to April’s. Carl’s words also reflected how some participants communicated the tendency to fuse their feelings toward one predominately White institution with all predominately White
institutions. For Carl, in that moment, he felt hostility toward a “police officer, whoever, a counselor”. Carl’s words further indicate this fusion: “You weigh them both the same.”

During the member check process, Carl confirmed “whoever” referred to White people.

Oz spoke openly about his anger and hostility toward some of the White medical and mental health professionals that he has encountered in treatment. Oz insists:

It’s their trickery, their little way of doing things, reverse psychology, when your young they’re swifter than you are. As you get older, you can checkmate them a little faster. ‘No, we’re not doing that today.’ Now I know how to control that anger. I grew up and matured.

Oz expressed pride in his ability to recognize these types of biased situations and have some amount of control over them. He attributes much of this control to maturity.

Each participant who expressed anger or hostility did so in diverse ways. The data facilitated an understanding of how levels of hostility and anger could be experienced and expressed very differently in each participant. The most fervent expression of anger was done by Roger. Roger wanted to share his experiences. He saw value in his input and was open to expressing his feelings. Even though Roger originally showed no hostility or anger, at one point during the interview he began to demonstrate frustration. This frustration became noticeable when he discussed his reasons for not seeking professional psychological help. He mentioned White counselors and racism, as well as stories of racial mistreatment. He’s anger became salient during those conversations. Roger displayed the ability many African Americans have in common. An ability to function normally and even pleasantly, while sheltering feelings of hostility and anger towards
racist systems and some of the people associated with those systems. This ability allows us to control these emotions to various degrees within our individual capacities.

Roger’s expression of anger was interesting because he ended our conversation using the word *Cracker*, which is a derogatory term that has been used by some African Americans to describe racist White people. Roger explained why he never pursued professional counseling: “…I ain’t talking to no White man. Yeah, you got that. Angry Black Man Syndrome. Cracker, Cracker, Cracker. You got that too…They taught us not to trust them.” At this moment Roger’s anger was palpable. We sat in silence for a minute.

When I asked Roy about his thoughts on pursuing professional psychological help, even before he expressed his anger verbally, it was clear from him hitting the table that he was experiencing some amount of hostility related to professional psychological help (he explained that he always assumed the counselor would be White). Roy agreed that he was feeling some hostility in the moment when he hit the table. When I asked Roy to tell me what he was feeling, he said:

How can they…Look, I’m sorry. I’m going through my brother act right now (he raises his fist in the air showing a commonly recognized symbol of Black solidarity). How the hell can they tell me about my problems and I’m experiencing this stuff. I know, they’re just surprised that I’m not dead yet or in prison.

The significance of the anger and hostility expressed by these participants is that they acknowledged that these feelings have influenced their decisions to pursue
professional psychological help. This is particularly related to the prevailing assumption that the help provider would be White.

*Suppression of Feelings and Hostility Expression*

This subtheme represents a prominent aspect of the conversations with participants who expressed feelings of anger or hostility toward White people or systems. Which is that at some point each person needed some degree of assurance that these feelings were welcomed to be expressed. Some participants hesitated when I initially explored signs of anger or hostility they may have demonstrated. Once I assured each participant that these feelings were ok and may be helpful to explore, they each showed signs of relief and began to comfortably voice their anger or hostility. It was as though they needed permission to freely express this anger or hostility. Once I provided that permission through reassuring nods, words, and affirmative body language, participants expressed anger and hostility that seemed to be suppressed yet resided just below the surface of each answer or comment they had made prior to that critical interview moment.

The data analysis revealed evidence that most of the participants sometimes felt varying levels of anger and hostility toward some White people due to historic and current experiences of discrimination and degradation. The data also reveals participants’ capability to live fruitful and productive lives while suppressing these feelings of anger and hostility.

Participants demonstrated anger and hostility suppression in a variety of ways. When April’s body language and voice tone indicated anger, I asked her if the situation
we were discussing regarding her brother being medicated by White professionals made her angry. At first, she responded “Yes it does.” April quickly added “You know maybe it’s just a disappointment.” It appeared as though she was adding nuance or softening her initial honesty. Roy apologized and described his expression of anger as his “brother act”.

When Oz discussed his experience with White counselor and his feelings of anger, he prefaced his words, stating: “Ok now, I’m going to be totally honest with you.” This statement sounded much like a warning, but also a question. It was as though he was warning me that he was about to be honest but simultaneously asking for permission. I assured Oz that it was ok to be honest. Oz then sucked his teeth in disgust and said: “…There ain’t nothing a White counselor can tell me. I want a Black woman.” Oz points his finger toward me to emphasize his point.

Some participants explained that their feelings of anger and hostility were heightened because of recent occurrences of racial injustice and police brutality. Carl spoke about police interactions with African Americans with tears in his eyes and anger in his voice. Carl said: “Police are supposed to help us.” He strongly emphasized the word “supposed”.

These interviews were conducted during a period when two brutal police killings had recently occurred within two days of each other. The murders of Philando Castile and Alton Sterling were recorded and widely broadcasted on television and social media in the days leading up to many of these interviews. These murders and the unjust treatment of African Americans by police officers were present in the minds of this study’s
participants. For most participants, anger and hostility were understandably present as well.

Each of the participants who discussed the anger or hostility they were feeling said these feelings have influenced their decision to pursue or not pursue professional psychological help. In many of these cases the decision was to not seek professional psychological help, notably with the prevailing belief that the mental health professional would be White.

Participants experienced feelings of anger and hostility. Suppression of feelings was discouraged, while the expression of any hostility being experienced was encouraged, with the aim of more effective exploration. Table 5 displays the aggregation of this subtheme.

Table 5

<table>
<thead>
<tr>
<th>Categorical Aggregation of Theme 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger and Hostility Toward White People</td>
</tr>
</tbody>
</table>

Theme 3: Resilience, Religiosity, and the Black Church

Resilience has been described as the capacity to recover from trauma, illness, adversity or other substantial stressors (American Psychological Association, 2017). Researchers (Miller, 1999; Miller & MacIntosh, 1999) contend that there are elements of African American life and culture that may provide protective factors and promote resiliency (Brown, 2008). The researchers suggest that those elements of African American life and culture, which include social support networks like the Black church,
be explored to comprehend how some African Americans have recovered from hardship and adversity (Brown, 2008).

In this study, I considered the influence of resilience on Black Christians’ decisions to pursue or not pursue professional psychological help. The data analysis showed that some participants’ perception of their resilience and ability to handle psychological discomfort in the past did influence their decisions to pursue professional psychological help. This theme demonstrates participants’ proclivity to associate physical and emotional wellness with God and religiosity. While some of the participants attributed their past resilience to religiosity and their connection with the Black church, the data collected also showed that there were times when acts of religiosity and the influence of the Black church have dissuaded participants’ professional psychological help seeking and encouraged increased acts of religiosity instead.

“Too blessed to be stressed” is a popular saying amongst Black Christians in response to routine questions related to their state of being. How are you doing? How are things going? How is work? How are you feeling? These questions are sometimes answered with this simple reply. This response implies that the blessings of God are in such abundance that stress could not possibly exist in that person’s life. Similar statements that are staples in Black church vernacular are God is good..., Stay prayed up, Pray it away, The devil is busy, and Take it to the Lord in prayer. For many African American Christians, these words have validated their faith, reinforced their actions of prayer, and publicized their blessings by God.
However, for some of the participants in this study, there have been times when these types of words and phrases have made them distrust their faith, doubt their actions of prayer, and question their blessings from God. When asked about the influence of the Black church on their decisions to pursue or not pursue professional psychological help, most participants referenced these phrases or similar vernacular from the Black church in their response when they described their perception of how the Black church has viewed mental health related situations.

As indicated in the findings, participants were equally proud of their religion, faith, and connection with the Black church. Likewise, they equally attributed their survival and endurance to those elements. Therefore, data were analyzed using the constant comparative method to understand the differences and similarities that existed in the way participants experienced resilience, religiosity, and the Black church and how that experience may influence their decisions to pursue or not pursue professional psychological help.

**Connecting Resilience to Religiosity**

The data analysis illuminated examples of participants’ ascription of resiliency to religiosity. When Junnie discussed why she never pursued professional psychological help, she responded: “You don't tell everybody your business. I’m blessed because I know what to do and how to do it. I’m just fortunate…I read the Bible.” Then Junnie begins describing a difficult day that she had a few weeks ago trying to deal with the death of her son and some family discontent in the household. “The Spirit just told me to
Junnie explains that she never went to counseling because “I’m blessed…I know what to do…I read the bible.” This statement shows that Junnie is referring to her well-being as being blessed and connecting her being blessed with reading the bible. Therefore, attributing her resilience to religiosity. Junnie also implies that she alters her religiosity when she has an increased need for fortitude, when she talks about sitting down notes and reading the Bible from the beginning, “this time”.

This attribution of resilience to religiosity is similarly implied when Miss Bernice talks about her experience and how she has dealt with the death of her husband and past emotional problems. Miss Bernice shares:

If you are deep in the Lord, and you believe the word as it is then you'll rest on that. But if you're just halfway in church, you hear it, but it's in one ear and out the other. You'll fail, because you don't believe. That's why a lot of people going around like they are today. They miss out on their blessings, because they don't believe. You don't receive. They don't receive. Things don't work out for them.

Me, myself I thank God for everything because I trust God for every little thing.

Miss Bernice’s reference to being “halfway in church…you’ll fail” implies that more church attendance and participation would improve a person’s condition. This reference provides another example of a participants’ linking of religiosity and resilience.

Roy also associated religiosity to resilience and well-being when he discussed African Americans and mental health. Roy stated, “People who attend church on a
regular basis, I think they are more mentally healthy than those who do not.” The connection between resilience and religiosity was referenced in a variety of ways. Participants made this connection between wellness and religiosity when referring to physical wellness as well as mental health wellness. Roger discussed his fight with cancer and his sister’s death and his choice not to pursue professional counseling. Roger articulates:

I think my walk as a Christian, I think I got more from that. Going through the cancer thing. I had this spinal surgery I had to go through, so I experienced pain, physical pain. One thing you know, in the Bible it says pain don't last always for you. You get closer to God when you are going through something.

Roger spoke with confidence when he declared that his “walk as a Christian” did more for him than professional counseling would have done. Roger supports his declaration by adding the confirmation that he received from the Bible that the pain would not last forever. Finally, Roger contended appreciatively, “You get closer to God when you are going through something.”

Each participant who ascribed their resilience to their acts of religiosity displayed a significant sense of pride and conviction in that pronouncement. Participants’ assurance that their wellness has been sustained and restored by their faith and the practice of that faith was both conspicuous and consequential.

**The Influence of the Black Church**

When participants were asked to discuss the influence the Black church has had on their decisions to pursue or not pursue professional psychological help, most talked
about their perception of how the Black church has viewed mental illness and professional counseling. While all the participants demonstrated pride in their overall connection with the Black church, some were sincere in their expression of disappointment with the way mental illness and professional psychological help had traditionally been treated by the Black churches they attended.

Participants’ experiences and perceptions included, the Black church promoting religiosity and discouraging counseling, associating emotional wellness with religiosity (pray more, go to the altar, etc.), being reluctant to recognize the issue, and promoting stigma. My understanding from the data analysis is that participants universally agree that their experience in the Black church has traditionally encouraged sole reliance on God, religiosity, and the church for mental health treatment. It was also evident from the data that their professional help seeking decisions were influenced by their experience in the Black church.

Participants used some of the traditional Black church vernacular previously mentioned to support their perceptions. Carl explains that even though he eventually went to a professional counselor, that decision came after years of believing what he was taught in church. Carl expressed himself:

Church had an impact on me not going to counseling. Nobody there pushes you to go for counseling. It's not a bad thing, but I think they want you to pray and not talk about stuff. Leave it there and go through it. I mean I know we're supposed to go to God, and you pray. You don't worry about it, but you're human. At least I am. I pray every day, in the morning when I get up and before I go to bed. There's
still some things just because of who I am. I know I should leave it with God. I
can't, because I am, how should I say, a person who, I'm a go-getter. I like to have
plan A, B, and C. I guess I'm going to let God do a lot of things until I get up
against the wall. I try to do it for myself.

Like Carl, Mitch believes that the Black church emphasizes healing by praying
when dealing with mental health issues. Although Mitch has never pursued professional
psychological help, he says that he believes it is a valuable resource for everyone. He
states that he was raised in a church that helped him develop a negative view of seeking
counseling help outside of the church. Mitch says this view influenced his help seeking
decisions for most of his life and he choose not to pursue professional psychological help.
Mitch discusses his perception:

Counseling, historically, I believe, and especially with the Pentecostal and
Apostolic, I believe that holiness has us believe we can pray everything away.
While, again, I believe in prayer, and I believe in healing. I believe in deliverance.
All the things that are part of our faith, I believe it, but I believe that the older
church, and I'm not saying they didn't get results, but really, listen, people are
sick. "You got high blood pressure; we're going to fast and pray." No. Put the
pork down and all the sodium that you're taking in… Even with physical stuff. It
was about prayer. Again, growing up, I've been in church, and they're laying
hands on people for healing and things like that. The older church, again, I don't
know if they were as receptive because we felt like the power of God can
deliver…If you go to a counselor because you need help psychologically, emotionally, then you're not trusting God. You don't have faith.

Carl and Mitch both offer a reasoning for some of the perceptions they have discussed. Carl declares “It's not a bad thing, but I think they want you to pray and not talk about stuff.” While Mitch shares, “They can go and they can still pray, but when you leave church, go to the doctor. That's what I believe. I don't believe it's been malicious, just out of ignorance, they think that anything outside of the church or outside of the Bible, means you're not having faith.”

Participants collectively identified prayer as the Black churches response to mental illness and emotional issues. And although they all stated that prayer has been their first response to any challenges that they have faced, some participants offered reasoning as to why prayer may sometimes seem ineffective for some people experiencing problems that may need professional counseling help. Miss Bernice says, “The first thing they tell us is to pray and ask God to help you, because God will take care of you. He can solve your problem, but you have to let Him. You have to let Him solve it, and you have to believe it. That's what we're taught in church.” Likewise, Donna shares, “In your prayer, God may be answering it and you're not hearing, you're not listening.”

It was salient to hear participants provide their reasons why prayer and other acts of religiosity may not be effective for some people. These statements are interesting because they were made by participants who encourage counseling, yet the reasons they state seem to put the responsibility of improving one’s condition on themselves by telling
him or her to “let him solve it” and “you’re not listening”. This stance could make a
person feel as though something is wrong with their faith if they don’t get better by
praying. This was reflected in Sandy’s experience. Sandy believes that her mental illness
could have been treated effectively earlier but she was influenced by the teachings of the
church. She believed prayer and spiritual healing would eventually make the difference in
her mental health condition. As her mental illness progressed, Sandy underwent mental
health treatment. Sandy explained, “I thought that I wasn’t praying enough. The church
was telling me to go talk to the pastor, pray, get healed, get hands laid on. That was the
answer, but it wasn’t enough.” Sandy explained that when her condition got worse, she
thought that she was not a good Christian because God wouldn’t take away her mental
illness.

Participants’ perception of the Black church’s historic promotion of prayer and
religiosity as mental health treatment was prominent throughout each interview. Regina
said, “They spiritualize it and we’re going to pray. We’re going to pray it away. Back in
the day, it was, come to the altar and give God your heart.” Donna shared like thoughts:

Some church folk will just pray, but what I’ve learned also is that God created
psychologists. He created counselors. He created medication. We don’t even use
the tools that He gave us, and sometimes it’s right there, and we don’t use it. Truth
be told, all of us have our issues. It’s just how we choose to deal with them, and
some require more help than you can get just by praying.

Donna and Carl’s words were similar. Donna said, “Church promotes prayer rather than
counseling...Yes, because I know when people are dealing with things in the church, I’ve
never heard anyone say, “You know what? Maybe you need to go speak to someone. I've never heard that.” Similarly, Carl said, “Nobody there pushes you to go for counseling.”

Overall, the data presented in this theme provides a comprehensive understanding of the multifaceted relationship participants have with resilience, religiosity, and the Black church. The complexities of the interrelatedness of these elements in participants’ lives is uncovered in the nuance presented in the subthemes. The influence these elements have had on the participants’ decisions to pursue or not pursue professional psychological help is also revealed in this theme and subthemes. The findings clearly demonstrated the relevance of these elements in the lives of all participants.

Participants’ experiences of resilience, religiosity, and the Black church were interrelated and captivating. Participants connected resilience to religiosity and discussed the influence of the Black church on their decisions to pursue or not pursue professional psychological help. Table 6 displays the aggregation of these subthemes.

<table>
<thead>
<tr>
<th>Resilience, Religiosity, and the Black Church</th>
<th>Connecting Resilience to Religiosity</th>
<th>The Influence of the Black Church</th>
</tr>
</thead>
</table>

**Theme 4: Getting Help**

While each of the 12 participants had considered pursuing professional psychological help, eight of them did engage in a professional psychological help relationship at some point in their lifetime. I found it surprising that most participants had
pursued professional psychological help. However, after hearing participants’ stories and reading their narratives, this number was less of a surprise. Participants described their experiences, and as I attempted to make meaning of these experiences, it became obvious why they pursued professional psychological help. Reasons participants pursued treatment varied; however, each of those who pursued treatment described their choice as a last resort due to a crisis. Some described overwhelming personal situations, depression, and marital issues. All participants who attended counseling were clear that life had become unmanageable. The data in this theme provides an understanding that life becoming unmanageable influenced these participants pursuit of professional psychological help. April described her experience and why she decided to pursue professional psychological help. April says:

I basically raised myself. There’s a lot of issues that I’m still dealing with today. I wanted to seek help but I didn’t know how. Finally, I did. I had too much pressure and stress on me at that point. I had to utilize the avenues that I had…That’s pretty much when I had my first counseling session.

Ralph also shared his experience regarding when he and his wife decided to get marital counseling. Ralph recalled, “Things at home were falling apart. We needed serious help.” Carl spoke about his final decision to attend counseling as well: “I guess I was going to let God do a lot of things, until I got up against the wall. That’s when I had to do things for myself.” Roy explained his marital counseling as a last resort. He expressed: “That’s when I knew I had to leave this crazy lady.” These statements reveal professional
psychological help was not pursued as a first option to resolve personal or marital conflict among those who eventually made the decision to pursue counseling.

While most of those who pursued treatment made the decision to do so on their own. A small number of participants were forced into treatment. Oz and Sandy had different experiences regarding choice. Both participants described their initial mental health treatment as being mandated based on their psychological state at the time. Therefore, the decision to pursue treatment was not their choice. Their experiences of being mandated to pursue psychological services is important to this study because it demonstrates the use of psychological services as a last resort for those in need and the pursuit of those services by their care-givers. This implies that when examining the influences on the help seeking decision making process of individuals in need of services, it is also imperative that the influences on the care-givers of these individuals are also considered. Oz describes how he felt when he was mandated to counseling:

It started in school. They made my mother take me to counseling. I hated it. I felt like a victim. They were trying to label me. That was the beginning of the end. I used to get frustrated and I always said, “Why are they doing this to me? They said my behavior was disruptive.”

Sandy shared her experience when she was forced to get psychological treatment:

I remember as a child telling my dad that I had some mental issues, and my dad said, "You don't need to see a psychiatrist." Then I told my mom I had some emotional challenges. She said, "Turn it over to God." That was what they said as
a teenager, but it wasn't until all hell broke loose in my 40s that I finally got the help that I needed.

While Oz and Sandy were both exposed to mental health concerns as children, the difference in their experience is noteworthy. The parents of Oz and Sandy had to make the decision to pursue treatment for their child. In these two cases, different decisions were made. Oz’s mother pursued the recommended treatment, while Sandy’s parents did not. Sandy said her parents wanted to “depend on God.” Sandy believes their thoughts about treatment influenced her and, therefore, even as an adult she depended on God and church for her psychological help. Sandy’s professional treatment came as an adult when she was forced into counseling after what she described as “all hell breaking loose.” Oz seemed to resent the fact that his mother put him in counseling services and refers to his treatment as “the beginning of the end.” Then he adds “But they made her do it,” referring to the school officials who mandated him to psychological services. He is clear that his early experiences being forced to see White mental health professionals discouraged any consideration he might have given to future voluntary individual counseling situations.

The experiences of Oz and Sandy are thought-provoking because they represent the decisions that caregivers must make when faced with the mental health concerns of their loved ones. Therefore, it is beneficial that the Model of Mental Health Help-Seeking used as the theoretical framework in this study, includes the perspective of the help seeking decisions of caregivers. Consequently, this study also considers the
influences on African American Christians’ decisions to pursue or not pursue professional psychological help for people in their care.

Within the participants’ narratives, there were indications that the decision to pursue or not pursue professional psychological help was made various times throughout all their lives. This theme explored the experiences of those participants who did pursue professional psychological help. In this theme I presented descriptions of participants experiences that described their decisions to pursue professional psychological help. I attempted to make meaning of the participants’ experiences with deciding to get help and what influenced those decisions.

It was interesting to notice that even though all participants who pursued treatment did not consider that treatment favorable, they all expressed pride in the fact that they tried treatment. Each participant agreed that mental health treatment is useful for everyone. The data suggests that even though some participants feel they would not pursue mental health treatment in the future, they would still recommend it to others. This was the case, even for those who had unfavorable past experiences or no experience with mental health treatment at all.

**Summary of Findings**

African American Christians’ decisions to pursue or not pursue professional psychological help are influenced by numerous factors. While the impact has varied, each participant has acknowledged some degree of influence related to the themes that emerged.
The four emergent themes from the analysis are: trust and mistrust from a sociohistorical context; anger and hostility toward White people; resilience, religiosity, and the Black church; and, getting help. Specifically, participants experienced a lack of trust in White people and the systems they professionally dominate and control. The field of professional psychological help is professionally dominated by White people and included in those systems. Participants also expressed feelings of anger and hostility rooted in historic and current experiences of discrimination, injustice, and mistreatment. Participants integrate the concepts of resilience and religiosity and attribute their resilience to God, prayer, and other various acts of religiosity. Participants’ perceive that the Black church has traditionally discouraged professional psychological help and encouraged increased acts of religiosity as the treatment for mental health or counseling issues. Finally, participants who engaged in professional psychological treatment, did so as a last resort or were mandated into treatment due to crisis situations.

In the concluding chapter of this study, I will discuss the findings as they relate to the literature, consider implications for the field and practice, and share recommendations for future study.
CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

This study examined the influences on African American Christians’ decision making to pursue or not pursue professional psychological help. A basic qualitative interview research design was used to explore their individual thoughts and experiences related to professional psychological help seeking. Twelve African American Christians participated in in-depth interviews and discussed their professional psychological help seeking perspectives and recollections. This chapter provides an overview of the study, a discussion of the findings in relation to the literature, and a discussion of implications for policy and practice. The chapter concludes with recommendations for further study.

Overview of the Study

The purpose of this study was to explore the influences on African Americans Christians’ professional psychological help seeking decisions and identify those influencers that may or may not be specifically related to the Black experience in America. This study was conducted to help provide a deeper understanding of the experiences and perceptions of African American Christians’ decisions to seek counseling services outside of the church. Additionally, it was also hoped that the data collected in this study would assist churches, African American Christians, and mental health professionals in developing more effective collaborations and working relationships.

Twelve African American Christians participated in this project. All participants exhibited the following characteristics: (a) self-identified as African American and/or
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Black; (b) were between the ages of 39 and 78 years old; (c) self-identified as Baptist or African Methodist Episcopal (AME); (d) currently attends or has attended a historically Black church; (e) has at some point in their lifetime, considered whether to pursue or not pursue professional psychological help. Exclusionary criteria included people who did not identify as African American or Black, AME or Baptist, and those who never considered the pursuit of professional psychological help.

This research study utilized qualitative inquiry to collect data from in-depth interviews. These interviews were semi-structured and consisted of open-ended questions that were continually evaluated and recalibrated as needed to achieve data collection saturation. Data were organized, coded, and analyzed using the Nvivo qualitative data analysis computer software package. Open coding was used to analyze and synthesize the data. Transferability, credibility, dependability, and confirmability were the criteria used to establish trustworthiness (Guba & Lincoln, 1998) in this study. Transferability was addressed through purposeful sampling and the provision of thick descriptions. Triangulation was used to support the credibility of the findings of this study. This triangulation included multiple interviews with some of the participants, as well as the member check process. To establish confirmability and dependability, an audit trail and reflexivity were utilized consistently throughout this research study. This process of establishing trustworthiness was also supported by including a critical friend whose frequent inquiries illuminated the need for accuracy.
Discussion of Findings

The findings from the analysis of data showed a set of themes that described how African American Christians interpreted and communicated their experiences and how their decision making related to some of those experiences was influenced by a foundation of set practices and beliefs. The four themes that emerged are: (1) trust and mistrust from a sociohistorical context, (2) anger and hostility toward White people, (3) resilience, religiosity, and the Black church, and (4) getting help. Each finding will be discussed.

Theme 1: Trust and Mistrust from a Sociohistorical Context

Jeffry Simpson contends that to build and sustain fulfilling and effectual interpersonal relationships, one of the primary elements necessary is trust (Krause, 2015). All participants discussed trust as having some influence on their decisions to pursue or not pursue professional psychological help. A query of words revealed that of the ten most frequently used words in the data collected, trust was the fourth most frequently used word. Trust was also the number one word used in the data collected that related directly to professional psychological help-seeking.

The results of this word query suggest that trust was the concept most discussed by participants. Data analysis also revealed that the majority of participants (10 of 12) spoke about lack of trust and how their perspective of trust influenced their decision to not pursue professional psychological help at some point in life. The two remaining participants spoke more neutrally regarding trust. Participants identified elements in the
emergent theme of trust and mistrust from a sociopolitical context as having considerable influence on their decisions to not pursue professional psychological help.

Ferrera, Feinstein, Walker, and Gehlert (2016) found that fear contributes to African Americans’ mistrust of government, medical, and business systems because of historic maltreatment practices and events. Some of these same events, like the Tuskegee Syphilis Study (Kennedy et al. (2007) were mentioned by participants in my study. The events mentioned were associated with systems dominated and controlled by White people. My study’s participants also indicated that their fear of history repeating itself added to their mistrust of White people as well.

Therefore, this lack of trust expressed by participants towards White people is partially based on historical and current traumatic experiences and has been identified as a barrier to seeking medical and psychological help. The word query and data analysis of this theme concluded that the concept of trust is fundamentally noteworthy in the professional psychological help seeking decision making of African Americans Christians participating in this study. Overall, similar to the Ferrara et al. (2016) study, my study’s participants demonstrated a concern that historic systems and those who control them are not to be trusted. This concept of trust and mistrust was a broad theme that permeated the discussion and subthemes surfaced as the participants continued to discuss their mistrust.

**White People and Their Systems**

Two subthemes emerged from the theme of trust and mistrust from a sociohistorical perspective, *White people and their systems* and *race and compatibility*. 
These two subthemes allowed further exploration of nuance being uncovered in the larger theme. The first subtheme to emerge, *White People and their Systems*, delved into the more specific issues of participants’ mistrust of White people and the systems they have historically dominated and used as vessels of marginalization and destruction of Black people in America. This subtheme incorporates participants’ perceptions and the influence of America’s history of slavery, Jim Crow, educational discrimination, medical experimentation, mass incarceration, police brutality, and other instances of individual and systemic racism. This subtheme also described participants’ fusion of their distrust for White people with their distrust of the systems and institutions White people historically control (e.g., criminal justice, medical, and educational systems). This fusion was salient in most of the interviews. Participants’ used words like *them*, *their*, *they’re*, and *most* repeatedly when referring to White people and systems. Participant statements like “They teach us not to trust them” demonstrated their fusion of White people and the systems they control. Similar statements were made throughout the interview process.

The display of distrust participants experienced toward White people and the systems they control was most prominent and pertinent when they discussed the Tuskegee Syphilis Experiment (TSS). While all participants had some knowledge of the TSS, the knowledge varied. However, most of the participants acknowledged that this historical event influenced their mistrust of medical systems, which includes mental health treatment. Some participants expressed that their concern is also because medical systems are still predominately controlled by White people. In addition to the devastating impact the TSS had on its subjects and their families, there are also inherited societal
implications that continue today. As demonstrated by the twelve participants in my study, a general mistrust of the medical community still exists among African Americans (Morris, 2016). Nevertheless, the findings suggest that even though mistrust existed, perceived risk was a strong motivational factor that influenced participants’ decision making.

Findings of this subtheme are consistent with prior studies (Terrell & Terrell, 1981; Terrell, Taylor, Menzise, & Barrett, 2009) that examined the concept of cultural mistrust and described it as a theoretical level of distrust and suspicion some Blacks have toward White political activities, educational systems, business interactions, and interpersonal and social contexts. These researchers acknowledge a belief that Black Americans’ historic and current experiences of discrimination and oppression may cause them to maintain a slight paranoia in the form of mistrust of White people and these systems. This research also supports the findings presented in this subtheme that cultural mistrust has influenced participants’ decisions to pursue or not pursue professional psychological help.

What I also found was that participants tended to assess the risks associated with the treatment they were skeptical of, and made decisions based on their perception of the consequences of not seeking treatment. This was evident when one participant explained how her senior citizen friends would refuse a flu vaccination because of the suspicion created by historical medical experimentation, yet the same people might accept a pneumonia vaccination. The refusal of the influenza vaccine is not an uncommon conversation amongst African Americans. Research verifies that African American adults
receive the influenza vaccine substantially less than White adults (Li & Mukamel, 2010). The hazard of this difference is also noted in the current literature. According to Quinn, Jamison, Freimuth, Hancock, and Musa (2017), the disparity in vaccination acceptance contributes to more flu related sickness and deaths amid African Americans.

Similar risk assessment was also apparent when several participants spoke about how they did not seek professional psychological help until their situation became chronic. These findings align with the research that reports, more often than Whites, African Americans are more likely to receive mental health care in a crisis or emergency situation (Carpenter-Song, Whitley, Lawson, Quimby & Drake, 2011; Cook, Zuvekas, Carson, Wayne, Vesper, McGuire, 2014; Hu, Snowden, Jerrell, & Nguyen, 1991).

**Race and Compatibility**

The second subtheme, *race and compatibility*, includes the concepts of congruence and compatibility. In this subtheme, these concepts represent the degree to which a feeling of coexistence and togetherness would exist between two people. Participants related these concepts to a match in race and emphasized the lack of trust they had in the ability to have a positive and effective professional helping relationship with a White counselor. Every participant in the study had considered seeking professional psychological help at some point in their lifetime. Yet, the race of the counselor was carefully considered and discussed by participants as a factor influencing their compatibility with the counselor.

According the National Alliance on Mental Illness (2018), the national average of African Americans who engage in mental health treatment is 25%, compared to 40% of
Whites, yet in this study the majority had engaged in mental health treatment. Therefore, it is noteworthy that eight of this study’s 12 participants had engaged in professional psychological help. It is also significant that 5 out of the 8 participants who engaged in professional psychological help considered their experience favorable. This is relevant to the subtheme of race and compatibility because these participants attributed their favorable experience with the fact that their mental health care provider was a person of color. So, it appears that compatibility is related to race in their experience.

Participants felt there was a connection and concern apparent in the counseling session with a counselor of color. This connection and concern made participants feel like they were being heard and that their experiences were being understood by the counselor. It was interesting that participants attributed these feelings to the match in race immediately above all else. Participants who sought an African American counselor said race was their first concern. This concern of race is discussed by Meyer and Zane (2013) who found that one of the most crucial features clients first take note of in counseling is the ethnicity of the therapist. It is only after the racial match has been assessed that most clients evaluate additional variables like age and gender (Meyer & Zane, 2013).

Data from this subtheme highlights the participants’ importance of race and the need for congruence to exist between them and their mental health treatment provider. From the comments it seemed that a counselor of color created greater compatibility and also lessened the distrust of pursuing mental health treatment. The literature supports the experience of these participants and validates that cultural congruence is necessary in a
counseling setting and that people typically associate with people they view as similar (Pope-Davis, Coleman, Liu, & Toporek, 2003; Smith, 2009).

It is important to note that almost all participants who had favorable past counseling experiences pursued an African American counselor. Particularly because although they did not have any unfavorable experiences with a White counselor like the others did, they anticipated that they might. The anticipation of an unfavorable experience with a White counselor is the participants’ response to their exposure to historic and current incongruence with White people. Therefore, in addition to participants’ mistrust of White people, there is also a mistrust in compatibility of White counselors.

Three of the eight participants reported their counseling experience as unfavorable. These three participants mentioned no connection, feeling judged, misunderstood, and dismissed. All three participants attributed their unfavorable experience to the fact that the mental health care provider was White. While some of these barriers may have been created by other differences, such as gender, age, or ability of the mental health professional, participants attributed their unfavorable experience to the difference in race, particularly the fact that the mental health professional was White. This data revealed that for participants who were not satisfied, the lack of compatibility reinforced their mistrust of the White counselor. One participant said, “I knew it wouldn’t work before I went.” Some of the participants’ mistrust was not only directed toward the White counselor, it was directed toward the counseling process. They did not trust that the counseling process could be effective with a White counselor because of incompatibility.
The importance of understanding this theme is that it shows perceptions of compatibility can be preconceived and sometimes based on sociopolitical and sociohistorical events. These perceptions may have initially been beyond the control of the counselor yet connected to trust in that counselor. Therefore, the counselor’s actions and reactions possibly reinforced the participants’ feelings of mistrust and incompatibility. This may suggest that cultural congruence and compatibility can impact trust and have current day implications on the therapeutic process. The experience of the three participants who described their previous experiences with mental health professionals as unfavorable is broadly in line with researchers such as Meyer and Zane (2013) who found that if a cultural element was important to a person receiving mental health treatment and they did not feel it was present, they reported being less content with aspects of the treatment they received.

Similar racial matches in a therapeutic setting have produced results consistent with the experiences of these participants. Several research studies have revealed a connection between increased satisfaction and favorable treatment outcomes with a racial match between client and counselor (Blank, Tetrick, Brinkley, Smith, & Doheny, 1994; Meyer, & Zane, 2013; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). One study noted that counseling dyads of the same race had greater service utilization (Blank et al., 1994). This is consistent with the findings of this study because the participants who engaged in counseling longer were working with counselors of the same race.
Theme 2: Anger and Hostility Toward White People

Anger is a common response to stressful life situations. African Americans’ history of slavery and oppression may cause feelings of anger, hostility, hopelessness, and self-destructive behavior (Pittman, 2011; Vontress, Woodland, & Epp, 2007). Historical hostility and anger in African Americans can be similar. Hostility can be as subtle as a day to day defensiveness or it may appear as robust as fury (Vontress & Epp, 1997). This description of historical hostility is parallel to the way it was displayed by some of the participants in my study. There were times when I needed to probe to explore participants’ feelings of hostility. However, there were times when the hostility was more like anger and much more apparent. This indicates the importance of understanding that anger may present itself in a variety of ways. Therefore, an understanding of these concepts could have implications in a counseling relationship.

Seven of the twelve participants exhibited discrete and indiscreet feelings of anger towards White people. At times this anger was specific, however, there were times when this anger was general and less precise. Even though the participants expressed their feelings of anger differently, each of those who did, admitted that those feelings influenced their decisions regarding mental health treatment. It was interesting to find that almost all of the participants who experienced anger that influenced their decisions to seek professional psychological help, did eventually seek that help.

Notwithstanding feelings of anger, the majority of those who felt anger and sought treatment considered that treatment experience favorable. However, it is also notable that those who had favorable experiences while possessing feelings of anger all
had African American mental health practitioners. Participants attributed these favorable outcomes to the racial match between them and the mental health practitioner. These findings may indicate that because the counselor was a person of color, the feelings of anger and hostility did not impede the favorability of the counseling experience. Participants suggested that these feelings of anger and hostility were able to be expressed, explored, and understood more effectively due to the race match between the participants and their counselors.

**Suppression of Feelings and Hostility Expression**

The subtheme to emerge from the analysis of data related to anger and hostility was the suppression of feelings and hostility expression. The suppression of anger and hostility and the preliminary reluctance to openly express those feelings was a surprising development in this study, yet in line with the research of Dr. Clemmont Vontress, who is the pioneer of research on *historical hostility*. He describes this phenomenon of historical hostility as a continual form of reactions shown by African Americans that come from long term exposure to degradation and marginalization in America (Vontress & Epp, 1997). In a groundbreaking 1993 interview regarding multicultural counseling, Dr. Vontress and Dr. Courtland Lee discuss historical hostility and African Americans’ suppression of anger. Vontress mentions the necessity for African American men to suppress this hostility during the day because they are working in the mainstream culture of White America. Vontress contends this hostility is sometimes expressed during sleep and may have deleterious health effects (Lee, 1994). The hostility often described in the
research conducted by Vontress is like that expressed by my participants and developed into this subtheme.

During the interviews, some of the participants’ anger suppression was displayed in a hesitation to express anger and hostility, which was salient and consequential. This was salient in the interview process because although at times these feelings were expressed with words and inflections, there were other times when only body language and physical actions indicated their existence. Noticing this hesitation was consequential to the data collection process because I was then able to explore participants’ nonverbal responses into our conversations and found that often, they needed reassurance that their actions were understandable, suitable, and acceptable during our interviews. By highlighting and validating this nonverbal communication of suppressed hostility, I was able to help develop the trust participants needed to verbally articulate the feelings of anger and hostility that were being manifested nonverbally.

Much of the reassurance that I provided the participants to express their nonverbal communication was also provided via my own nonverbal communication. I used gestures like nods and opened hands to encourage participants’ expression of these feelings. Levine and Ambady (2013) contend that comprehending how these nonverbal actions and interactions impact outcomes and the satisfaction of patients is critical to improving racial disparities in health care. Evidence presented in this subtheme concur with the work of Levine and Ambady (2013) because my understanding of the participants’ nonverbal actions and interactions helped us move to a deeper discussion of their anger and hostility. This suggests that a counselors’ understanding of these nonverbal actions
and interactions, regardless of race, could possibly have a similar impact. This type of understanding may have assisted me in communicating more concern and interest toward the participants in this study.

Some of the hostility and anger demonstrated by participants was a direct result of the historic police brutality and misconduct that is more often being documented and displayed daily via television and social media. While many African Americans have long been aware of this unjust detrimental treatment by some police officers, the recent televised events have visually depicted the types of stories and tragedies we often heard about, but rarely viewed. Participants who expressed anger and hostility recognized that those feelings influenced their decisions to pursue or not pursue professional psychological help. They also recognized that sociopolitical issues such as police brutality have influenced their current level of trust, anger, and hostility toward systems.

I found it interesting that the participants related the current sociopolitical environment to their hostility and anger. This seemed to validate their decisions not to pursue assistance from professions dominated by White people. White people may not be aware that when racially charged events take place and are nationally broadcasted, sometimes African Americans who are strangers to each other engage in conversation about these events spontaneously. These conversations could take place in the supermarket, bank, and various other public spaces. Sometimes these conversations develop out of an intense, immediate desire to converse with someone who may understand situations similarly. Participants shared that African Americans are familiar with seeing things differently than Whites based on our experiences. Because the
televised police murders of several African American men were so recent, several participants mentioned the stories to me before our interviews even started.

Such spontaneous dialogue about racially associated current events shows that these happenings were on the minds of some participants at that time. It also shows participants’ desire to share how they felt about the events. However, based on the findings, if I were a White interviewer or counselor, the participants may not have engaged in that conversation. Based on the findings, the discussion about the recent police killings and expression of feelings related to them might have gone suppressed by those participants. This is relevant to understanding the impact of sociopolitical events on many African Americans.

These findings are consistent with previous literature that emphasizes the need for mental health workers to acknowledge the influence of sociopolitical factors. This may help clients address some of the issues that are causing problems and conflict in their life (Marsella, 2011). White counselors may have a different worldview and understanding of the same historical and current racial bias and discrimination incidents in our country (Marsella, 2011). From my participants’ experiences, this anger and hostility of Blacks toward Whites is facilitated by not being understood from a sociohistorical context and may be expressed simply as “no connection, not interested, or I didn’t feel comfortable.” Participants who experienced anger and hostility emphasized that these feelings did influence their decisions to pursue or not pursue professional psychological help.
Theme 3: Resilience, Religiosity, and the Black Church

Grounded in their experiences, study participants articulated and demonstrated a set of beliefs, behaviors, and practices that emphasized a foundation of Christianity nurtured in the community and fellowship of the Black church. This theme reflects the emergence of data that highlighted the association participants made between resilience, religiosity, their connection with the Black church, and the influence these factors had on their decisions to pursue or not pursue professional psychological help. Even though the experiences of each participant varied, the commitment to their identity as a Black Christian was strikingly similar. Across participants, their relationship with the Black church, appeared to be their most salient identity. This was true even for participants who no longer attended church services. Considering the pursuit of psychological services was viewed through the lens of their Black Christian identity. Avent and Cashwell (2015) discussed the identity many African Americans have with the Black church. The researchers contend that the Black church and the expression of its numerous theological viewpoints are crucial elements in the identity of many African Americans.

Connecting Resilience to Religiosity

This subtheme was developed from the original theme of Resilience, Religiosity, and the Black Church when the data emerging from the larger theme indicated there was a need to further examine participants’ attribution of resilience to religiosity. The data analysis revealed this subtheme, which helps us better understand the influence this attribution of resilience to religiosity may have had on participants’ decisions to pursue or not pursue professional psychological help.
When asked about why they were hesitant or unsure about receiving professional psychological help or why they never sought such help, participants were consistent in their responses. They often used phrases common in the Black church to explain that they made those choices because their connection with God, faith, and the Black church had been enough to sustain them and that those factors are responsible for their survival. Therefore, the findings show that all participants’ felt that their connection with God and the church was what helped them handle their problems in the past and some believed that the same connections would continue to get them through the problems they were experiencing. Again, historically, this reflects the African American experience of Church as a refuge for safety and strength (Avent & Cashwell, 2015, June, 2008).

June (2008) describes the Black church as providing hope for African Americans and credits that hope with the resilience we have experienced. Because of this commonly understood connection in the Black church, the participants’ expression of connecting resilience to God, the church, and religious acts did not come as a surprise. This connection of resilience and religiosity is a robust part of the African American experience. Throughout generations of enslavement, African Americans worshiped secretly, prayed for each other, and practiced other forms of religiosity. For some, religion and faith has been, and continues to be credited with the resilience of African Americans. Popular church sayings sometimes reference dependence on faith when someone is experiencing challenges. Participants mentioned terms like “go to God, leave your problems at the altar, tell Jesus.” These types of references are commonly reinforced in songs during church services. At times, the songs reinforce the sole reliance on faith.
over all else in times of trouble. An example of this comes from a popular hymn called *I must tell Jesus*. The song describes handling trouble and says:

> I must tell Jesus all of my trials, I cannot bear these burdens alone; In my distress He kindly will help me, He ever loves and cares for his own. I must tell Jesus! I must tell Jesus! I cannot bear these burdens alone; I must tell Jesus! I must tell Jesus! Jesus can help me, Jesus alone.

This song emphasizes “Jesus alone” as the only source of help in times of distress. For some African American Christians who may be feeling emotional distress, attending a worship service and singing a song like this may be uplifting and reassuring.

Participants expressed these experiences in terms of resilience and their connection to the church. These actions might provide comfort, even though that comfort may be temporary. The experience of religiosity can provide a personal comfort that rejuvenates the mind and reinforces a person’s perception of their capability to manage stressful situations. The invigorating music, sermon, and fellowship offered by the Black church has a comforting effect that the participants expressed as helping them with a positive push through many difficult times. Although some people may not understand this type of reliance on faith, it has been what many African American Christians have considered their primary survival resource (Cashwell & Young, 2011; June, 2008).

Participants reported that because of this connection with resilience and religiosity, they did not consider professional psychological help as a first response to emotional issues. For some, even after the consideration, professional help was not pursued because faith and religiosity had worked in the past and the hope was that it
would work again. These data tie well with previous studies wherein researchers report compelling evidence that the religious aspect of a person’s life is significant in the developmental process and can assist in the advancement of general well-being (Cashwell & Young, 2011).

**The Influence of the Black Church**

The data depicting the influence of the Black church on the professional help seeking decisions of participants was reflected in this theme. Each participant declared that prayer or other acts of religiosity was the response of the Black church to issues of mental health. Several studies on attitudes and beliefs about depression imply that about two-thirds of African Americans trust that faith and prayer would be the best treatment for depression (Chamberlain, Muntaner, Walrath, Nickerson, LaVeist, & Leaf, 2001; Neighbors, 1985; Wang, Lane, Olfson, Pincus, Wells & Kessler, 2005). Participants expressed that in their experience, the Black church has discouraged professional counseling or ignored the subject all together.

It was thought-provoking that even when participants mentioned the Black church’s response to mental health issues, some of the participants defended the church’s response of encouraging religiosity over professional counseling, even though they admitted that they disagreed with the response. There was a reasoning for the Black church’s position attached to most participants’ statements of disagreement. This defense of the Black church’s response to mental health issues was an unanticipated, yet important finding garnered from the data. This indicated that participants may want
change in the Black church regarding its response to mental health issues, yet do not want to seem as though they are speaking against the traditional teachings of the church.

Several participants stated that the traditional teachings of the Black church caused them to feel inadequate in their faith when life’s challenges did not dissipate as a result of increased religiosity. While some participants extolled how the power of prayer and other acts of religiosity helped their problems diminish, others articulated skepticism that increased acts of religiosity alone would improve mental health issues. One participant contended that people should pray, go to church, and also go to counseling.

**Theme 4: Getting Help**

Each participant in this study had considered pursuing professional psychological help at some point in her/his lifetime. Although counseling experiences varied, all participants espoused that they believe there are some benefits to seeking professional psychological help. Beginning with the recognition that their lives had become unmanageable and all other interventions were not working, most of the participants in this study engaged in professional psychological help. My findings show that more than half of the participants in this study received prior mental health treatment. These findings are contrary to the National Alliance on Mental Illness (2018) that reported about 25% of African Americans engage in treatment services. My findings on participant population do not indicate why the numbers are different in the amount of people who sought help. However, it could be that the topic of this study attracted participants who were more open to seeking professional psychological help.
For two of the participants who engaged in professional psychological help, the help was mandated by a court or a school. For others who engaged in professional psychological help, it was their decision. Participants spoke at length about personal crisis situations that propelled them into treatment. Hearing participants discuss their reasons for pursuing professional counseling was revealing. One participant disclosed that drug use was devastating his family, while another revealed that an extramarital affair was causing a lot of guilt and shame and that there was no other way to deal with the problem but to go to a professional counselor. Participants also felt as though they would be judged as not being Christian enough. This feeling of not wanting to be disgraced or dishonored by the pastor or church members was a form of stigma. Stigma has been identified as a major barrier to the mental health treatment seeking of African Americans (Anderson, & Edmonds, 2012). Hearing the reasons participants sought professional help, gave me an understanding of why participants said they could not go to the pastor with their problems. They shared that there was a large amount of guilt and embarrassment involved.

Findings from this study inform the existing literature, since according to Hardy (2014) there is not a lot of information available that explains the specific reasons African American Christians would pursue professional help when they are distressed. Additionally, Hardy (2014) emphasizes the importance of understanding which challenges would determine the type of provider African Americans Christians would select. The participants in this study explained that their personal crisis situations that led to professional psychological help seeking included matters as various as depression,
drug abuse, grief, adultery, sexual promiscuity, marriage crisis, and more. Participants said these challenges had become debilitating and were not issues they felt comfortable discussing with their pastor or any church leader. Therefore, they pursued professional psychological help.

Those participants who received professional psychological help and found it favorable, advocated for the utilization of mental health services. They consistently spoke of the benefits of professional counseling being combined with their faith in God and practice of religiosity. One participant exclaimed, “God created psychologists. God gave us the counselors.” This was the common sentiment of those who experienced favorable professional counseling. They made a decision to pursue professional help and had all resolved that it was a good decision.

All of these participants said they either still attend counseling or that they would attend in the future. Whereas, those participants who had unfavorable counseling experiences said they would not attend counseling again and that they would depend solely on God and religiosity. This dichotomy indicates that perhaps the favorable counseling experiences helped participants reconsider their traditional teachings and effectively integrate religiosity and counseling. On the other hand, conceivably, the unfavorable counseling experiences served as a persuader for those participants to rely only on God and the church and not reconsider professional counseling at all.

A small number of participants were mandated to mental health treatment services due to their crisis conditions. Therefore, they had no choice in pursuing or selecting the professional psychological help they initially received. Nevertheless, their experience with
getting help is significant to this study because it speaks to the importance of understanding
the help seeking influencers on the family members and care givers who made many of the
help seeking decisions for these participants. Comparison between participants who
received professional psychological help voluntarily with those who received it
involuntarily, showed no substantial differences in experience or favorability.

**Theoretical Framework for Help Seeking**

The Model of Mental Health Help Seeking (Cauce et al., 2002) was selected as
the theoretical framework to be used for this study. This study emphasizes the importance
of culture and context on individuals’ help seeking beliefs and actions. While mine is not
the first study to review the influences on help seeking beliefs and actions, the emphasis I
have placed on cultural and contextual factors provides a more holistic exploration of the
experiences of the participants in this research project. Although this model is presented
in three interconnected steps, they do not always occur in the same order.

The three steps to this model are: problem recognition, decision to seek help, and
service selection. Considering the participants’ lived experiences and the findings of this
study within the framework of this help seeking model, provides a more comprehensive
exploration of those lived experiences, as well as the influences on their help seeking
decision making processes. Each step of this model could be impacted by the elements
explored in the themes of this study.

Problem recognition is defined as need that is epidemiologically defined or a need
that is perceived (Cauce et al., 2002). Both need types may be influenced by cultural
components explored throughout this study. Since epidemiologically defined need is
usually evaluated using the Diagnostic and Statistical Manual of Mental Disorders (DSM), this type of need could be influenced by a misinterpretation of culturally accepted or encouraged behavior. For instance, certain religious rituals or acts of religiosity could be mistakenly pathologized due a mental health practitioner’s lack of understanding. Transformational religious acts like talking in tongues (speaking in an inaudible language) or catching the Holy Ghost (known as a physical manifestation of being filled with the spirit of God) could be perceived as abnormal, although this is a routine practice performed by mentally well Black Christians on a regular basis.

According to the findings in this study, participants’ perceived need was influenced by past resilience, religiosity, and the Black church. The findings reflect that participants often attributed past resilience to God, religion, and the Black church. On occasion, this type of ascription, along with some of the teachings and traditions of the Black church, convinced some participants that they did not need professional psychological help. I also found that some participants ‘perception of their need for help had sometimes been distorted by having overcome past challenges, as well as the inclination to significantly depend on religiosity and the experience of the Black church for mental health treatment.

This model postulates that the decision to seek help is more probable after a mental health problem is acknowledged and deemed not likely to diminish on its own. Although this acknowledgement of the problem increases the chance that help will be sought, it does not ensure that help will be sought (Cauce et al., 2002). In order increase my understanding of participants’ experiences, I explored the data to see which of the
components discussed in this study might have the most influence on the decision to seek help phase of the Model of Mental Health Help Seeking.

Participants openly discussed how their decisions to seek help were influenced by various cultural and contextual components. Resilience, anger and hostility suppression, religiosity, and the influence of the Black church were emphasized as the main elements of this study that have impacted participants decisions to seek help or not seek help after they accept that a mental health issue exists. Past experiences of resilience sometimes allowed participants to believe their mental health issues would dissipate, as they seemed to have done before. This reliance on past resilience encouraged some participants to wait extended periods of time for the problems to go away. Once some participants realized that the problems were not going away, and in some cases escalating, they sought professional psychological help. For the few participants whose problems escalated beyond their control, treatment was mandated. This stage of the model considers treatment that is voluntary and involuntary.

Suppression of anger and hostility also impacted this phase of participants’ help seeking experience. The suppression of these feelings increased participants’ ability to deny that they might need professional psychological help to effectively address the problem. By suppressing their anger and hostility, some participants were able to rationalize that because they were able to function effectively, even while experiencing these feelings, they could delay or deny professional psychological help.

Each participant discussed many ways their lives have been influenced by their religiosity and connection to the Black church. They discussed the views of the church
regarding mental health treatment and some gave examples of how they thought they might be able to *pray away* their issues related to mental health. All participants mentioned that the Black church has historically discouraged professional counseling and that at some point in their life they were influenced by that perspective. Yet, although influenced by that perspective, most participants did engage in professional counseling at some point in their lifetime. Several participants admitted that they would have pursued counseling sooner if it were promoted in their church.

The final phase of the Model of Mental Health Help Seeking is *service selection*. The phase of the model examines who people enlist for help, once help is being sought. This stage of the model worked well for this study because service selection considers informal supports, collateral services, and formal mental health services. Based on the data reported in this study, I contend that participants’ service selection was influenced by most of the cultural and contextual elements mentioned in this study. These elements included, trust and mistrust, mistrust of White people and their systems, race and compatibility, and the influence of the Black church.

Trust and mistrust and mistrust of White people and their systems influenced service selection significantly for participants who had experience with professional counseling. Due to these matters of trust, participants sought out a counselor who was a person of color. Some participants said race was a factor because they wanted compatibility and were skeptical about White people and the systems they control. Participants did not anticipate that compatibility with a White counselor would be possible due to historic racism and cultural differences. This compatibility was described
as a connection. These participants attributed that connection to the match in race. Due to the influence of the Black church, some participants would only consider seeing a counselor who emphasized training in spiritual counseling. These participants surmised that such a counselor would understand their link with church and religion.

**Implications for Practice**

The findings from this study offer numerous implications for counselors in practice, counselor education, and pastors. These implications for practice may also be useful for church leaders, as well as various others who serve in the capacity to influence the mental health treatment of African Americans. These implications will be directed by the four themes of trust and mistrust from a sociohistorical context, anger and hostility toward White people, resilience, religiosity, and the Black church, and getting help.

**Counselors in Practice**

Vital experiences were included in the theme of trust and mistrust from a sociohistorical context. These experiences were some of those that influenced participants’ decisions to pursue or not pursue professional psychological help from counselors. Trust is a well-researched and necessary element in an effective counseling relationship. African Americans’ high termination rate in counseling has been attributed to lack of trust in White counselors (Terrell & Terrell, 1984; Watkins & Terrell, 1988).

This theme illustrated some of the multilayered and intricate elements encompassed in African American Christians’ trust toward White people and White mental health professionals. An analysis of the findings determined that this trust was impacted by historical and contemporary experiences of racism, racist practices, and
prejudicial treatment. As such, it is imperative that counselors understand the impact of past incidents of racism and mistreatment may have on the trust-building process when working with African American Christians.

Since connection was the word used by some participants to describe what was missing in their past unfavorable counseling experiences, as well as what was present in favorable counseling experiences, it would befit White counselors to purposely create an atmosphere that acknowledges and incorporates the sociohistorical and Christian perspectives of their African American Christian clients. Connection and trust development between African American Christian clients and White counselors might also be positively affected by the counselor’s increased knowledge of African American Christian culture. Particularly, possessing knowledge about the culture of the Black church could assist the counselor’s understanding of the client, while also communicating concern and interest in their experiences and understandings.

The data reported in this study suggests that holistic approaches to counseling would include counselors exploring how the existence of suppressed anger and hostility might be impacting the lives of some African American Christian clients. If counselors engage in these practices, perhaps increased connection and compatibility will be established, having a more positive impact on trust development with African American Christian clients.

It is noted in the data that participants who received professional psychological help that they considered favorable felt it was because the counselor was a person of color. White counselors may benefit from an increased effort to understand the elements
included in these types of therapeutic sessions and evaluate the possibilities of developing increased multicultural capabilities that not only focus on diversity in race and religion but more specifically, the Black church.

Counselor Education

While counselor education programs provide various aspects of diversity in the training and education of future counselors and counselor educators, based on the findings in this study, several considerations may be helpful. The theme of trust and mistrust from a sociohistorical perspective revealed participants’ fusion of White people and the systems they have historically dominated. Several participants also assumed that they would have to receive mental health treatment from a White counselor. Although choice of ethnicity of provider may exist for some consumers of mental health services, the truth is that most of the providers are White. It has been reported in Towns et al. (2009) that only 3.8 percent of counseling professionals identify as Black.

Therefore, evidence-based consideration from this study’s data include increased minority student recruitment efforts at the undergraduate and graduate levels of counseling and counselor education programs. Such action would increase the amount of people of color in the field of counseling, thereby, increasing the options of counselor ethnicity choice for African American Christians and other minority populations. This recruitment should include concerted efforts to reach potential African American students. These efforts could possibly include recruiting potential students from Black churches, as well as Historically Black College and University undergraduate programs. These recruitment efforts should be conducted by counseling and counselor education
programs that provide supportive and culturally conscious services to support the retention of their students of color. Counselor education programs may also consider providing students with more exposure to African American Christians and the culture and history of the Black church. Curriculum in these programs should be designed to inform students of some of the experiences of African American Christians and how those experiences may impact their lives and their decisions to pursue or not pursue professional psychological help. Through these efforts, future counselors and counselor educators might be encouraged to gain increased knowledge and understandings about how historic and current happenings impact the help seeking behaviors of various populations.

Counselor education programs should aim to prepare students to identify signs that an African American Christian client may be suppressing her/his anger or hostility and how to broach this type of situation most effectively. These programs should also caution students not to overgeneralize findings and assume that experiences are the same for all African American Christians or people connected with the Black church.

**Pastors and Leaders of Black Churches**

Collaborations between churches and mental health service programs do exist. Some leaders of Black churches have made advances in strengthening connections with community mental health services and are reconsidering past narratives about mental health treatment. One participant in this study who is an African American pastor was knowledgeable about recent mental health trends. He is currently in the process of
developing a mental health initiative at his church, as well as a collaboration with a community counseling agency.

Increased collaborations between mental health treatment providers and Black churches could provide those involved with more exposure to each other’s historic and current practices and beliefs. Mental health treatment providers and church leaders could work together to change norms and validate each other’s perspectives and worth. Establishing presence amongst each other and spending time together in shared spaces might help develop increased connections and levels of comfort. Collaborative initiatives like community health fairs could be held at Black churches. At this type of event, mental health service information could be promoted by local mental health treatment agencies. Through these efforts, mutual trust and understanding may increase. This may also decrease some African American Christians’ fusion of White people and the systems they control. This type of exposure may assist in more effective management and navigating of the anger and hostility some African American Christians may feel toward mental health systems and White people. Increased exposure could enhance the work of counselors, pastors, and church leaders by enhancing their knowledge of each other’s perspectives, bias, and individuality.

It is also incumbent upon more seminary schools and other faith training organizations to provide education on some of the mental health perspectives of African American Christians and the importance of mental health treatment within their faith communities. Since the findings suggest that high risk is a strong motivational factor for pursuing help, mental health service initiatives and collaborations with the Black church
could result in an increased amount of African American Christians pursuing professional psychological help before mental health situations become critical. These actions may promote more effective ongoing counseling relationships since they would be supported and validated by the pastor and church leaders.

**Limitations**

Although the elements of cultural mistrust, historical hostility, religiosity, and resilience have been studied before, this study supports a critical gap in the literature because it examines these elements with African American Christians within the context of the Black church. Therefore, the findings and implications of this study should be interpreted and considered, notwithstanding its limitations.

One limitation of this study is the small sample size. This study recruited 12 African American Christians to be interviewed. Study results gathered from this small number of participants may restrict generalizability. However, saturation was reached, and this limitation was considered and countered by reading and interpreting the data meticulously.

I should stress that my study has been primarily concerned with the influences on the professional psychological help seeking decisions of African American Christians who were either AME or Baptist. Therefore, another limitation to be considered is that due to this study’s restrictive qualification of all participants being African American Christians, generalizability to other populations may be limited.

The final limitation to be noted is that I am an African American Christian who attends a Black church. Therefore, one related consideration is that participants identified
my background and responded with answers that they thought would be appropriate based on the teachings of Christianity or the Black church. This limitation also considers an assumption that many African Americans have toward each other, that we are all familiar with the culture of the Black church, which is not always true. The findings of my study do not imply that the experiences of these participants are the same for all African American Christians. However, the commonalities that exist amongst the experiences of these participants, merit further research.

**Suggestions for Future Research**

This study explored the influences on African American Christians decisions to pursue or not pursue professional psychological help. Four themes were reinforced by the findings related to the influences on the mental health help seeking decisions of twelve African American Christians. Recommended research in areas connected to these themes would contribute to the literature. Such research might explore African Americans’ sometimes protective and sometimes disparaging emotional navigation of historical hostility, constructive collaborations between the Black church and mental health agencies, and the concerted effort to increase the recruitment and retention of African American men in counseling and counselor education. Additional research in these areas should consist of mixed methods and longitudinal studies. Mixed methods studies would likely optimize triangulation and increase generalizability. While longitudinal studies may provide useful data about patterns, changes, and connections over an extended period.
Because the current study examined historical hostility from the perspective of African American Christians, it is suggested that additional related research explore samples of African Americans that are more diverse in religious affiliations. This diversity would also include African Americans with no religious affiliations or beliefs. The field of literature would benefit from this additional research that would provide insight into how historical hostility has mandated a necessary cautiousness in the day to day interactions of some African Americans, yet at the same time prohibited productive interactions between some African Americans and White people.

Although the traditions and teachings of the Black church were identified by participants as influences on their mental health help seeking decisions, these same traditions and teachings have also provided emotional sustenance and survival for African American Christians throughout eras of inhumane treatment and generational discrimination. Therefore, additional research could explore collaborations that encourage African Americans’ utilization of mental health treatment systems, yet at the same time preserve, respect, and embrace the values of the Black church.

Some of the most impassioned reflections came from the male participants in this study. The depth of their expressions and demonstrations permeated the conversations and beckoned for further expression and exploration. Additional research into the psychological and counseling needs of African American boys and men may highlight and help us to better understand this population. A counseling environment could offer a secure space for an African American man to engage in exploration and expression. Data from my study highlighted participants’ experiences with connection and compatibility.
From that data, it could be implied that some African American boys and men might prefer an African American male counselor. Therefore, concerted efforts should be made to increase the number of African American men in the counseling profession. Increased efforts in the recruitment and retention of African American men in counselor education programs, would increase the amount of African American men in the counseling profession, as well as research with this population. The increased presence of African American men in the counseling profession would generate more options of gender and race match between African American boys and men and African American male counselors. To that end, further research might usefully focus on concerted efforts to increase the recruitment and retention of African American men in counseling and counselor education programs.

**Conclusion**

The wellness of our nation is contingent upon the wellness of its people. While resources to improve emotional wellness do exist, those resources are not accessed equally by all populations. African Americans are less likely to engage in mental health treatment than White Americans (Gonzalez, Alegria, Prihoda, Copeland, & Zeber, 2011; Snowden, 2001;) and have poorer treatment outcomes (American Psychiatric Association Fact Sheet (APAF) Office of Minority and National Affairs, 2017; Atdjian & Vega, 2005). According to the American Psychiatric Association (2017), African Americans also obtain less quality mental health services, as well as reduced access to care that is culturally competent.
The aim of my study was to contribute to efforts that address the elements that impact African Americans’ utilization of mental health services. By exploring the experiences of African American Christians, I was able to evaluate how those experiences have influenced their professional psychological help seeking decisions. This study was guided by the research question: What influences African American Christians’ decisions to pursue or not pursue professional psychological help? Four themes emerged from the data; trust and mistrust from a sociohistorical context, anger and hostility toward White people, resilience, religiosity, and the Black Church, and getting help. Each theme was described and supported by data, which was then analyzed and considered within the context of the Model of Mental Health Help Seeking.

My literature review reflects that some of the concepts that emerged in this study have been researched in the past. However, this study should contribute to the existing literature because of its unique qualitative evaluation of these concepts through the experiences of African American Christians connected to the Black church, more particularly the Baptist and AME denominations.

My investigation has produced evidence that demonstrates participants’ vital reactions to being Black in America. The timeline of this study is significant because it began when America was experiencing something many people thought would never happen based on our country’s history of racism and degradation. A Black man, Barack Obama, had been twice elected President of the United States and was serving with dignity and inclusivity. Today, as this study is completed, a White man, Donald Trump, is the current President of the United States. The Presidency is significant to this this
study because for many people, Donald Trump’s ideology validates many of the feelings and concerns that have been expressed by participants in this study. America once watched as President Trump referenced an African American person attending one of his rallies and said, “Look at my African American.” This reference embodied the historic White American ideology of exhibition, possession, and justification.

The subject matter and the data collected in this study support mentioning the racist words and actions displayed by the current President of the United States; however, those words and actions have been too numerous to be adequately discussed in this conclusion. Nevertheless, this study provides valuable insight into how systemic racism and America’s validation of racist actions and leaders continues to promote some African Americans’ fusion of White people and the systems they historically control. For instance, even though the first African American man recently served two terms as President of the United States, the man who now serves often demonstrates a dogmatic and marginalizing approach to policy and practice. This approach reinforces the understanding that the system of the federal government can be controlled by people who openly communicate racist views and enact policies and procedures that are discriminatory and result in deleterious consequences for people of color.

My primary goal with this study was to honor the experiences of the African American Christian participants. Along with my research question, this goal guided the process while I conducted the study. As an African American Christian woman, who is also a Licensed Professional Counselor, I remained cognizant of my multiple identities and how they could influence the research process. I aimed to produce a study that
commenced with a review of the literature related to the concepts being explored, as well as utilized a methodology that was sound and ethical. Next, I presented the data that emerged, along with an analysis of the findings. After a discussion of limitations and directions for further research, I concluded my study with a brief overview and a discussion of contributions and sociopolitical connections to this research.
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APPENDIX A

BRIEF ADVERTISEMENT FOR CHURCH PROGRAM OR NEWSLETTER

There is currently an opportunity for you to participate in a research study about Black Christians and counseling and mental health services. This study is being conducted by Dawn Norman who is currently a student in the Counselor Education PhD Program at Montclair State University. This study will involve a discussion with Black Christians about their life experiences and their thoughts regarding counseling and mental health services. The study will involve an interview that will take about 60-90 minutes of your time. If you are Black and Christian over the age of 18 you may be eligible to participate. If interested, you can get more details from Dawn after service on (date) or contact her at (908)230-6148 or normand1@montclair.edu.

Thank you for considering participation in this study. This study has been approved by the Montclair State University Institutional Review Board.
Hello,

I would like to let you know about an opportunity to participate in a research study about Black Christians and counseling and mental health services. I am currently a student in the Counselor Education PhD Program at Montclair State University. This study will involve a discussion with Black Christians about their life experiences and their thoughts regarding counseling and mental health services.

This will take about 60-90 minutes of your time. If you are Black and Christian you may be eligible to participate. You must be 18 years of age or older to be involved in this study. If you are interested in participating or have any questions, please contact me at (908)230-6148 or normand1@montclair.edu.

Thank you for considering participation in this study. This study has been approved by the Montclair State University Institutional Review Board.
CONSENT FORM FOR ADULTS

Please read below with care. You can ask questions at any time, now or later. You can talk to other people before you sign this form.

Study’s Title: African American Christians’ Decision Making to Pursue or Not Pursue Professional Psychological Help: A Qualitative Study.

Why is this study being done?

This study is being conducted to explore how the lived experiences of Black Christians may influence their decision to pursue or not pursue professional psychological help. Investigating these experiences may provide an understanding of how historical and current societal conditions may influence this decision when made by Black Christians.

What will happen while you are in the study?

- You will be asked to complete a questionnaire about your demographic information (age, income, religious affiliation, etc.)
- You will be interviewed and asked questions related to your life experience as a Black Christian
- Your interview will be audio recorded
- I will write notes during the interview
- Audio files will be transcribed and then destroyed
- You will be contacted to verify the accuracy of the transcription
**Time:** This study will take about 90 minutes for the interview.

**Risks:** You may have some discomfort while answering some of the interview questions.

The following precautions will be taken:

1) Informed consent will be signed by all participants
2) You can disclose only the information you are comfortable with disclosing
3) You can skip any question that makes you feel uncomfortable
4) You can discontinue participation in this study at any time

Although we will keep your identity confidential as it relates to this research project, if we learn of any suspected child abuse we are required by NJ state law to report that to the proper authorities immediately.

**Benefits:**

- You may benefit from this study by discussing your experience as a Black Christian.
- Others may benefit from this study because the information received may improve the research specifically related to the influences (cultural and other) on Black Americans’ decision to pursue or not pursue professional psychological help.

- Others may also benefit because the information received may help identify facilitators of and barriers to the mental health treatment of Black Americans.

**Compensation:** N/A

**Who will know that you are in this study?** You will not be linked to any presentations. We will keep who you are confidential.

“You should know that New Jersey requires that any person having reasonable cause to believe that a child has been subjected to child abuse or acts of child abuse shall report the same immediately to the Division of Youth and Family Services.”

**Do you have to be in the study?**

You do not have to be in this study. You are a volunteer! It is okay if you want to stop at any time and not be in the study. You do not have to answer any questions you do not want to answer. Nothing will happen to you.
Do you have any questions about this study? Phone or email: Dawn Norman, (908) 230-6148, dnorman@mail.montclair.edu and/or Dr. Leslie Kooyman, Montclair State University, (973) 655-7216, kooymanl@mail.montclair.edu

Do you have any questions about your rights as a research participant? Phone or email the IRB Chair, Dr. Katrina Bulkley, at 973-655-5189 or reviewboard@mail.montclair.edu.

Future Studies
It is okay to use my data in other studies:

Please initial: _____ Yes _____ No

Study Summary
I would like to get a summary of this study:

Please initial: _____ Yes _____ No

As part of this study, it is okay to audiotape me:

Please initial: _____ Yes _____ No

One copy of this consent form is for you to keep.

Statement of Consent
I have read this form and decided that I will participate in the project described above. Its general purposes, the particulars of involvement, and possible risks and inconveniences have been explained to my satisfaction. I understand that I can withdraw at any time. My signature also indicates that I am 18 years of age or older and have received a copy of this consent form.

Print your name here

Sign your name here

Date

Name of Principal Investigator

Signature

Date

Name of Faculty Sponsor

Signature

Date
APPENDIX D

DEMOGRAPHIC INFORMATION SHEET

The title of this study is: African American Christians’ Decision Making to Pursue or Not Pursue Professional Psychological Help: A Qualitative Study.

Please complete each of the following demographic items. Thank you for your participation.

1. Gender (Please check one)

□ Male □ Female

2. Age

__________

3. Approximate annual income

□ Under $10,000 □ $10,000-$25,000 □ $25,000-$45,000
□ $45,000-$65,000 □ $65,000-$85,000 □ $85,000-$105,000
□ $105,000 or more

4. Race/Ethnicity

□ African American □ Caribbean □ Other_____________________

5. Highest level of education completed

□ Elementary School □ High School □ Some College □ AA/AS Degree
□ BA/BS Degree □ Graduate School

6. Religious affiliation

□ Baptist □ AME □

Other__________________________________________________________
7. How often do you attend church?

________________________________________________________________________
APPENDIX E

INTERVIEW QUESTIONS

African American Christians’ Decision Making to Pursue or Not Pursue Professional Psychological Help: A Qualitative Study

1) Tell me about a time when you considered seeking any type of professional help for a mental health concern with you or a family member.
   a. What did you decide?
   b. How did you come to that decision?
   c. Were there other times that you have struggled with this type of decision?
   d. Did you get any type of help at that time?
   e. How did you make that decision?

2) Did you ever consult with your pastor or another church leader about any of these issues?
   a. Why or why not?
   b. What was their response/suggestions?
   c. Did you find their response helpful? Why or why not?

3) Black Americans often decide not to seek professional mental health help. Why do you think that is?

4) I am particularly interested in how mental health concerns might be impacted by religion, church attendance, Bible readings, etc. Could you talk with me about that, in your own life? What do you think about your mental health and your religion/faith?