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The exploration of treatment fearfulness in African Americans.

Aprile C. Maxie
University of Massachusetts Amherst

THE EXPLORATION OF TREATMENT FEARFULNESS IN AFRICAN AMERICANS

A Thesis Presented

by

APRILE C. MAXIE

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APRILE C. MAXIE

Approved as to style and content by:

Margaret Stephenson, Chair

Ronnie Janoff-Bulman, Member

David M. Todd, Member

Melinda A. Novak, Department Head
Department of Psychology

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ABSTRACT

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APRILE C. MAXIE, B.A., CORNELL UNIVERSITY

M.H.S.A., UNIVERSITY OF MICHIGAN

M.S., UNIVERSITY OF MASSACHUSETTS AMHERST

Directed by: Professor Margaret Stephenson

There is much to be learned about the concerns, apprehensions and fears that treatment seekers experience. The purpose of this study was to investigate the relevance of treatment fearfulness as a multidimensional construct in African Americans. The focus of the research was on the fearfulness that is experienced before initial help-seeking and during the treatment process. Eight African American women relayed their help-seeking concerns in in-depth interviews in this qualitative study. The results of the study support the hypothesis that treatment fearfulness is a relevant construct for African Americans. Specifically the dimensions of social stigma, coercion concerns, image concerns, therapist responsiveness and self-concealment were endorsed. Therapist responsiveness and social stigma were identified as the most salient dimensions. Other sources of fears were also identified in the sample. Some dimensions of treatment fearfulness were found to be uniquely expressed in participants based on how race and culture affected treatment apprehensions. This study also identified other areas of investigation that may increase

our understanding of treatment fearfulness with African Americans, other ethnic minority groups and the population at large.

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INTRODUCTION

A large gap exists between the need for mental health services and actual service consumption (Stefl & Prosperi, 1985). It is estimated that approximately 15% of the U.S. population is in need of mental health services (President's Commission on Mental Health 1978). Of this group only three percent seek professional help, thereby creating a 12% "service gap." One study estimated that only six to seven percent of persons needing treatment actually receive mental health services (Vessey & Howard, 1993). The size of this service gap is alarming given the effects on the quality of life of individuals suffering from psychological problems who remain untreated, and the myriad of social and economic effects to society resulting from non-treatment. There is strong evidence that suggests that significant differences in utilization exist among groups. Women are more likely to seek professional help than men (Rickwood & Braithwaite, 1994; Vessey and Howard, 1993), the young more than the old (Gurin 1960), and mainstream populations more than ethnic minority populations (Sue, 1977; Comas-Diaz, 1992; Nickerson, Helms & Terrell, 1994).

There are multiple factors that can influence treatment-seeking. These factors can relate to the characteristics of the individual, characteristics of the psychological problem or symptoms, and the attitudes and beliefs that a person possesses about the causes and the treatment of the problem (Sussman, Robins & Earls, 1987). Many theorists have posited that treatment fears are one of several factors that may influence utilization of mental health services (Deane &.Chamberlain, 1994; Kushner & Sher, 1989; Pipes,

Schwartz & Crouch, 1985). Treatment fearfulness has been defined as a state of apprehension that an individual experiences associated with the belief and expectation that psychotherapy will be a negative experience (Kushner & Sher, 1991). In establishing a conceptual context Kushner and Sher (1991) identified treatment fearfulness as a multidimensional construct (Kushner & Sher 1989, 1991; Pipes et. al., 1985) with numerous sources of treatment fears (embarrassment, change, treatment stereotypes, negative judgment-stigma, specific problems). Fears associated with an individual's negative experiences with the mental health system were also viewed as a potential source of apprehension and concern. Researchers have suggested that for those persons who do seek professional help, treatment fears may affect the person's ability to fully participate in psychotherapy or counseling, and its impact may be seen in premature termination (Kushner & Sher, 1991). In addition, treatment fearfulness is viewed as a dynamic concept that can change over time throughout the help-seeking process. It may directly inhibit treatment-seeking or work in association with other avoidance factors (Kushner & Sher 1991). There is also evidence that it is likely to be culturally influenced (Sussman, Robins & Earls, 1987).

This study explored treatment fearfulness in African Americans. It is an important area of study for several reasons. First, there is evidence that this population may be at higher risk for mental illness. Second, there is an underutilization of psychotherapy and counseling services in this population, with significant barriers existing for African Americans to access the mental health delivery system. This current study is grounded in research in a variety of areas; the body of literature on treatment fearfulness was explored

in addition to other areas that informed the investigation of the topic. It is important to have a clear understanding of the current knowledge of what influences mental health services in ethnic minority populations and then to specifically examine the literature on African Americans and help-seeking.

Treatment Fearfulness

As reported by Kushner and Sher (1991), several researchers have examined treatment fearfulness within the context of Miller's (1944) influential approach-avoidance theory. From this framework, the decision to seek or avoid psychotherapy or counseling is based on the strength of the pull between motivational or approach factors, and inhibitory or avoidance factors (Deane & Chamberlain, 1994; Kushner & Sher, 1989, 1994). There are two motivational factors frequently cited in the literature as explanations for why an individual chooses to seek help. Mental or psychological distress is considered the most dominant factor for motivating help-seeking behavior (Richwood & Braithwaite, 1994). Pressure from others is viewed as another important approach factor. In this regard, a family member or friend recognizes that there is a problem and either advises or coerces an individual to seek treatment. The literature on avoidance or inhibitory factors identifies lack of access and availability of mental health services, the cost of services (Stefl & Prosperi, 1985) and the use of non-professional support networks that lie outside the mental health system as important inhibitory factors (Neighbors 1985; Rickwood & Braitwaite, 1994). Despite limited empirical research in this area, (Stefl & Prosperi, 1985) treatment fears are also considered a

potential avoidance factor influencing help-seeking (Pipes et. al.; Kushner & Sher, 1989; Deane and Chamberlain, 1994).

The literature on treatment fearfulness has focused on conceptualizing this multidimensional construct and on the validation of a scale to measure its various dimensions. The fear of being judged negatively by others (e.g. family, friends. employer) or being stigmatized, has long been viewed as a key variable when evaluating significant barriers to seeking mental health services (Socall & Holtgraves, 1992; Mechanic, 1980). Stefl and Prosperi (1985) found that those persons who experience psychological distress and do not seek help are twice as likely to identify stigma as a barrier to help-seeking when compared to those who do seek help. Stigma has also been identified as an avoidance factor in studies that have examined attitudes toward seeking professional help (Dadfer & Friedlander, 1982; Fisher & Turner, 1970).

Fears associated with misconceptions about psychotherapy or treatment stereotypes have also been studied. As Kushner and Sher (1991) reported, one study showed that people hold misconceptions and stereotypes about the nature of mental health services (Schneider1987). These misconceptions were found to center around the role and competency of the therapist and the therapeutic process. Also reported by Kushner and Sher (1991) are two studies showing that some persons hold the view that psychotherapy is inherently bad (Gardner & Hinton 1960) or that therapists are not competent (Mayer & Timms 1970).

It is believed that some persons avoid psychotherapy due to the fear of disclosing information that they view as embarrassing or negative (Kelly & Achter 1995).

According to Larson and Chastain (1990) there is a distinction between the constructs of self-disclosure and self-concealment. Self-disclosure is defined as revealing personal information about oneself whereas self-concealment is conceptualized as an individual consciously and deliberately holding back personal information (thoughts, feelings, behaviors) that one has experienced and perceives to be negative. Some theorists have also referred to this phenomenon as secret keeping (Hill, Thompson, Cogar & Denman, 1993). Kelly and Achter (1995) explored the relationship between self-concealment, and attitudes and intentions toward seeking counseling services in a university population. They found that high concealers (more likely to self-conceal) held less favorable attitudes toward seeking counseling than did low concealers. As reported by Larson and Chastain (1990), many studies have also shown a relationship between self-concealment and psychological and physiological distress (Pennebaker & Kevecolt-Glaser, 1988).

The fear of a specific problem has been theorized to be another fear of treatment that an individual may experience. This source of fear may be distinguished from other fears in that it may be a realistic and accurate perception of what the therapeutic process will entail. Heinberg and Barlow (1988) found that patients with social phobias avoided psychotherapy because the thought of discussing their disorder produced high levels of anxiety. Individuals who have experienced traumatic events (e.g. rape victims) may also avoid professional help because of the fear of talking about the event and the anticipation of overwhelming anxiety associated with re-living the experience, as cited by Kushner and Sher (1991), (Veronen & Best, 1983).

Initial work on treatment fears involved the identification of multiple fears in a clinical and non-clinical population (Pipes et. al., 1985). The research involved asking subjects to rate 15 potential fears that they had concerns with in seeking or considering psychotherapy. Based on study results two factors were identified relating to the dimensions of treatment fears, therapist responsiveness and image concerns. Differences in the level of fearfulness were found between client and non-client subjects, with clients experiencing less fears.

Kushner and Sher (1989, 1991) continued to build on this early work through the validation of The Thoughts about Psychotherapy Scale (TAPS). The TAPS is an instrument that has its origin in the Thoughts About Counseling Scale (Kushner & Sher, 1991; Pipes et al., 1985). The scale was later expanded by Kushner and Sher in 1989 by adding four additional items that measured fear of change which has also been hypothesized as a dimension of treatment fearfulness. The second revision to TAPS occurred in 1994 when Deane and Chamberlain included 10 items that measure fear of social stigma. In the first expansion (Kushner & Sher 1989) definitions of mental health professionals were expanded to include psychologist, social worker, and psychiatrist. Counseling was substituted for therapy services to reflect the wider range of services provided by various mental health professionals. The result of this revision was the development of a 30- item scale with four dimensions of treatment fearfulness: 1) therapist responsiveness, 2) coercion concerns, 3) image concerns and 4) stigma.

Several studies have utilized the TAPS to identify correlates of treatment fearfulness. One study that has utilized TAPS showed a relationship between treatment

fears and treatment-seeking decisions (Kushner and Sher, 1989). Psychological distress, fear of therapy and past treatment history were evaluated in a clinical and non-clinical population. Study results showed that students who were planning to begin counseling had fewer fears than those students who had not seriously considered psychotherapy. In addition, high treatment fearfulness was also found to relate to a history of low utilization of mental health services by these students. This study divided non-clinical subjects into three groups, treatment avoiders, treatment seekers, and never having needed helped. Treatment avoiders were defined as those who stated they needed help but had chosen not to seek it. Treatment seekers were those who needed help and had decided to receive services. And the third category were those students who had identified themselves as never having needed help. Treatment avoiders were found to have the highest level of treatment fears, followed by those who never needed treatment. The treatment seekers had the lowest fears of treatment. These findings indicate that treatment fears may play an important role in avoidance of help-seeking in college populations.

Other studies that have examined treatment fearfulness have identified relationships between psychological distress and level of treatment fearfulness. Higher levels of psychological distress have been associated with higher levels of treatment fears (Deane & Chamberlain, 1994) in a non-clinical student population. However this association was only found to be significant for the image and the coercion concern dimensions, and not for the therapist responsiveness and stigma dimensions. Further work by Deane and Todd (1996) with an older student population examined how treatment fearfulness and attitudes toward counseling could predict help-seeking

intentions. This study found that attitudes toward counseling did predict help-seeking for those who were seeking help for emotional problems and suicide ideation. Specifically, the dimension of social stigma was found to predict attitudes toward help-seeking.

It is theorized that the saliency of a treatment fearfulness dimension may be related to age, gender, ethnicity and other variables within a population (Kushner & Sher, 1991). In one study, women were more likely to have greater level of treatment fearfulness when compared with men, whereas there have been mixed results when age has been examined (Deane & Chamberlain, 1994; Deane &Todd, 1996). There are no studies that have examined the relationship of ethnicity to treatment fearfulness as a multidimensional construct.

Mental Health Services and Ethnic Minority Populations

Research on ethnic minority populations and mental health services have often focused on examining the factors influencing low utilization. There is considerable evidence that supports underconsumption of these services within minority populations. One epidemiological study showed that only one out of ten persons who sought psychotherapy was non-white (Vessey & Howard 1993). Studies have been conducted that demonstrate underutilization in Asian American (Sue, Fujino, Hu, Tackeuchi & Zane, 1991), Mexican American (Sanchez & Atkinson, 1983) and African American (Nickerson et. al., 1994; Sussman et. al., 1987) populations. Despite strong evidence of underutilization of mental health services some studies have showed overutilization of

services within selected ethnic minority groups. Within African American populations there appears to be an overutilization of inpatient and residential services (Snowden & Cheung, 1990) and lower utilization of counseling and psychotherapy services especially in selected health delivery settings (Mays, Caldwell & Jackson, 1996; Sue 1977). For example, differences in utilization of public health facilities as compared to private settings have been identified. According to Snowden and Cheung (1990) there is higher utilization of public health care facilities in minority populations and greater private utilization among Whites. Additionally there are studies that indicate Asian American populations (Sue et. al., 1991; Cheug and Snowden, 1990) overutilize selected mental health services.

Premature termination rates are also believed to drive overall low utilization in ethnic minority populations. According to Sue (1977) minority populations frequently terminate treatment in the early stages of the treatment-seeking process. Over 50% of minority clients actually terminate after one session when compared to a 30% termination rate for White clients. Sue examined 14,000 clients in the Seattle mental health system and found that ethnicity was a significant predictor of premature termination even when other demographic variables were controlled. In another study Acosta (1980) found that ethnic minority clients were likely to report negative attitudes toward counseling and the belief that therapy would be of no benefit as a reason for premature termination. These findings of lower utilization and premature termination rates have important implications given some evidence that suggests that the need for mental health services may be greater in these populations.

There is mixed evidence for a higher need of mental health services within ethnic minority populations. One study found that non-whites are more likely to have a DSM III diagnosed psychiatric disorder (Vessey & Howard, 1993). This study pooled survey data from multiple sources (National Health Interview Survey 1985,1986,1987,1988; National Medical Care Utilization and Expenditure Survey 1980; National Survey of Access to Health Care, 1986) to estimate the likelihood of help-seeking in various sociodemographic groups. Four types of disorders were examined in the study (depression, dysthymia, obsessive-compulsion and phobias). Non-whites were found to suffer at higher rates for phobias, and phobics were less likely to have a mental health visit.

Several studies have shown differences in the diagnosis of schizophrenia and affective disorder patients when Black and White groups were compared (Snowden & Cheung, 1990). For example, differences in psychiatric admissions throughout the U.S. exist for schizophrenia, with Whites comprising 31.5% of total admissions, Blacks 56.3% and Hispanics 43.9%. With affective disorders the breakdown is 15.6% for Whites, 7.7% for Blacks and 15.2% for Hispanics. These study results indicate a possible over-diagnosis of schizophrenia and under-diagnosis of affective disorders in Black populations.

As Snowden and Cheung (1990) reported, one large epidemiological study comprising five catchment area sites (Eaton & Kessler, 1985) conducted by the National Institute of Mental Health, examined ethnic-related psychopathology. One part of the study examined Black and White differences in lifetime prevalence of 15 different

disorders. In the reporting of three epidemiological catchment area sites there were 45 separate comparison groups. Of these 45 groups only 4 groups were identified with significant differences in psychopathology between Blacks and Whites. These four groups reported a higher prevalence of simple phobia, agoraphobia, and cognitive impairment in the Black comparison group. In another study (Robins, Helzer, Weissman, Orvaschel, Gruenberg, Burke, & Reiger, 1984) small differences were identified in lifetime prevalence rate when Blacks and Whites were compared, with the Black group showing a higher lifetime rate of psychopathology in selected sites. Studies that have identified higher need for mental health services often cite lower socioeconomic status and other factors associated with poor economic conditions as impacting the likelihood of developing mental illness. However these studies and other research which indicate similar findings should be viewed cautiously in light of some evidence that suggest that there exists misdiagnosis or bias in diagnosis of minority patients and differences in access to care between groups (Snowden & Cheung, 1990).

Problems in the delivery of mental health services have been commonly cited (President's Commission on Mental Health 1978) by many researchers who have hypothesized explanations for why underutilization or treatment avoidance within ethnic minority populations exist. Researchers have evaluated how the cultural competence of the mental health delivery system and the responsiveness of both individual clinicians and institutions affect the services that are provided to these populations. According to Jones and Thorne (1991) difficulties conducting valid psychological assessments have affected the ability to provide adequate services to ethnic minority clients. They theorize that due

to the limitations of traditional assessment instruments there are difficulties in understanding the experiences of ethnic minority clients and hence any psychological problems and disturbances. In a similar vein, several studies have found that ethnic minority groups receive inferior services as compared to Whites (Sue 1977). This discriminatory treatment was shown, in one study where minority clients were more likely to receive brief supportive therapy as compared to individual or group therapy that was recommended for Whites (Yamamoto, James, & Palley, 1968).

Many studies have examined client-therapist relationships to determine if differences in ethnicity, race and social class impact the use of mental health services. Although the evidence is mixed, preferences for therapists or counselors within one's own ethnic group has been found in several studies (Sue 1991, Sanchez & Atkinson, 1983). Sue et. al.(1991) found that the ethnic match of client and therapist related to length of treatment in all groups studied (African Americans, Asian Americans, Mexican Americans and Whites). When clients and therapists were of the same ethnic group there was a higher likelihood that they would remain in counseling longer. According to Leong, Wagner and Tata (1995), the ethnicity similarity hypothesis postulates that all other things being equal, ethnic minority clients will have a greater preference for a counselor or therapist who belongs to the same ethnic group. Many researchers have theorized that beyond being more comfortable or preferred by the client, the same ethnic match actually leads to improved client-therapist communication, therapeutic process and outcomes (Carkhuff & Pierce, 1967).

In considering the implieations of the ethnie mateh hypothesis one must also examine the availability of ethnie minority eounselors and therapists to determine the likelihood of an ethnie mateh for a person of color who seeks eare. There are a relatively small number of minority therapists that exist within the U.S. mental health system when compared to the number of ethnic minorities who aetually need help and choose to seek it. It is highly likely that a minority person who seeks psyehotherapy will receive services from a professional who is White or not of the same ethnie group.

In ethnic minority populations, relationships between aeculturation and help-seeking attitudes have been examined. Acculturation is the process of ehange that occurs when individuals of different cultural groups come into continuous contaet (Berry, 1986). In a study that looked at multiple factors affecting help-seeking (gender, ethnicity, acculturation) in Asian Americans, Atkinson and Gim (1989) found a signifieant relationship between acculturation and attitudes toward counseling. Those Asian Americans who were more immersed in mainstream culture had more favorable attitudes. In addition, those who were most immersed were more likely to be tolerant of the stigma associated with help-seeking. Similarly, cultural commitment has been shown to relate to how an individual is likely to view counseling and psyehotherapy services. Sanehez and Atkinson (1983) studied Mexican Ameriean eollege student's commitment to the Mexican-American culture and Anglo-American culture. Students strongly committed to their own culture expressed less willingness to self diselose and a greater preference for a counselor of their own ethnie group. In a third study eonducted by Priee and McNeill (1992) cultural commitment and attitudes toward counseling services in an American

Indian population were examined. The researchers found that subjects who were strongly committed to their ethnic culture were more likely to hold negative attitudes toward counseling. It is believed that immersion in one's ethnic group may account for different views of the healing process and thus less favorable attitudes about counseling within ethnic minority populations (Comas-Diaz, 1992). Specifically, cultural beliefs and values, and religious and spiritual orientations, may influence individual attitudes and consequently affect help-seeking behavior. There are many variables that may potentially affect the consumption of mental health services. It is important to note that some factors have been more extensively reviewed in the literature than others. With the mixed study results regarding service consumption, there is a need to further examine the many variables that may influence utilization in ethnic minority groups.

Treatment-Seeking and African Americans

The evaluation of help-seeking and treatment avoidance within African Americans is complex. It is believed that an individual's ethnic, cultural and racial identity has a significant impact on one's worldview (Leong, Wagner & Tata, 1995). Moreover there is strong evidence that there are multiple factors that can influence attitudes and help-seeking behavior. Some of the factors that have been examined within this population include negative views on mental illness, cultural mistrust of Whites, non-traditional use of mental health services and fear of treatment. Additionally, there is a large body of literature that provides considerable evidence for the importance of strong networks of

social support in African American communities and the importance of religion and spirituality, in impacting whether counseling and psychotherapy services will be sought.

Many researchers suggest that African Americans are at higher risk for mental illness in the U.S. According to Neighbors and Jackson (1996) there are three areas of research that provide support for this assertion. First, they state that there are multiple social indicators that demonstrate a greater economic disadvantage in African American as compared to White populations. Second, it is believed that there are greater life stressors caused by low socioeconomic status, adverse conditions associated with minority status, and the experiences of racism. The body of research in this area is unclear since both low socioeconomic status and racism may operate together or exist independently, as significant contributory factors to psychological stress within African Americans. Lastly, there is mixed evidence supporting whether greater psychopathology exists as a result of these identified factors.

Many theorists have hypothesized that there is a relationship between treatment avoidance and views on mental illness in this population. Some researchers have shown that African Americans are more likely to possess negative views of mental health patients and associate stigmatization and labeling with psychiatric disorders. As Nickerson et. al., (1994) reported, one study showed racial differences in opinions about mental health (Silva De Crane & Spielberg, 1981). Black patients viewed mental patients as inferior to non-mental patients and had less paternalistic attitudes toward them when compared to White subjects. It is believed that African Americans may want to escape the label of mental illness and its associated rejection and stigmatization. For this

population, "avoiding the label of mental illness might translate into avoiding therapy altogether" (Nickerson et al. 1994, p379).

It is also suggested that African Americans may utilize mental health services in a non-traditional manner. According to Leong et. al.(1995), a study conducted by Wood and Sherrets (1984) found that Africans Americans are more likely to seek help for community resources or administrative type problems and when experiencing problems with social service agencies, the justice system, or schools. They are less likely to seek help regarding personal problems. This is further supported by a study by Webster and Fretz (1978) also reported by Leong et al. (1995), which compared Black, Asian American and White preferences for different sources of help. Black college students ranked the university counseling center as 1 or 2 for help with educational or career concerns. Constrastingly, the counseling center had a lower score, and was ranked 6, for help with personal and emotional problems.

Fear of treatment has been identified as an important factor in examining African Americans' views of mental health services. In a study that compared treatment-seeking for depression in Blacks and Whites, Sussman, Robins and Earls (1987) found that Blacks identified both the fear of hospitalization, and seeking treatment as having prevented them from seeking help. Snowden and Cheung (1990) also found the fear of hospitalization in African Americans to be a realistic concern given the higher rate of hospital admissions in this population when compared to Whites. This may suggest the inappropriate hospitalization of Africans Americans as the result of higher rates of misdiagnosis in the population.

Many studies have examined the importance of the ethnic match hypothesis within the African American population. A large number of studies have found that there is a greater preference for therapists or counselors of the same ethnic group (Riccio & Barnes, 1973; Thompson & Cimbolic, 1978). As previously stated, in addition to client preference, it is also believed that client-therapist communication and certain counseling outcomes are enhanced by ethnic matching. An early study conducted by Carkhuff and Pierce (1967) examined how differences in race and social class influenced the effectiveness of therapy as defined as "constructive exploration with the client." The researcher found that therapists who were different in class and race from their clients had the most difficulties. Other research in this area has indicated that the counselor's education, attitudes, values, age, competence, style and technique is of greater importance than race and ethnicity (Peoples & Dell, 1975; Atkinson, Furlong & Poston 1986). As reported by Leong et al (1995), several researchers have hypothesized that the ethnic match hypothesis is more likely to be a reflection of the incompatibility of worldviews and cultural values between the client and therapist. It is not surprising that as the client and therapist look at the world through distinctly different lenses that difficulties can emerge in creating effective therapeutic connections.

Another dimension affecting professional help-seeking in African Americans is the strong evidence that large networks of informal support serve as viable sources of non-professional help (Taylor, Hardison & Chatters, 1996). Extended family support systems have been found to be very important to African Americans. An informal system of social support can include family members, friends, neighbors, co-workers and

church members (Hatchett & Jackson, 1993). One study found that for those individuals who do seek help, there is a higher likelihood among Blacks that they have discussed their problem with a friend or family member (Sussman, Robins & Earl, 1987) prior to treatment-seeking.

Religion may also play an important role in how African Americans view the mental health system and treatment-seeking. As Leong et al. (1995) reported, the importance of spirituality and the church in the Black community have been studied to examine their effect as a coping resource (Lincoln & Manyia, 1990). Dressler (1991) studied Blacks in a southern community and identified four coping resources that were dominant. Two of the resources related to spirituality and religion. For this community, it appeared that individuals were able to use religion as a way to cope with the stressors of daily life. Within the African-American community there is a linkage between social support as a factor influencing help-seeking and religion. When an individual possesses strong religious beliefs and attitudes there is a higher likelihood that they also maintain church involvement and membership and subsequently may seek support within the church as an alternative to professional help. As Leong, Wagner and Tata (1995) reported, a study conducted by Miller (1994) also supports the importance of religion for African Americans. The study explored how attitudes about mental illness were linked to beliefs about the causation and treatment of mental illness. The researcher found that Black college students were more likely than Whites students to attribute greater importance to spirituality in both the etiology of mental illness and what they viewed as helpful and effective treatment.

Any review of the literature on African Americans and mental health services should include the examination of cultural mistrust within the context of societal racism. "Terrell and Terrell (1981) argued that because African Americans as a group have a long history of race-related mistreatment by Whites, African Americans may have developed a general suspicion and mistrust of Whites" (Nickerson et. al 1994, p378). Terrell and Terrell (1984) examined premature termination in African American clients. The study evaluated the effect of several variables, client's "cultural mistrust," the race of the therapist, and client sex, in predicting premature termination. Based on study results the level of cultural mistrust had a significant effect on termination regardless of the race of the therapist. This study lends support to the work by Ridley (1984) that conceptualized healthy cultural paranoia of African Americans. The research defined two types of paranoia that might exist in this population. The first, cultural paranoia, is a healthy psychological reaction to racism. The second, functional paranoia, is considered to be non-healthy and often relates to a specific mental illness. In a study conducted by Nickerson et al. (1994), cultural mistrust, opinions about mental illness and help-seeking attitudes among Black college students were examined. The hypothesis that higher levels of cultural mistrust were related to negative attitudes towards seeking help was supported by their findings.

In summary, there are many African Americans who do not seek help because of effective informal networks of support. This population was not the focus of this study. However, a large population exists that experience psychological problems and can benefit from professional help that cannot be provided through support networks. These

individuals may choose not to seek help or avoid treatment due to an unresponsive mental health system, negative views of mental illness, healthy distrust due to racism and fear of treatment. The literature on African Americans and treatment-seeking provides support that for those who do seek help, there is a high likelihood that they will prematurely terminate and also benefit less than Whites and other ethnic minority groups. It is important to better understand what factors influence these outcomes.

Throughout this discussion I have examined studies that looked at differences between groups that are both racial and cultural. Many researchers have examined differences between Blacks and Whites as racial groups. Although these comparisons are important they are not synonymous with cultural and ethnic comparisons and can be limiting. For example, in this country in considering Blacks as a racial group there also exists multiple cultural groups of African descent (e.g. African Americans, Jamaicans, Haitians). In a similar vein, in considering Whites, Irish, Italian, Dutch and Portuguese are only a few of the many cultural groups that reside in the U.S. This study focused specifically on African Americans as both a cultural and racial group.

Research Questions

The purpose of the present study was to investigate the relevance of treatment fearfulness as a multidimensional construct in African Americans. The focus of the research was on the fearfulness that is experienced both before initial help-seeking and during the treatment process. Many researchers have identified multiple factors that influence the help-seeking process. These factors can be categorized into avoidance and

approach factors, and may relate to specific characteristics of the individual, the problem, or beliefs and attitudes that are held (Sussman, Robins & Earls, 1987). Additionally, the responsiveness of the mental health system and how services are delivered play an important role in whether one decides to seek help and the nature of the process once treatment has begun (Leong, Wagner & Yatu, 1995). Although treatment fearfulness is one of many factors in treatment avoidance, it is an important factor that merits further investigation.

The exploration of treatment fears in African Americans is an important area of study in light of past research that provides evidence that the population is at higher risk of mental illness and that there is underutilization of counseling and psychotherapy services. Understanding treatment fearfulness may have important implications for the mental health delivery system. If clinicians and service providers are able to address treatment fears with clients, there may be a positive effect in encouraging help-seeking behavior, reducing premature termination, and enhancing the overall effectiveness of the therapeutic process (Kushner & Sher, 1991).

The body of literature on treatment fearfulness as a multidimensional construct is limited. Many studies in this area have been conducted with university and mainstream populations. The instrument (TAPS) that has been developed to measure treatment fearfulness has been validated through multiple studies. However, it is not clear whether the dimensions of treatment fearfulness that have been defined in this scale are relevant to the African American population. Several theorists have speculated that treatment fears are culturally influenced with differences existing relative to age, gender and ethnicity

(Deane & Chamberlain; Kushner & Sher, 1991). Although age and gender have been examined, no studies have investigated the construct within an ethnic minority population. An important goal of the study was to closely examine treatment fearfulness in African Americans giving careful consideration to the multicultural research on treatment-seeking in ethnic minority populations. It may be important to evaluate whether what is known about African American's views of mental health, cultural mistrust, and ethnic-client matching will assist in the understanding of specific treatment fears.

The research questions explored in this study are as follows:

1) What are relevant dimensions of treatment fearfulness in African Americans who have decided to seek help, as reported by participants?
2) What dimensions are most salient in contributing to apprehension, concerns and fears within this population?
3) Are social stigma, therapist responsiveness, image concerns, coercion concerns and self-concealment relevant dimensions of treatment fearfulness for African Americans?

CHAPTER II

METHOD

Design

This study investigated the relevance of treatment fearfulness in a group of African Americans who had accessed psychotherapy or counseling services. Specifically this study examined the dimensions of treatment fearfulness within the help-seeker by utilizing a qualitative methodology. This approach has been chosen because of the exploratory nature of the research hypothesis and the fact that limited research on treatment fearfulness with ethnic minority populations exists. "In a study of human experience, it is essential to know how people define their situations" (Marshall & Rossman, 1995, p40). The proposed methodology attempts to minimize the imposition of preconceived beliefs about treatment fearfulness and its implication in the treatment-seeking process. The semi-structured interview was the primary method of data collection. In addition, supplemental data collection techniques were utilized that included questionnaires and surveys. The "subject as collaborator" (Jones & Thorne, 1987) emerged, allowing for a rich dialogue about the individual's concerns in beginning psychotherapy and during the treatment process. Additionally, the goal of the research was to assist in gaining knowledge that will allow for the generation of additional research hypotheses.

Sample

The sample consisted of eight African American adults who had a history of previous treatment and were willing to talk about their experiences in help-seeking. The sample was drawn from college students at the University of Massachusetts and residents of the Amherst, Massachusetts community. All participants in the study were women. All participants had some college education, and two of the participants had completed a bachelor's degree. The mean age of the participants in the study was 26.5 with a range of 19-42 years. Two of the eight participants had only sought treatment on one occasion. Six participants had sought professional help on multiple occasions, which ranged from two to six treatment episodes (3.5 median). For these purposes, an episode of treatment is defined as receiving psychotherapy over a course of more than one session with one mental health provider. The time of the first help-seeking experience ranged from less than six months prior to the study, to one participant who had initially sought help fourteen years ago in 1985. Although this time range is large it was not seen as a problem given the research design employed in the study. Three of the eight participants had initially sought help when they were in high school and prior to the age of eighteen. Two of the eight participants had experienced hospitalization at some time in their life related to a mental health problem. Four of the participants were accessing psychotherapy at the time of the study and all participants had experienced some treatment in the past eighteen months. Selected demographics are presented below in Figure 1. A pseudonym was assigned to protect participant confidentiality. Based on the recommendations of

numerous researchers the sample size consisted of eight participants to ensure a thorough and comprehensive analysis of study results (Kvale, 1987).

PSEUDONYM	AGE	NO. OF TREATMENT EPISODES	CURRENTLY RECEIVING THERAPY	YEAR OF FIRST TREATMENT EXPERIENCE
Angela	19	4	yes	1995
Brenda	22	1	no	1996
Carla	35	2	yes	1994
Donna	19	1	no	1998
Eve	42	6	yes	1988
Fran	22	3	no	1993
Gayle	19	3	no	1997
Hope	34	6	yes	1985

Figure 1. Participant Demographics

Measures

The primary method of data collection was a semi-structured interview that was developed for the express purpose of the study (see Appendix C). The in-depth interview allowed for the critical exploration of treatment fearfulness in subjects by giving the individuals considerable latitude to respond to questions that were posed. The informality and conversational nature of the inquiry assisted in fostering an environment where the experiences of the client could be uncovered. According to Marshall and Rossman (1995) there are many advantages to in-depth interviewing which include the ability to facilitate cooperation from the participant and the uncovering of phenomena which consists of multiple interconnections. The majority of questions were designed to

elicit information on how the participant was experiencing the beginning stage of treatment-seeking as well as their experience throughout the course of treatment, whether treatment fearfulness is a relevant construct, and the potential sources of these fears. Prior to conducting the study, the interview was piloted with two participants to assess completeness, clarity of questions, timing, and perception of relevance as judged by the participants. Based on the result of the pilot study, appropriate changes were made in question format to improve interview flow.

The in-depth interview was supplemented by a life history questionnaire that was completed in collaboration with the participant (see Appendix B). This technique obtained general information about significant life events and experiences, the roles (familial, social and occupational) that the individual assumes (past and present), and other demographic data that was useful in providing an understanding of the individual who seeks help. Additionally, this information helped establish a context for the interview and the exploration of why treatment-seeking had occurred and what factors may have influenced treatment concerns and fears.

Two measures were utilized to supplement the primary data collection method. The Thoughts about Psychotherapy Scale (see Appendix D) is a 30- item scale designed to measure various dimensions of treatment fearfulness (Kushner & Sher 1991). The scale has a likert rating system where respondents are asked to rate their level of concern from 1= no concern to 5=very concerned. The scores range from 30 to 150 with higher scores indicating greater fear of treatment. There are four subscales or factors that have been identified. The social stigma subscale assesses an individual's fear of being judged

negatively by family, friends, or one's employer as a consequence of seeking treatment. The image concern subscale assesses an individual's fear of being judged by a therapist. The third subscale, therapist responsiveness, assesses the individual's concern about who the therapist will be, whether the therapist is competent to treat and able to help the person resolve his or her psychologieal problems. The fourth subscale, coercion concerns, assesses the individuals concerns and fears regarding change, both change within the therapeutie proeess and as a possible outcome of therapy. The scale's internal eonsistency ranges from a low of .87 to a high of .92 which indicates satisfactory reliability.

The second measure is the Self-Concealment Scale (see Appendix E) that assesses an individual's "predisposition to aetively conceal from others personal information that one perceives as distressing or negative" (Larson & Chastain, 1990, p440). The scale eonsists of 10 items and subjeets are asked to rate their level of agreement on a five point seale that ranges from 1= strongly disagree to 5= strongly agree. Scores on the scale range from 10 to 50, with higher scores demonstrating higher levels of self-concealment. The SCS has a Cronbaeh's alpha of .83.

Procedure

Participant Recruitment

Several strategies were employed to recruit study participants. First, the project was communieated to clients receiving mental health services at three treatment sites, Dimock Community Health Center in Boston, Massachusetts; University of

Massachusetts's Mental Health Services and the Psychological Services Center in Amherst, Massachusetts. Participants were selected based on the following criteria: 1) Self-identify as African American 2) 18 years of age or older 3) had received psychotherapy or counseling services during the past few years. Each participant was paid twenty dollars for their participation. Information sheets describing the study were made available to clients in reception areas at the treatment sites. The sheets contained information communicating that the study was investigating concerns individuals have when first seeking treatment and that the time commitment would be approximately two hours.

Second, subjects were also recruited through the University of Massachusetts's psychology department to students enrolled in psychology courses where experimental credits could be granted. Third, recruitment took place though a listserv that is distributed to graduate students of color at the University of Massachusetts. Through this listserv the study became known to a wider audience that included persons affiliated with nearby colleges and universities and community residents in the area.

Through all recruitment mechanisms, potential participants were given the researcher's telephone number to call to communicate their interest and have their questions about the study answered. The researcher pre-screened potential participants to determine if all eligibility requirements were met with specific consideration given to whether the individual had experienced treatment in the last several years. Individuals who had not experienced individual treatment were excluded from consideration.

The researcher is cognizant of the potential effect of study participation on the treatment-seeking process. Although the primary goal of the research was to identify the source of fears for individuals beginning therapy and during the treatment process, careful consideration was given to providing appropriate support and empathy to the individual around seeking counseling. According to Stiles (1993) qualitative research will often utilize empathy with subjects as an observational strategy. This strategy may allow for a deeper understanding of what a person "thinks, feels and experiences." It is my hope that having an opportunity to discuss treatment concerns did not negatively impact help-seeking for the participant, but may in fact be supportive of current or future treatment-seeking.

Data Collection

Upon presenting at the interview site, the researcher re-introduced the project to participants. First, the general goals of the study were stated and the participant was given the opportunity to ask any questions that they had about the study and their participation. Following this, participants completed an informed consent form (Appendix A). The second step involved the completion of the demographic and life history questionnaire, which provided information, that helped facilitate interview questioning. Following this, the participant was asked to complete a treatment history form where they listed in chronological order the dates of prior treatment and also estimated how long each episode of treatment lasted. Based on their ability to recollect, the participant listed the number of sessions and start and end dates for receiving services.

During the third step the in-depth interview was conducted. The participant was asked a series of questions about her experiences in first seeking help. There was a general adherence to the established interview questions. However, based upon participant responses to open-ended questions, there was an exploration of other areas that the researcher believed might contribute to understanding the participant's experience. After the interview had been completed, the participant completed two questionnaires, Thoughts about Psychotherapy and the Self-Concealment Scale. During the fourth step, the participant responses to these two scales were perused by the researcher. Additional questions were then posed for items that the participant had rated as having a high level of concern, which was defined as "extremely concerned" or "very concerned" on the TAPS or "strongly agree" or "agree" on the SCS. Items were also selected if they had a moderately high rating and had not been previously discussed in the interview. The last step was providing the participant a feedback form and responding to any final questions that the participant had about the study. The data were recorded in a manner that ensured confidentiality, efficient analysis and minimized the intrusiveness of the process which can have the potential to hinder information that is obtained from the participant.

Data Management and Analysis

Data for this study consisted of the demographic-life history questionnaire, the TAPS, the SCS and the verbatim transcripts of the interview for each participant. The researcher used a process of data management and analysis that is recommended by Miles and Huberman (1994). The first phase of the analysis involved the transcription of the

audiotapes. After this phase was completed the researcher did a general reading of the each transcript accompanied by a review of the data obtained from the demographic-life history questionnaire. In preparing for the second reading of the transcripts, contact summary sheets were developed. The contact summary sheet is a data management tool that assists in summarizing the data presented in each participant interview and is a mechanism to identify main issues and themes. During the second reading of the transcripts the sheet was also used to identify how the participant contact directly related to the five dimensions of treatment fearfulness that were being explored in the study. The researcher also recorded notes on the sheets that related to new hypotheses and haunches that were obtained from the interview.

After reviewing and considering the eight contact summary sheets, the next phase of the analysis involved establishing a preliminary coding scheme. Coding categories and sub-categories were developed based on the dimensions of treatment fearfulness that had been reviewed in the literature and were central to the study. Other selected dimensions of treatment fearfulness that were not directly related to the research questions but had been the subject of research speculation were also included. The categorization process also included establishing codes related to the multicultural literature on treatment-seeking. The initial codes that were developed were both descriptive and interpretative and supported the use of an inductive coding technique. A third reading of the transcripts involved application of the codes. During this reading there was identification of other interpretative codes, patterns and thematic categories.

The next phase involved a multi-task process of data analysis. Theme documents were created that focused on data specific to stigma, coercion concerns, image concerns, therapist responsiveness, and African Americans and help-seeking. A second step included the creation of theme documents that were data driven. This thematic categorization involved the exploration of multiple themes. A critical part of this process was the search for disconfirming evidence in the data set. In this process many themes were identified that were worthy of further exploration and other weak themes were eliminated. The last step of the analysis included tabulating the scores on the TAPS and SCS. This process was performed at the end of the analysis so that the results would not influence the identification of themes.

During the entire process of data analysis the researcher attempted to stay close to the data. The importance of balancing theory versus data driven analysis was always kept at the forefront of the process. In the following chapter narratives and quotations will be utilized to assist in illustrating the important themes that emerged in the study. Selected figures are also utilized to depict other data sources.

Personal Biases

It is not reasonable to assume that a person can stand outside of his or her own personal frame in most investigations of scientific inquiry. However, this is especially relevant in conducting qualitative research where subjectivity is a fundamental tenet. There are both strengths and limitations to this subjectivity. "Deep personal involvement and passionate commitment to a topic can bring enmeshment with its risks of distortion,

but they also motivate more thorough investigation and a deeper understanding" (Stiles, 1993, p614). It is important to diselose my awareness of preconeeptions, values and perspectives that I bring to the research. My interest in exploring treatment fearfulness was motivated by my strong interest in the psyehological health and well-being of Afriean Americans and my desire to be a part of building healthy eommunities for a population of whieh I am a member. My personal interest was also influenced by my personal experienees with mental illness in my family. During early adulthood my aunt beeame mentally ill. Prior to her illness she had been a vibrant, productive woman who had attained great personal and professional sueeess. Her illness was unexpected and I was surprised by my family's inability to eope and seek support for her. There are questions that I ponder about her illness; what were the eontributory faetors that impaeted her laek of help-seeking when it had become clear that all other options has been exhausted?

As a elinieal student who is in training, I also hold my own beliefs regarding the value of eounseling and psychotherapy whieh is greatly influeneed by the edueational process that I am a part of at this time. I am also biased by my own experiences in treatment-seeking. In conducting the interviews I was frequently moved by the participants's expression of their distress at the time they made the deeision to first seek help. I eould not avoid remembering my own distress when I decided to embark on psychotherapy. There were many concerns and apprehensions that I had at the time, many of whieh remained with me through other therapy experiences. I have made my best attempt to be aware of when these biases appeared to influenee my analysis and the

interpretation of study results. I utilized consultation when appropriate from my committee chair and peers to assist me in this endeavor.

CHAPTER III

RESULTS

There were several research questions that were addressed in the interviews with participants. The discussions focused on the following general topic areas: A) what were the reasons for initially seeking help and what strategies were employed by the participant to cope with their problem prior to aeeessing professional help. B) what were the eoneerns, apprehensions and fears that were experieneed around the initial treatment-seeking experience C) what were the eoneerns, apprehensions and fears that existed through out the treatment-seeking process D) thoughts that the participant had about Afriean Amerieans and treatment-seeking based on their own experience.

The following results are presented about the participant's experienee of treatment fearfulness utilizing seleeted words that deseribe their fears. Frequently the participant's own voiee is utilized through quotations or longer narratives. However, other words that are seleeted to report results have a more subjeetive meaning as determined by the researeher. In this seetion fears will be deseribed in three areas of eategorization; eoneerns, apprehensions and fears. Generally, "fears" deseribe the highest level of treatment fearfulness, "apprehension" a moderate level of fear and "eoneern" the lowest level of treatment fear. Some of what was learned about treatment fearfulness in the study takes plaee in the context of what is deseribed as the internal and external experienee of the treatment seeker. The internal experienee is how a person is thinking and feeling about the help-seeking experienee and the external experienee relates to how the individual interaets with others around the therapy experienee.

Why I Needed Help

Most participants were experiencing a high level of emotional distress at the time they sought help. All participants were asked to rate the severity of their problem. Two participants reported having problems that they rated as "mildly upsetting," whereas six participants rated their problem as severe. The five severe responses ranged from a "moderately severe problem" to one that was considered "totally incapacitating" by the participant. Four of the five participants with severe ratings stated that they were also experiencing suicidal ideation at the time they initially sought help. The reasons for help-seeking and problem severity identified by participants are provided in Figure 2.

Angela, Fran and Gayle decided to seek help when they were in high school. Angela and Gayle had received prior treatment that had been initiated by a family member and therefore those experiences were not considered their first help-seeking experiences. Angela had been involved in family counseling when she was a child and Gayle was hospitalized at age fourteen for depression. Angela described her feelings of depression, concern about her mother and her adjustment to living in a new place at the time she initially sought help.

> I had just moved from a small town in North Carolina to this big town, this big city, Philadelphia. It was a really hard transition for me to make. I was very lonely, and my family, they were going through hard times, um, separate from the moving my mother was having mental problems. She felt that she was being persecuted, and, um, I didn't know who to talk to about that. I didn't have anybody to talk to about that and I felt very depressed, and I, and I didn't think much of myself. I didn't think I was smart, because I wasn't doing well in school, um, at that time, just, it was really because of the transition, but I didn't realize it

at the time, that it was just my, like, emotional state that was affecting my schoolwork.

PSEUDONYM	REASON FOR SEEKING HELP	SEVERITY OF PROBLEM
Angela	Depression	Extremely severe
Brenda	Demands of being a student athlete	Mildly upsetting
Carla	Anxiety	Moderately severe
Donna	Friend's suicide attempt	Very severe
Eve	Self-exploration	Mildly upsetting
Fran	Family and relationship issues	Very severe
Gayle	Depression	Totally incapaeitating
Hope	Panic attaeks	Very severe/extremely severe

Figure 2. Reasons for Help-seeking and Problem Severity

Gayle explained that three years after she had been hospitalized for a suieide attempt she had eome to reeognize her own depression. She had been feeling bad and was also having problems eating and sleeping. Gayle had bad memories of her hospitalization at age fourteen and then having received outpatient eounseling at that time. She expressed that she knew that she needed to see someone to help her feel more like herself again.

Fran deseribed how eontinuing thoughts of suieide affected her decision to seek help.

> Yeah, I was feeling bad. I think it was like family issues, and then another part of it was a relationship I had ...or aetually didn't have anymore....So it was those two things.. He broke up with me for another girl, so I was feeling pretty bad..... And, I thought about, um I guess this is probably mostly why I went to the nurse's offiee that day, um eause like, I was feeling real bad, that I was often thinking about um, things that I eould do, like to end my life. And so not like really wanting to do that, but it was a thought that kept eoming.

Carla was worried about her general health because of the physical symptoms she was experiencing. She initially saw her primary care physician. He performed several tests and ruled out any medical problems that could be causing her difficulties. Her physician asked her if she had ever considered therapy. She described what was going on for her at the time.

> I was under a lot of stress at my job. At the time I was working, um, at the University of the Colorado, and I was chairing a national convention. I was experiencing a lot of stress in my life. I don't think I really, I don't think I really realized it at that time, and that the stress was being manifested in a number of ways and, um, I think the biggest thing that happened was I started having heart palpitations a lot.

Brenda describes that as a student athlete she was experiencing some stress and an overall feeling that something was not right for her. She explained that she did not consider it a "big problem" but thought that she might benefit from counseling. She wanted "things to work out" for her at school and with sports because she did not want to let her parents down. She relayed that her parents had very high expectations that she would be successful at college.

Donna, Eve and Hope described how other family members' or friends' difficulties served as a catalyst for their own treatment-seeking. Donna described her experience when a close friend made a suicide attempt and the difficulties she had coping with this unexpected crisis. Donna's friend was hospitalized for three weeks and Donna had assumed her friend had been in a car accident. She was unaware of the depth of her

friend's depression and Donna felt both guilt and anger when she learned that her friend had tried to take her own life.

Eve had been feeling conflicted about a lot of things that were going on in her life. She recalled that when she saw her twin brother going through a "downward spiral" related to a substance abuse problem it became an impetus for help-seeking. "I wanted to go and talk to somebody about the feelings that I'd been having".

Hope described how her grandparents' problems were affecting her own well being at the time she decided to seek counseling.

> I was very depressed about my family, very depressed about, um, what was going on at home, because every time there was a problem at home, they called me. .um, and I think that's what triggered me seeking help, because I couldn't take it. You know, I couldn't, uh, I couldn't focus anyway on school, and then them calling me and telling me about my grandmother and grandfather, um. My grandmother would call me intoxicated and drunk, and tell me that my grandfather did this, and he did that, and I was leaving school around two in the morning, trying to fix what was going on there. And not focusing on myself. And it was really hard. it was really, really hard, and trying to keep the facade, you know, that everything was going ok at school, and everything wasn't going ok.

How I Tried To Cope

All participants reported having employed some strategy to cope with the difficulties they were experiencing prior to seeking help. Talking to a friend or partner, exercising, meditating, writing, spirituality, and support through church were strategies that were mentioned by the participants. Most participants found these approaches to be somewhat effective, however many stated that they had reached a point where they became overwhelmed by their problem, or that "things just started to fall apart." Angela

described how the church she attended has served as a safe haven for her, "the church was like my rock". Whenever she had a problem there were other people at church that she would talk to and she would usually pray. She explained that there was not a time that it stopped working for her, but "after a while it just wasn't enough."

One theme emerged in discussions about coping mechanisms. Several participants (three) used "avoidance" or "withdrawal" as a way of dealing with the difficulties they experienced. This often led to social isolation for two participants. Fran and Gayle described different ways they withdrew from family and friends. Fran was in school and working a part-time job. She would ask her boss to schedule more work hours for her to minimize the time she was available to spend with friends. Gayle would spend an excessive amount of time in her room and away from other family members. She relayed that, "my mom catered to that, because she knew how I was feeling. So if I didn't want to leave my room, she would bring dinner to me." On the other hand, Eve described how difficulties in a relationship ("it was not a good thing in my life") played a major role in her taking an unplanned trip to Spain. "What prompted that was sheer survival, you know, it was like, I have got...to get out of this situation where I am now."

Others Provide Entry

A prominent theme emerged in the interviews; the majority of participants (five) knew someone who may have also been receiving therapy, or had a prior positive experience with professional help at the time of their initial help-seeking. In no case was this individual a family member, and it was likely to be an acquaintance or co-worker.

These individuals appeared to provide an "entry way" for participants in help-seeking or "planted the seed" that psychotherapy might be a viable option to help the person cope with their problem. Donna and Eve decided to contact the same professional that the person they knew had seen and recommended. Eve described her experience in meeting someone who was candid about her experience in therapy.

> I think the other thing that happened is that, um, I met someone who, um, who was very open about talking about her experience in counseling, and, um, spoke very positively about the person who I eventually ended up seeing..... And so that, I think, was the thing that got me over the hook to like actually make the phone call. That it wasn't like I was calling anyone out of the blue, uh, I, I met someone through my professional work who I respected a fair amount. I didn't know her, really, that well, um, but I think her openness about being able to talk about, you know, counseling and being supported and helped by it, and that the person that she was working with was so phenomenal, um, gave me the, the courage, I think, to go ahead and, and make the first phone call.

Brenda had heard from "someone" she knew that there was a sports psychologist at a nearby community college that others student athletes had seen. The person had told Brenda to try several different colleges that were in the area to see if she could locate "this woman" and had given her the name of the college where she believed the psychologist practiced. Brenda was given the impression that this psychologist had been helpful to women she counseled.

Although Donna was not one to talk about her problems to others, she had a friend who encouraged her help-seeking. Her friend told her, "if you can't deal with it by yourself you should talk to someone." Carla had a co-worker that she had spoken with about seeking professional help. Her co-worker had communicated that counseling had

helped her deal with several issues including her marriage and stresses that existed at work.

It appeared that these individuals served a valuable role in helping the participants contemplate treatment-seeking and perhaps allayed some initial treatment fears. Participants had learned first hand that therapy had been helpful to "someone" they knew and it was possible to consider that it could also be beneficial to them.

Treatment Fearfulness Dimensions

Stigma

Stigma emerged as a salient theme in the participant interviews. All eight participants affirmed that at some time in the treatment process they worried about the stigma associated with seeking help. Their concern about being judged by others, or stigmatized, was often linked to whether participants chose to discuss treatment-seeking with others. Participants expressed their apprehension in talking to friends and family members about their problem and specifically about the need to seek therapy or counseling. Only three of the eight participants stated that they shared this information with a friend or family member before they saw a therapist. However, all participants were able to discuss treatment-seeking with at least one friend or family member in the later stages of their therapy or after treatment had been terminated. In this sample, participants were equally likely to share their experience with a family member or a friend. Four participants had spoken with one or more friends, and four participants had

spoken with a family member. For the four participants that had spoken with a family member, all of these participants had chosen to confide in their mother.

Many participants expressed their concern about initially communicating help-seeking to family and friends because they feared judgment. There was also concern that their families would not be able to provide support. Carla was concerned that her parents would not be supportive of her decision at the time that she started to seek help. She appeared to be most concerned about her mother's possible reaction, "I didn't think she would understand." Carla also believed that her mother might say, "if you need to talk to somebody, you can talk to me."

Hope spoke about the steps she took to keep her secret of help-seeking from her friends at college.

> Yeah, because, sometimes people would say, "Where are you going?" you know, "I got to go." you know, "Where are you going?" "I got to go to the library," then I'd walk to the library, then make a U-turn to the counseling center. Her office was in the back and stuff. So it was, it was, a lot of deceiving there, you know, with people, um, I just didn't want to tell them.

Eve felt that there was "a real stigma" associated with receiving therapy and did not want other people to know. She did not know what she might expect from them. She felt apprehensive about going into the office building for her initial appointment and was concerned about being seen in a waiting room by someone who knew her. Her fear was that somehow she could be "held in lesser esteem....for having sought someone out." Eve could not consider talking with family members about her decision to seek help because

she believed that she knew how they felt about therapy. She described her mother's beliefs about therapy:

> If you talk to my mother today, she would say, "oh, therapy hogwash," you know. I mean, why, won't you just talk, don't you have, don't you have people to talk to, don't you have friends to talk to? So it's this sense that, um, I think that, um, that, that the whole industry is a sham, you know? That we should be able to, within our circle, you know, um, deal with our own issues. Or frankly, I mean, you know, my parents are depression era, you know, folks, you know you should just basically should just get over it, you know, self indulgent to be going and talking to somebody about your problems.

Fran shared her experience of not finding support from her mother when her mother was notified by her high school that Fran had sought out counseling. Fran believed that her mother felt that Fran's treatment-seeking also provided a negative judgment about her mother. She expressed, "she didn't like people in our business, she felt like, I was making her look bad."

Brenda and Hope discussed their concern about treatment-seeking being known to others because there could be negative consequences. Brenda expressed a strong interest in continuing her involvement in sports despite the fact that some of the difficulties she experienced related to the stress of competition. She was concerned about the athletic program having knowledge of her utilizing counseling to help her cope with the demands of being a student athlete.

> It's my coach... you know. If I told my coach I was seeing someone, that she'd may make me sit out or something if she really thought I had a problem, or, you know, there's all kind of stuff that goes through your mind.

Hope was concerned about how her problems might be perceived by others because she had been a child development major and wanted to be able to pursue career opportunities that involved working with children. She feared that if others knew that she had been in therapy that this could affect her being hired for a job.

Although stigma was a relevant dimension of treatment fearfulness for all participants, it is important to identify that from the beginning both Donna and Eve had someone they were able to talk with about treatment-seeking without experiencing any hesitation or concern. Despite Eve's concern about her family or friends knowing, she expressed no hesitation in telling her husband about her plan to seek help. Donna did not have difficulty talking with two friends about it because they both had seen therapists in the past and she assumed that they would also understand. After Carla had received therapy for some time she spoke about communicating her need for professional help in a casual way to a friend.

> I just might have told them, like, "Oh, by the way, I started seeing a therapist, because I feel like some things are just overwhelming." ....: and they're like, "oh, ok"..that was about it.

The majority of participants were able to share their experience of seeking help with others either later in the treatment or after treatment had terminated. A few participants said that they found both friends and relatives to be supportive or non-judgmental and that they were "a little surprised" by this reaction. Carla relayed her mother's reaction when she told her that she had been in therapy for a few years. Her mother responded "I think that is great, that is a good thing." In a similar vein, Gayle

appreciated a college professor's response after she let her know that she had missed several classes because she was depressed. Her professor also shared that she too had suffered from clinical depression and communicated the importance of Gayle seeking professional help.

In exploring stigma as a dimension of treatment fearfulness, participants talked about what it meant to them to seek help and their negative view of mental illness. One half of the sample (four participants) stated that they were concerned that they could actually be "crazy" and that this might be associated with severe mental illness or being psychotic. Fran explained her feeling "kind of embarrassed" and believing that counseling was only something that "crazy people" did and that it was not for "normal people." She believed it meant that one was "unstable." She also shared that her own feelings were also apparent in her mother's thinking. "I guess, I think she had the mentality too, that it's for crazy people.....and she doesn't want to think that I'm crazy." Carla's physician asked her if she had ever considered therapy because he suspected that she could be experiencing anxiety. She relayed that the first thought that entered her mind upon hearing the physician say this was "I'm crazy." Hope did not tell anybody initially that she was seeking help because she believed to do so would be the same thing as telling someone that you were "crazy", and that was something that she did not want to do. Eve also had the same concerns and "didn't want anyone to think that I was crazy" or that there was "something wrong with me."

Coercion Concerns

Five of the eight participants had apprehensions about being coerced in the therapy. For a few participants this concern was most dominant prior to treatment-seeking, for others it occurred during the therapy. Several participants came to therapy with the belief that the therapist would tell them what to do. There were also concerns expressed by participants of being asked to talk about things that the participant didn't want to discuss, being told to make lifestyle changes that they were not ready to do, or to end relationships that the therapist perceived were "bad." Participants had different images of how this would happen.

Prior to help-seeking, Donna and Gayle were concerned that they might be forced to take medication. Gayle realized that medication therapy could be effective in treating her depression, but she was concerned that she might not have the freedom to explore other choices. Brenda did not want to talk about things that she believed to be irrelevant, and had strong feelings about how she wanted to utilize the therapy. She emphasized that her problems were not severe and she only wanted help in managing the stress she experienced. She did not want to delve into other issues. Donna also expressed her apprehensions, "a big concern of mine was that I didn't want someone to dictate to me what I was feeling." She also expressed concerns that the therapist might tell her to stay away from "certain individuals" and that this advice could be based on an individual doing "one thing that could be bad for you."

For three participants, concerns about coercion came up after they had started therapy. Gayle expressed feeling coerced to do things in the therapy that she was

uncomfortable with because the therapist's style was not compatible with what she wanted.

> So I'm like, all right, I'm going to have to be here for the next hour, so, I'm, like, all right, I 'll play along, and I'm, like, yeah, I will sit Indian style, and, like, I don't think there's anything wrong with meditation, but, like, this woman didn't even know who I was, you know? ..... you know? and so, she, like, handed me this, like, stress ball, and I, like, took it, and didn't need it, but, like, I felt uncomfortable, like, I felt pressured to do it.

Carla felt pressured to take an assertiveness training class that was being recommended by her therapist. She recalled her frustration when the therapist " kept pushing it and pushing it and I just didn't appreciate that." Carla did not believe that the class was a "bad thing" but had decided that it was something that she did not want to do. She described her interactions with the therapist.

> I kept coming up with excuses. And so every excuse that I had, she had an answer to. You know, so, "I can't afford it." "Well, I'll take, then, I'll take payments." "you know, we'll set up a payment plan for you" well, you know, and I just couldn't, every excuse that I had, she had an answer for. And I just did not want to do it. And instead of just my saying, "Look, I don't want to do it, you know, leave me alone," you know, I kept going through this, I kept beating around the bush.

Angela described how coercion concerns have been a major issue for her in several treatment experiences. It appeared that Angela terminated therapy on more that one occasion because she believed that she could not do what her therapist was recommending. She spoke about her failure to make life changes and how this made it impossible for her to return to therapy. Angela discussed feeling resentment about therapists taking these "stances" in the treatment. She communicated that she understood

that therapists are human but felt that they should not impose their own beliefs on the individuals that they treat. Angela left treatment after her therapist was clear in communicating that he felt it was in her best interest to leave a relationship.

> I stopped speaking to him because he told me to leave my boyfriend, like all the other counselors did, and like I should have done, but, um, I didn't leave him, and I was too ashamed to go back and see him, seeing that I didn't leave him.

When Angela was asked if she had ever considered going back to the therapist after deciding that she was not ready to end the relationship she expressed her apprehension about being able to continue.

> It never occurred to me that I could go back there and they could support me, um, through my decision. You know, even though it wasn't what they said. It never occurred to me that I could go back there and say, "you know, I didn't do this," and they could support me um. Your saying that was the first time that I ever thought that maybe that could happen, but I, I don't know. I, I don't think it would.

Image Concerns

Many participants reported image concerns in seeking help. Image concerns relate to the concern an individual has in the therapy relating to how they might be judged by the therapist, and how they perceive their own image in the therapy. Image concerns like stigma concerns relate to judgment. However unlike stigma, image concerns are primarily focused on the client's image in the therapeutic relationship. In the first treatment-seeking experience, seven out of the eight participants identified image concerns as relevant to the apprehension they experienced. For a few participants, these concerns appeared to be

more dominant once therapy had started and also after a relationship had been established with the therapist.

Fran and Angela expressed their concern with therapist judgment. Fran thought that it was somewhat natural that therapists would be judgmental because they were human beings. She was concerned about what a therapist might think of her and she wanted to avoid being judged. Angela felt that she was being judged for her problematic relationship with her boyfriend and did not want to be judged for having made mistakes. She relayed that in one treatment experience the therapist was not working for her. " I just needed somebody to talk to and help me work through it...she couldn't do that for me. She was being really judgmental and really making me feel like a heathen."

Hope, Gayle and Brenda spoke about wanting to present a more "positive image" of themselves in the therapy. These women expressed concern that they may be viewed as weak, stupid, or unable to handle their own problems. Hope said that she wanted everything to be " perfect" and that she worked hard to present a certain image to her therapist. She recognized that this was a very tenuous position. It was very easy for the therapist to "bring up something and, you know and the whole shield would go down." Hope would often determine when she would keep therapy appointments based on how she was feeling and the image she was capable of presenting. She would not keep an appointment if she was having a really bad day, but would go the next week when everything was "ok." After she had established a relationship with her therapist, Gayle had concerns about how she might be viewed and did not want anything to affect the relationship. " I don't want some of the things that I am thinking and feeling to interfere

with how I relate to him." Gayle perceived that some of her feelings might make the therapist view her less favorably. Brenda was very conflicted over the image she presented to the sports psychologist. On one hand, she did not want the therapist to believe that she had a problem, because " I really didn't feel like I had a problem," but she also expressed concerns about being taken seriously by the therapist.

Donna and Fran's image concerns related to losing control of their emotions in a therapy session. It appeared that this related both to the therapist seeing them in a situation where they were not in control, and their own uncomfortableness when they experienced intense emotion. For Fran, she was concerned that she could become so emotional that she would not be able to talk. Donna described that she had a concern about crying uncontrollably in the therapy.

> I thought that I would get in there, and after I would start talking, I'd just start to cry, and cry and cry and cry throughout the whole thing. And have someone just like, trying to console me, and make me feel ok, and I would just feel like a nervous wreck.

Brenda and Angela expressed their concern about the image that they presented to the therapist transcending judgment about them as individuals and also relating to how they might be viewed as African Americans. For these women there was the fear of being in some way stereotyped. Although the sport psychologist that Brenda saw in her first treatment experience was an African American woman, she had made the assumption that the psychologist she would see would be White. Having made this assumption, she thought that the psychologist might view her in a certain way.

> I didn't know she was going to be Black. So I mean, maybe just, you know, stereotypes about black women or stereotypes about black athletes, or, black athletes in college, you know, there's like all these stereotypes about, you know, well, maybe she can't cope because she really doesn't belong here. Or you know, maybe she's just there because she's black, and you know, they say, like, muscles, and you know, that's why she's a good athlete.

Angela felt that she had to put up a "front" in the therapy, especially as it related to the type of language she might use. She was concerned that she would be viewed negatively if she did not do this.

> I always feel like I have to put up a front. Like, I always have to, I always feel like I have to act like I'm so, you know, because I feel like they have this idea of, of what a black person is, and, and I feel like, um...like, say if I. if I started talking you know, my broken down style, the way I feel comfortable, I feel like they're going to start looking down on me and thinking, you know, black folks they don't know how to speak properly, that type of thing. Or after that, they start making judgments about me, based on, um, the way that I speak, or the way that I carry myself. So whenever I'm with them, I don't care who they are, most of the time, um, I always have to put up this front, and act really proper, and, um, act very, like, just how I would in an office setting, or a business setting, even though it's a one on one situation, and I'm talking about my personal things. I always feel like I have to put up this front, and act more proper than I would, say, if I had a black counselor.

Self-Concealment

Self-concealment relates to an individual deliberately withholding information about themselves that they view as negative, embarrassing or distressing. Self–concealment was a relevant dimension of treatment fearfulness for five of the eight participants. Gayle had difficulty imagining finding enough safety in a therapeutic relationship that would enable disclosure of what she perceived to be negative information

about herself. For Gayle, these feelings continued after she had established a relationship with the therapist and had experienced a certain level of trust.

> In an intimate environment where I'm already kind of letting a lot of stuff out to my, um, psychologist. Sometimes I feel if, I even need to even draw, like, a boundary line around what I can and can't share with him.

For Eve, the thought of revealing information that was "intensely private" had been such a great concern to her that it had prevented her from seeking help in the past. She expressed that although in general she is a person that talks a lot, she also felt very "vulnerable" in being able to talk about the "very painful stuff" in her life. After starting therapy she realized that it was the type of "relationship" that she had developed that influenced how difficult it was to open up completely to the therapist. Eve has had several treatment experiences and relayed that not every therapist was able to elicit the "real nitty gritty stuff."

On the other hand, Fran focused more on time being a determinant in how apprehensive she was about revealing difficult personal information about herself. Fran felt that she had to spend a certain amount of time with a therapist to feel comfortable enough to do this type of disclosure. In her first treatment experience, she 'had not gone enough times" and therefore did not have the opportunity to reveal some of her more difficult experiences.

Hope and Angela concealed information in their first treatment experience that they viewed to be at the center of why they were seeking help. Hope concealed that she had a drinking problem in the first four months of the therapy. She explained how she

would talk about her family and almost anything else that would help her avoid the topic of her drinking. On one occasion, she recalled the therapist asking her how she had spent her weekend. She could not respond honestly, and relayed that " I wouldn't tell her that I was going back and forth to the package store."

Angela was unable to talk to her counselor about her mother's mental illness, which she considered to be a large part of the problem she was experiencing.

> I didn't know what to tell her. And, plus the situation with my mother, I had never discussed with anybody, and I didn't even know how to bring it up... And in fact, it took me about a year to bring that up. Even though that was the real problem, the real reason why I was seeing her. um, I spoke to her about everything else, but the situation with my mother. Because I didn't know how to.

Although Carla acknowledged that one of the most difficult aspects of therapy is having to share your "dirty secrets", she did not have major concerns or fears about opening up to her therapist. She relayed that she had more trouble talking to her friends about personal problems but was able to talk about distressing things with her therapist.

Therapist Responsiveness

Therapist responsiveness is the dimension of treatment fearfulness that relates to the concerns an individual has about the therapist. These concerns relate primarily to who the therapist will be, his or her competency to provide treatment and how the individual perceives the therapist's overall ability to help with the problem. An individual's perception of therapist responsiveness may also relate to flexibility, honesty, and the style or technique that is utilized in the therapy. Other concerns explored with

this sample are perceptions about whether the therapist will take the individual's problem seriously and whether confidentiality will be maintained. Therapist responsiveness is distinguished from image concerns in that the focus of this dimension is on concerns and fears that do not relate specifically to therapist judgment.

Therapist responsiveness was a salient dimension of treatment fearfulness for all participants in this sample. Several themes emerged relative to therapist responsiveness. All participants remembered having concerns about who the therapist would be prior to seeking treatment. For the six participants that had experienced more than one treatment episode many of the apprehensions that they experienced went beyond the first help-seeking experience. In the interviews, therapist responsiveness was discussed relative to several experiences in treatment-seeking. For example, some participants expressed concerns that they had about the therapist in one treatment situation that did not exist in another situation with a different therapist. These comparisons were often useful in exploring the aspects of therapist responsiveness that related to more than one treatment situation.

In discussing the issue of therapist responsiveness, Eve relayed her thoughts about the role and importance of the therapist in the treatment process.

> I think that's really what a good therapist does, you know, they give you the grounding, to begin to, uncover uncomfortable things in your life, uncomfortable things about yourself, uncomfortable things about the mythology that you created, you know, um, about the people in your life, the situations in your life, as well as who you are. And that's really scary work. and, um, and, and that person really is very, really pivotal, um, you know.

Eve, Angela and Gayle were concerned about finding the "right person" to treat them. For Gayle, she viewed depression as a serious problem in her life since it had been the cause of a suicide attempt when she was fourteen years old. Gayle relayed how she would know relatively early in the treatment process whether the therapist would work for her. "If you're not comfortable with the person, if they don't sit well with you, you can't open up to them." She described how her "comfortableness" with the therapist determined if they could help her. Gayle could not articulate much more about what "comfortableness" meant to her other than she knew when it did not feel right for her. Gayle 's initial treatment-seeking did not last long because Gayle did not want to waste her time seeing someone she believed could not be helpful to her. She did not want to continue with the therapist she initially saw, but was successful in finding the "right person" after seeing two other therapists that did not work for her. She thought that she had to look for someone else because the sooner she did, the sooner she would get better.

Understanding

Several participants (four) initially spoke about their concerns about being understood by their therapists. In Carla's first treatment-seeking experience, she experienced not being understood. She relayed to her therapist how she had come to believe in divine intervention. As Carla had reflected on her life it was interesting for her to note how certain jobs had put her in a situation to meet certain people, which ended up leading to other opportunities for her. She believed that being at a certain place, at a certain time, had been responsible for the road she has taken and how she had come to

enroll in a doctoral program currently. Carla expressed disappointment that the therapist was unable to understand this point of view. Carla describes how the therapist responded

> You know, she's like, "well, you're the one who picked up the pencil, and you're, you know, you're the one who filled out the application," da-da-da-da-da, and it was just like she didn't understand- she just didn't see, we just didn't see eye to eye on that issue.

Donna expressed that she wanted to see someone who could understand what she was going through. Her thought was that "someone who was just like me." could better understand. Three participants spoke about being understood in the context of class, race, gender and ethnicity. For Angela, being understood meant that the therapist would be able to relate to her "on my level" and hopefully have an understanding of where she came from. She expressed her belief that differences in life experiences and "different backgrounds" could impede the therapist's ability to understand her problem. Angela expressed that she had grown up in poverty and questioned whether "just anyone" can understand that experience.

Brenda expressed that she had apprehensions about seeing a sports psychologist for the first time. A sports psychologist had come to her school to speak to students who were competing in sports. She relayed her initial impression of his talk. Although she and her teammates viewed him as knowledgeable, there was also the feeling that " this White man could not identify with what I go through here." Later when Brenda made the decision to seek help she was glad to discover that her psychologist was a Black woman. She remembered immediately feeling that this person " might have a better understanding of me because she's Black, she's female, and she's also competed in sports."

Eve described using her own "self-monitoring" in the therapy to determine what she would bring up to the therapist. She would address issues in the therapy that she believed the therapist was capable of understanding. She believed that not everything could be understood.

> I'm thinking, I've got 55 minutes here, or 50 minutes or whatever it is, you know. I'm, being as much a consumer in there, in terms of what I want to do with that time.so I'm, I'm not wanting to educate a therapist about what it feels like to be a Black woman in the world, do you know what I'm saying?

Gayle relayed a positive experience of being understood when she had found the "right person." She describes her frustration at being seen by a psychiatrist who insisted that she take medication for her depression. Gayle also was seeing a psychologist and he immediately understood that she wanted to investigate other options.

> Because like I felt like someone was on my side instead of telling me, like, "no, you have to do this, and you don't understand what's going on with your body," like, he gave me enough respect to, to know that I was making a choice for myself.

Ability to help

Two participants had concerns relating to the therapist's ability to help them solve their problems. For Fran, she expressed how distressed she was at the time that she sought help. " I felt so bad that I felt like I needed someone to talk to on a daily basis, and she was only willing to do it once a week." She recognized that her therapist had a busy schedule and that "she counseled other people too." However, Fran expressed that her needs were not getting met. She found that it was difficult to hold everything in all week and then express all that she was feeling in one day.

Angela described how important it was for the therapist to be able to focus on her problem. In one treatment-seeking experience Angela was frustrated by the therapist's inability to address her prior issues with abuse. She believed that the therapist knew that this was an issue for her because of how she was referred to the counselor. Angela admitted that she was doing everything she could to avoid the issue in her sessions. She would talk about school and her boyfriend but never the "real problem." Angela hoped that the therapist would "focus it back." She expressed frustration that they never ended up dealing with the issue during this particular treatment-seeking experience.

Competency

Therapist competency was a concern for three study participants. Brenda wondered if a therapist would be able to say that they were not qualified to treat or lacked competency in a certain area. She had difficulty imaging a therapist saying to a client that he or she did not have a great deal of experience or "I don't get a lot of people that talk about this." Her concern was that she could see someone who was not equipped to help her with a problem. For Eve and Angela competency was often equated with being able to see someone who was experienced, and this usually meant that it was an older or more mature therapist. Angela expressed that "one of my fears... was that this person is going to be inexperienced, and is going to be doing that whole um, echoing thing." Angela relayed that over time she had come to prefer having a therapist who was at least in their thirties. In one experience, she had sought help in a crisis situation. Angela spoke to a counselor on the phone that she believed to be young. She acknowledged that

the person was probably doing the best job that she could do, but that the person "did not really know how to guide her." Eve also equated competency with experience and age. In her first treatment experience, she was very impressed with how "wise" her therapist was and she was glad to know that she was seeing someone who had many years of experience.

Confidentiality

For the majority of participants (five) whether the therapist would maintain confidentiality was not a concern. They assumed that a mental health professional would maintain confidentiality and they did not worry about this as they started the process of help-seeking. However, Fran expressed that confidentiality had become a "big thing" for her because of what had happened in her first treatment experience. Fran had sought help when she was in high school and had not known that her mother would be brought into the counseling.

> I guess at that time, I was really upset because I had all these expectations that I thought that it would just going to be me and this other person. And they never told me that, oh, under these circumstances, it will have to be between you, me, and five other people. They never told me that.... so when that happened, I actually turned hysterical.

Fran expressed that the counselor had stated that they had to take this action because they were concerned for her safety. Now, she believes that this will always be a concern for her if she chooses to seek future treatment.

When Gayle initially sought help, she had a concern that the therapist might breach confidentiality. She did not feel comfortable when the therapist admitted that she knew many of Gayle's teachers in high school. She felt that she would have difficulty disclosing." Right off the bat, I'm not comfortable telling her anything." Brenda's concerns were somewhat different. She expressed that she was hesitant to access help at the university she was attending because she had concerns about confidentiality. She wondered if her help-seeking could be made known to others in the university system and preferred to seek help outside of this community.

Style Compatibility

A few participants (two) spoke in terms of therapist style or technique. Carla's first therapist made her feel uneasy. She described the therapist as "being in your face" and "very no nonsense." Carla realized that this related to the therapist's style after having other experiences with therapy. She remarked that other therapists utilized different approaches that were often more effective for her. Gayle compared what she considered to be a "responsive" and "non-responsive" therapist and how specific therapist techniques can possibly heighten or reduce fears. Her "responsive" therapist was very educational in explaining the biological basis of depression, which helped her to understand why she had been sick. The therapist was also willing to work with her desire to explore alternative ways to manage her depression and could support Gayle's preference for a "mind over matter" approach. Gayle only saw her "non-responsive" therapist for a short period of time. He wrote notes and reviewed her chart throughout the

entire session. She felt he could have learned more about her if he could look directly at her and listen to what she was saying.

Honesty

Although not a dominant aspect of therapist responsivenesss, two participants expressed concerns that the therapist might be dishonest. Brenda believed that it might be possible that the therapist would be dishonest about the nature or seriousness of an individual's problem. She felt that financial considerations could influence the honesty of the therapist, and that a therapist could lead a person to believe that he or she had a greater problem in order to see the client over a longer period of time. Fran was concerned that a therapist could filter information that was provided to the client and not communicate negative or troubling facts. " I want someone to give me honest information and help me. I wouldn't want them to, like, you know, censor what they say because they might think it would hurt me or something."

Flexibility

Carla, and Gayle expressed concerns they had with the ability of the therapist to be flexible in the treatment. For these two women they wanted to be respected for their own ability to consider options and make choices. For Carla, her experience with the therapist who insisted that she take an assertiveness training class reinforced her apprehensions that the therapist was inflexible. For Gayle, her initial difficulty in getting more than one therapist to consider other treatment options for her depression left her

with the feeling that therapists can be very inflexible. She believed that this occurred particularly when the therapist believes that his or her treatment approach is the best and only way to provide treatment.

Taking Problem Seriously

Angela discussed how she believed that one therapist was not taking her concerns seriously in the therapy. Angela was having issues with her weight and was trying hard to lose the weight that she had gained since starting college. She had the impression that the therapist did not view her "weight problem" as a serious one in a similar way to how her roommate had dismissed her concerns about weight. Angela considered that the therapist's own weight problem affected her ability to take her seriously on this matter. "I think, when I'm talking to her, she's thinking about herself. I, I don't know, like, she just had this like, 'why are you complaining?' kind of attitude."

Fran had fears that a therapist that was White might not be able to take her problem seriously because she was a Black person. Fran was concerned about being treated as a person in therapy. She relayed that her strong feelings about this may be attributed to her own family experiences (Fran's mother is White and her father is Black). She described difficulties in relating from her mother's side of her family through out her life and wondered if a White man "would see my problems seriously."

African Americans and Help-Seeking

The majority of participants (five) recalled being concerned about the race and ethnicity of the therapist they would see in their first treatment–seeking experience. For most of these women these concerns were not dominant in their own treatment- seeking experiences. However, for one participant this issue was the most dominant fear of all the concerns and apprehension that she brought with her to therapy. All eight participants expressed their belief that differences in race and ethnicity between the client and therapist could be a barrier in the therapeutic process for multiple reasons. Several participants relayed what had happened in their own experiences that led them to this belief, or speculated on why they thought this could be a concern for other African Americans. For several participants (three) the gender of the therapist was also an important concern, with some participants expressing a strong preference for a women therapist. One participant sought out a woman therapist for her first treatment-seeking experience. Although five participants expressed that they had concerns about race and ethnicity, no participants sought out a therapist that was African American in the first help-seeking experience.

Participants spoke about the concerns they had in this area both prior to starting treatment and then after they had experienced therapy. First, there was the concern whether someone who was not from their racial and ethnic group could understand them. Second, a few participants worried about being stereotyped in the therapy by the therapist and one participant expressed that she was engaging in stereotyping of the therapist based on the therapist's racial and ethnic identity. Third, language was a

concern as a few participants identified that there could be differences in how communication would take place based on the extent to which standard English was used as opposed to Ebonics or a more ethnic dialect. Fourth, cultural competency or the ability of a non-African American therapist to successfully treat an individual from another group was identified as a concern. Fifth, there was the concern of both cultural and institutional mistrust expressed by one participant who believed that "who" was providing the service related to the individual therapist and the organization who provided the service.

In the following section concerns that each participant had in their treatment-seeking experience are presented in addition to more general thoughts that they have about African Americans and help-seeking.

Angela

Angela had concerns about being treated by a non-African American. Her concerns were based on the belief that she might be better understood by someone who belonged to the same cultural group. Angela sought help through counseling services at her high school and knew that the counselor would be White. She had apprehensions because "I didn't think we could communicate." For Angela, her first experience with a White counselor "broke down some barriers" in this regard. Angela had a very positive experience with the counselor and described the relationship that formed as a "mother-daughter bond." She expressed that this woman would always be very special to her because this was the first person that she could open up to about her problems. Angela

continues to remain in contact with her high school counselor on an occasional basis. Angela remarked that she was not judged by this woman which was very important to her since judgment later became a major issue for her in other treatment-seeking experiences.

Angela has never experienced therapy with an African American professional. In the interview she speculated that she might feel more comfortable talking with a Black counselor.

> I don't consider myself a prejudiced person, but for some reason I feel that if I were to speak to, um, a Black person, and if it's not a Black person, then just a person of color, um, (sigh).... Like, first of all, when I'm in a room with a person of color, I automatically feel comfortable. When I'm with a White person, I'm always, I'm always automatically feel uncomfortable.

She also discussed the importance of language in the context of enabling "feeling comfortable" with the person with whom you were speaking. Angela expressed her belief that African American patients would be hesitant to use their "own dialect" in speaking to a non-African American therapist because they did not share the same language. She speculated that it might be easier to talk about some personal problems in that way, although she had never had that experience.

Angela expressed that it might be easier to talk about some issues with a person from one's own group because they may have been more likely to have similar experiences.

> Since I came to this university, I've had experiences, um, with a, what, what I feel is racism. And...You know, I could talk about it with my friends and get mad or whatever, but sometimes I like to talk to a counselor. And, um, the problem that I have, when it comes to White people, and talking to them about racism, is that I find that they usually try to minimize, um, my experience. And, and they don't, they don't understand....I feel that if I were to talk to a Black counselor? um, she

> would be able to sort of better relate to my baekground, because I feel like a lot of Black people, um, no matter how mueh money they have now, have seen my baekground or experieneed it at some level. I feel like White people...I guess it's just like a, you know, there's a preconeeive- I don't know, uh, it's not based on any faet, but I mean, like, I just feel like most of them eouldn't relate to my baekground. Maybe they eould. Maybe they've been poor, maybe they've, you know, had some experiences in the ghetto like I have, I don't know. But, um, I just feel like, they don't understand how mueh impact that has, um, on a person's life, another person's perspeetive of life. And, you know, I just feel like they ean't relate to me on that level.

Angela also spoke about her experienees in utilizing a non-traditional counselor, a woman who was her teacher. The person was a woman of eolor who was Angela's teaeher and she relayed that this woman was instrumental in helping her through a difficult time. She spoke about how she was able to help her.

> When I spoke to her, I was going through an abusive situation. um, it wasn't physieal abuse, it was emotional abuse, whieh, which can be just as bad. and, um, she was able to guide me through that. She was able to, um....we, we just, we just were able to bond really quickly, and I, and I really feel it's because, beeause we're people of color, we all have a lot of similar experiences, and we all ean relate to each other a little bit better.

Brenda

Brenda expressed concern about both cultural and institutional mistrust as she spoke about the apprehensions she experieneed when she first deeided to seek help. She wondered about what might be the motives of a therapist in the treatment process as it related to her being an African American woman. She wondered if a therapist would have genuine concern for her as a person or would there be something else. She voiced her coneerns:

> .....I didn't want to be like another university statistic, or like a university project, or, you know what I mean? Like, I didn't want it to be like, you know, let's find out, this will be a new study, you know, African American women in sport, or something, and then I'd be like, you know, the start of a new study or something, I just felt like, I don't know. And I just, it would be, just different, I guess.

For Brenda, it appeared that this institutional mistrust might have also been related to her concerns about confidentiality and accessing treatment within the university system and that led her to go outside of the university system. She expressed some ambivalence in discussing what she though might happen had she sought help at the university. Brenda felt that since she was being treated more for stress related issues rather than a major problem, that this probably would not have been a concern. However she stated that it was something that she thought about.

Carla

For Carla, the race and ethnicity of the therapist was something that "I didn't even think about it. " However she expressed her strong preference for a woman therapist. "The only thing that was important to me at the time is that she be a woman." Carla belonged to an HMO and knew that she had to see someone that was listed on their panel. She reviewed a list of participating mental health professionals and decided to try a woman who was in a convenient location. However, once treatment had begun Carla wondered if she might be more understood in some areas of her life if she was seeing an African American professional. This questioning for Carla occurred after her therapist

had challenged her belief in divine intervention. She expressed what her concerns were at the time.

> My first therapist she was Caucasian, and you know, when I was talking about, you know, this divine intervention, and, you know, I was led down this path, in, in general, I know I'm making a general statement, but in general, you know, African Americans are spiritual.

Although this difference in viewpoint was not a major issue in her therapy, Carla also remarked that as a speech pathologist, that she recognizes that there are language differences between cultures. She believes this could play some role in how communication takes place in therapy and therefore the overall effectiveness of the treatment process.

Donna

Race and ethnicity was not a relevant concern for Donna in her one experience in treatment-seeking. "I really wasn't uncomfortable at all, you know, I didn't even, I didn't even care, like that wasn't even a factor." Donna expressed that she feels differently than a lot of her friends who are African American, who want to see someone of their own racial and ethnic group. " I'm more open minded than the rest of them are." Donna relayed that she has several African American friends who were seeing therapists and only one of them sees an African American. She also expressed her belief that gender may play a larger role in help-seeking since most of Donna's female friends would not want to see a man.

Eve

The specific issues that Eve addressed about her treatment experiences and being an African American related primarily to being understood (therapist responsiveness) and social stigma. Eve's "self-monitoring " in the session was a way that she decided what to bring up based on what she believed could be understood by the therapist.

> ....still going to be a barrier between you and this person who's got all your personal information. Because there's going to be a level to which they really will not understand, or that you may not even bring up stuff in, conversation, you know, because, well, they don't get it. Or, or because, or because if it's too, um, aggravating to talk about to a White person.

Eve having had multiple treatment experiences relayed that the majority of the therapists she has seen have been non-African American. She relayed that the person who was most helpful or 'insightful" was a Caucasian woman. Eve also spoke briefly about seeing a male therapist of color and not being able to deal with the "difficult issues" with him. It appeared that both therapist experience and the type of therapeutic approach that was utilized were a more significant factor in how she has benefited from therapy.

Fran

Fran expressed strong feelings about the fears she experienced in seeking- help related to therapist race and ethnicity. She expressed that this was her greatest concern in entering therapy. When asked in general terms if she had any concerns with the first therapist that she saw, Fran responded that "he was White and he was a man." She expressed that the problem for her was what "he represented to me." Fran went on to

explain how her experiences growing up influenced how she felt about seeing someone who was not African American.

> I have a lot of issues with my, um, White people, versus Black people, because growing up, um, my mother's White, and my father's Black. And I only lived with my mom, and all of her family. And she lived in a white town, so it was like I was surrounded by all these White people. They were not nice to me. I went through in school, a lot of racism, um, even with her side of the family, like her brothers and sisters, like, all would really treat me bad. Her parents are very prejudiced, um, and weren't supportive of her. I just got a lot of bad tension from white people and that really had an effect on me. And I didn't feel like talking to him.. because he was White.

Fran was asked to elaborate on concerns she had with therapist competency and was asked specifically if she had any reason to believe that she would see someone that was not competent. Fran remarked that a "White guy" would not be competent to treat her. She believes that it would be too difficult for a White man to understand what she had been going through and it would also be difficult for her to open up and express what she was feeling. Fran also expressed that she "had issues around men, too", and that she did not know at the time that she could have requested a woman counselor.

Gayle

For Gayle, issues of race and ethnicity were not a dominant concern in the first or subsequent experiences in seeking help. She believes that it has not been an issue for her because she has always been seeking help for depression. "Depression is depression" she remarked and used the example of her last psychologist using icons in the environment to assist her in stopping the negative thoughts she had about herself. Gayle believed that

anyone could have related to this type of treatment. She relayed her belief that the types of treatment for this "disease" do not relate to race or culture. However, Gayle did speculate that there could be some issues that an individual might have difficulty bringing up in therapy to a therapist that is not of the same racial and ethnic group. Gayle felt that if she were seeking help for discrimination or racism, that it might be different: "I might not want to see a White psychologist for fear that they could not relate to me." She also hypothesized that there could be issues in family counseling situations where "family dynamics may differ between cultures." Gayle also believed that what might be more important than the racial and ethnic identity of the therapist is what have been their life experiences. She used the following as an example of this:

> You know, I'm, sure that there's White therapists who can relate to African Americans, um, given their, the way that they grew up, you know, if they grew up in a, in a primarily black neighborhood, they might be very quick to handle, um, an African American patient.....um, at the same time, and an African American therapist might have been, um, raised in a predominantly White neighborhood, in which case the White therapist would be more, um... understanding of them.

Hope

Hope relayed that race and ethnicity has not been a dominant concern for her but it has been something that she has thought about as it relates to differences between her counselor and her. Hope has had a variety of treatment experiences including both individual and group therapy. She has also been seen by mainstream and minority counselors. Hope expressed that now she is seeing a White therapist who frequently gives advice about parenting. Hope relayed that often she does not agree with the advice that she is given and she believes it relates to cultural differences. For example, Hope says

that the counselor has suggested that her daughter has too many responsibilities. Whereas Hopes views her parenting style as one that is fostering a certain degree of independence for her daughter. Hope relayed that this has not been a major problem for her in how she utilizes the therapy because she is able to freely express how she feels in the therapy. In her first treatment experience and with other earlier experiences she was so concerned about her image that her own "free" expression with the therapist would not have been possible.

Other Themes

Family Protection

Family protection was a prevalent theme identified in the analysis of factors that may contribute to treatment concerns and apprehensions. Many participants (four) expressed that they had concerns about what effect their problem and associated help-seeking would have on family members. It seemed in some cases that they wanted to protect their family from knowing about their problem and concealed their help-seeking because of this reason. This theme is similar to stigma in that it results in the individual withholding information about the treatment, but it is not due to family judgment as would be the case with stigma. Instead participants expressed genuine concern about their families' well being and did not want them to worry about their problems.

Donna expressed the concern she had about her father knowing that she was seeking help.

> And I guess with my dad, it's kind of weird, because he's like...he's a very, um, conservative, like, doesn't really show much emotion, um, type of guy. And...you know, I just didn't, I didn't want to be like, "Dad, I have to, I think I have to see someone," just because he seems so reserved at times that I don't really feel comfortable enough to admit that I need to see someone. ..... I guess in a way I was kind of, I was kind of looking out for him. ....Because my dad has been through a lot with our family, you know.....like, my mom dying, and my sister having cancer, and my older sister like, you know, I remember when I was little, they always were in arguments, and she left. And I, you know, and I, and I think that, um, it was kind of unclear, but I think that my younger sister was not suicidal, but extremely depressed. .... And it seems like, you know, I'm the only sane one, and I didn't want to, like, "Dad, I have to go see someone too" you know, so, it was kind of like looking out for him.

Angela initially bought up the issue of family protection when she discussed how she felt when she had suicidal thoughts. She relayed that when she started to think about ways she could end her life she immediately thought about the consequence to her mother. "When I was really that close to doing it, I realized how much that was going to affect my mother. I think that she would never recover from something like that." When Angela started to seek help in high school initially she did not discuss it with her mother because she wanted to protect her.

> I didn't discuss it with my mother, because, she had enough problems, and I didn't want her to know what I was going through. I think she was very, um, she was not self-absorbed, but she was so, like, she had so many problems of her own, that I didn't think she really saw what I was going through. and I didn't want her to know, either. um, I didn't want her to know that- how unhappy I was, so I didn't discuss it with her.

In addition, Angela also spoke about her need to protect her sister because her sister depended on her. She expressed that she has never cried in front of her sister, even when their was a "family tragedy" and everyone else was in tears that she would try to keep

herself composed for the family's benefit. "I always felt like I had to be the rock in the family."

Brenda's parents played a large role in her initial help-seeking. She believed that she was motivated to learn how to cope better with the stress of school and sport competition because of her relationship with her parents. She did not want them to know that she was having problems managing everything. " I didn't want to let my parents down, like I didn't want to say that I couldn't do it." Brenda relayed that because her parents had not gone to college that she believed her family had high expectations of her. She felt that she had to meet these expectations.

Family protection for Gayle was identified through her attempt to put off getting help for herself because her mother had been hospitalized for depression. She relayed that although her mother had remarried, she had been from a single parent home and had assumed a great deal of responsibility. Gayle spoke about the concern she had for her brother at a time when she was experiencing depression.

> I always kind of thought of myself as a second parent for a lot of his growing up, so I knew that I needed help for a while, but I thought that I could hold out until she (my mother) was better, um, because I didn't, even though my stepfather was there, I felt that I needed to be there for my family.

Attachment-Dependency

Another prominent theme that was identified through the interviews was that half of the eight participants (four) were worried about becoming too attached or dependent on their therapist. The fear of dependency appeared to be more relevant for participants who had already established a relationship with a therapist, where the relationship could

be described as "good" and 'trusting," and where the therapist had been perceived to be "responsive." It is interesting to note that this potential dimension of treatment fearfulness is in some ways the opposite of the concerns that an individual has about therapist responsiveness.

Carla expressed concern about her current use of therapy. At the time of the study Carla was seeing her therapist once a month. She acknowledged that there had been progress in the work that she was doing in the therapy, which was reflected in her going from weekly to monthly sessions. However, she continues to wonder about how long she will need help. "Is this ever going to end,? you know will I ever stop." Carla is concerned that she has become "dependent on my therapist to help me work out my problems." She remarked that she does not "want to second guess myself" in decisions that she makes, but also recognizes that there are still things that she wants to talk to a therapist about. She relays that in her own self-dialogue she tells herself that perhaps it is not "too bad" that she continues in therapy. Carla remarked that she should give herself more credit because there are only so many problems you can work out once a month for one hour.

Hope relayed that through out her experience in treatment-seeking she had often become too attached to her counselor or therapist. The consequence of these "attachments" is that she often feels abandoned when the therapy ended. On more than one occasion, Hope has been in a position to lose her counselor because they left the agency or organization where she had received services. Hope spoke about how one therapist had been helpful to her. "Nobody could compare to her because she was not

judgmental and understood my issues." She describes how she experienced the therapist leaving and her fear of becoming close to someone else:

> I didn't care how much notice she gave me, she was still gone. She was still leaving. and I, I felt a resentment for a long time, because of that. and, um, I didn't seek help for a long- not a long time, but long enough that I was...not willing to meet somebody else and have another counselor, or another advisor, and, I, I just couldn't do it.

Over time, Hope says that she has been able to cope better with therapy terminations that are not under her control, and will continue to seek help if she needs to do it.

Brenda considered "counseling dependency" during her first experience of treatment-seeking. She expressed her own self-dialogue where she told herself that because her problem was not "extreme" that perhaps she was less likely to become dependent. For Brenda, it appeared that in doing this she was also down playing the role of therapy in her life and was communicating that she could manage without it. Brenda expressed that she did not want the therapy to become her "scapegoat," where the therapist would be "somebody you can run to" when you did not know what to do.

Angela expressed how attached she had become to her counselor in high school, during her first treatment-seeking experience. It had been extremely difficult for her to imagine how things would be without her counselor when she was going away to college. She had referred to the relationship that they formed as a "mother-daughter bond." It appeared that in some ways the relationship has transitioned. Angela relayed that she still remains in contact with the counselor through occasional visits to the high school. She

relayed that her prior counselor was interested in knowing how she was doing and it has also been important for Angela to talk to her from time to time.

> I never really ended it. but, um, we just don't have that counselor thing going, um, she still, like, writes me eards. I went to see her about a few months ago. and, um, like, I sat in my old chair, and you know, the same offiee, and everything. It was really nice, you know. I don't talk to her as much as I used to. And it is, it is kind of hard, but I've adjusted.

She acknowledged that on some level she hoped that she could find someone to replaee this woman in her life. Angela also stated that she then also measured all other therapists by what this woman was able to provide for her.

Family Mental Illness

Family mental illness was identified as a factor that influeneed treatment fearfulness. A few participants (three) had experienced mental illness in their immediate families. Two participants had mothers that were chronically ill, one due to schizophrenia, and the third individual had several family members that suffered from depression. It appeared that for two of these women there were issues of confusion, shame and embarrassment associated with the family illness. In some circumstances their initial contaet with mental health professionals took plaee in the eontext of a family member receiving help. There seemed to be some relationship between how these women viewed mental illness through the lenses of their own family situation and how they experienced their own help-seeking.

Hope relayed that she had a high level of distress when she initially sought help. She was worried about her occasional suicidal thoughts and was also bothered by images she had of her sick mother. " Yeah, the only thing that I could think of was that I didn't want to be like my mom, I didn't want to be like her." Hope described her childhood experiences of visiting her mother in a mental hospital. She was frightened and intimidated by the other patients in the hospital. She now realizes that when she first considered seeking help that the only images that she had about how it might be were through these earlier experiences.

> My mother was always sick...and when I would go see her, I would see all these sick people...hospitalized all the time. um-hmm. And I would go see her, and you can tell that she's not right, and you could tell the people around her are not right, you know? And you talk to the doctor, and they're telling you all these big words about what's going on, and I really didn't understand... So I'm thinking, ok, if, if I go in there, I won't be like my mother. I mean, going and visiting my mom in a psych ward was the terriblest thing, I mean, it was terrible, to go see her there. But I felt obligated to go see her.. (laughs)....I'd come in there with ponytails and long hair, and they're (the other patients) just, you know, "oh, look at her," and, you know, and just. I'd freak right out.

Hope was raised by her grandmother and it was difficult for her to hear the comparisons her grandmother would make about Hope and her mother. She usually perceived these comparisons as negative and worried that at some point in her life she too might become mentally ill or "crazy." Hope wonders if she would have ever sought help if her problems did not become very severe. She believed that there was a part of her that wanted to ignore the problems she had so that she could prevent an impending mental illness.

Angela's difficulties in dealing with her mother's 'mental problems" was one of the reasons she initially sought help. However it is important to note that in her first treatment experience it took Angela one year to address the problem with her counselor. She relayed her hesitancy in talking about her mother in therapy because her mother's illness was a "family secret." Angela expressed relief at being able to talk about this with other therapists and in the research interview. It appeared that she feared this disclosure in the therapy because of her concerns about how her family would be viewed.

> The reason why it was so hard to talk about my mother's situation for the first time was, because, um, first of all, she'd been going through it for years. I've never heard of anybody having a problem like hers. And, I just felt like, we're the only people in the universe with a problem like this, and nobody would know, you know, what to say. Nobody would know how to relate, and, they would automatically look at my mother differently. um...how, um, Because my first experience telling somebody about that was a positive one, I feel a lot more comfortable. um, a few more years, a few years ago, I couldn't just tell you like that, you know, I couldn't.. I couldn't tell just anybody.

Gayle's experiences in treatment-seeking were also connected to mental illness in her family. Her experience was different from Hope and Angela in that it appeared that the illness in her family normalized help-seeking and may have served to allay some of the initial fears she experienced. Because her mother suffered from depression, Gayle was able to go to her mother for help when she was feeling depressed and wanted to seek professional help. Gayle also believes that it was her mother's understanding of the illness and her tenacity that made it possible for them to search for the 'right person." Gayle was not pleased with two therapists that she saw initially, however she was then able to find a psychologist that she could connect with. Gayle also remarked that

depression had been a problem for her family for generations. "My great grandmother, my grandmother, all my aunts, my mom, myself and my sister." She was able to also recognize that depression manifested in family members in different ways. Gayle commented that she withdraws from people when she becomes depressed, her mother becomes very irritable and her aunt has a tendency to gain weight.

The First Visit

Four participants in the sample talked about the specific experience of the first visit and the role this session played in either allaying or increasing fears. Three of the participants relayed that a positive first session helped them to feel less apprehensive about starting therapy. However, one participant relayed her experience of becoming more concerned about embarking on treatment after the initial visit. What happened in all four visits appeared to be related to the overall expectations that the participant had and how it compared to what actually took place in the session.

For some, the treatment concerns and apprehensions appeared to be reduced as an "unburdening" occurred. Participants felt better after talking about their problems. Eve described the relief she experienced after her first session with a therapist despite the fact that she was "nervous going in." She attributed this relief to two specific things that occurred in the therapy. First, the therapist asked Eve if she had considered that her sister might be jealous of her after she revealed something about their interactions. Eve recalls how that "simple question" had such a profound affect on her. Second, she communicated her experiences in elementary school. Eve relayed how she had

communicated to the therapist how her twin brother would sometimes get into trouble and she would be called out of her classroom to bring notes home to her mother. For Eve it was "totally shaming stuff" and she carried it around with her for a long time. Eve spoke about how relieved she was to be able to talk with someone about this. She appreciated hearing the therapist tell her how inappropriate that was for the teachers to do that to her. She described how she felt walking out of the first session.

> I walked out, feeling as though a burden had been kind of lifted off my shoulders. So then I was hooked, I mean, and that was it. I, I realized that, wow, this might not be such a bad thing. I like going to talk to somebody, you know, about, um, you know, about the things that you can't talk to other people about

Eve also relayed how pleased she was that for the first time in her life there was someone who was "focusing exclusively on me."

Brenda relayed that her first visit was different from what she expected. She had imagined that the sports psychologist would ask her about everything that was "wrong" and would also focus on "you're not sleeping?" and "you're having a bad time." However, Brenda experienced a more general dialogue with the psychologist. She was more interested in getting to know Brenda as a person. She recalls the therapist asking her about her major, what classes she was taking and how she was experiencing her practices. She expressed how she felt when she left the office.

> It was very short. and it was just like, I felt like, "ok, I've got to go back." like, I felt like I had to go back. and then like, you know, after a while, it just felt like, it just felt better, like, you know, someone to understand, someone to talk to about, you know, what's going on, and, kind of, you know, help you get through it.

Donna felt more at ease after her first visit. Donna acknowledged that there was a stereotypical image in her mind that the therapist would be someone in a "dull suit" at a "boring desk" in a room that was business-like and not inviting. She described how she liked and was somewhat taken by the therapist's personality in the session. She was "energetic" and "bubbly" and started off by talking about very mundane things, "what was the gossip in the school?" Donna explained that in the first session the therapist did most of the talking, "she kind of took over for both of us." Although in later sessions Donna acknowledged that this changed somewhat. Donna spoke about her impression of the first visit.

> I felt good, because she made, she put me at rest. I didn't feel so, like, worried anymore. She's very, you know, she even, she even said, she's like, "Yeah, you know, like, there are a lot of people that come here, and they automatically assume that I'm going to be like this stern therapist or something. I'm not like that at all." You know, so she started to talk about some of the things that I was concerned about. So, just because she wasn't what I was thinking made me feel better.

For Donna, her relief came from the therapist presenting in a way that was different from what she had expected.

Unlike Eve, Brenda and Donna, Carla's first visit to a therapist heightened the concerns she had with entering therapy. "I think my apprehension increased after the first session." Carla recalls that she had in her mind that she was seeking help for "anxiety management." She had not expected that it would involve exploring issues that were difficult for her. Carla describes her experiences of the first session

> She asked me some questions, and I just answered them. you know, I really wasn't giving much thought to them, and I just kind of answered them, and, then

that's, and that's when I realized, you know, that we're not talking about so much anxiety and this is how you can manage it, but this is how you view yourself..... I think I said the word perfect a number of times, you know, and she's like, "You're a perfectionist" you know, then it started turning in on me, you know, "You view yourself as a perfectionist," and all this other kind of stuff. and I was like, hold up. you know, I didn't know we were going to, kind of get into these issues. I thought I was just going to talk about how I manage my anxiety.

Participant Ratings of Thoughts About Psychotherapy Scale and Self-Concealment Scale

The TAPS and SCS were used primarily to assist the researcher in inquiring about the various dimensions of treatment fearfulness. Participants completed both scales after the initial interviews were completed. The researcher was able to explore areas that had not been addressed in the interview but were rated as being a high level of concern by the participant. Based on the research design employed in the study the interpretation of these results is limited. The overall scores on the TAPS and SCS are presented below in Figure 3. For TAPS, scores can range from 30 to 150 with higher scores indicating greater levels of fear. For the SCS scale, scores range from 10 to 50 with higher scores indicating increasing self-concealment. In this sample the results of the TAPS ranged from a low of 60 to a high of 117 with a mean score was 96.68. The results of the SCS ranged from a low 18 to a high of 45, with a mean of 30.5.

PARTICIPANT	TAPS SCORES	SCS SCORES
Angela	104	29
Brenda	96	18
Carla	60	24
Donna	82	25
Eve	117	36
Fran	90	45
Gayle	112	33
Hope	113	34

Figure 3. TAP and SCS Participant Ratings

CHAPTER IV

DISCUSSION AND CONCLUSION

The purpose of the study was to investigate the relevance of treatment fearfulness in an African American population and to inform future research. The results of the study support the hypothesis that as a multidimensional construct treatment fearfulness is relevant to African Americans. Specifically the dimensions of social stigma, coercion concerns, image concerns, and therapist responsiveness were endorsed by the study participants. Self-concealment, which has not been conceptualized as an independent dimension of treatment fearfulness in the literature, was also seen as relevant to this sample. The findings of the study support the likelihood that some of these dimensions are uniquely expressed in the experiences of African American treatment seekers.

It was important to determine which of the treatment fearfulness dimensions was most salient based on the data. Two dimensions, stigma and therapist responsiveness were identified as the most salient dimensions of treatment fearfulness. The narratives of all eight participants described help-seeking experiences where concerns, apprehensions and fears were identified related to the two dimensions. A third dimension, image concerns also received a high endorsement with seven out of eight participants expressing their concerns about how they were viewed by the therapist. The majority of participants (five participants) endorsed coercion concerns and self-concealment as relevant to their experience of help-seeking.

The study results suggest that two of the five dimensions of treatment fearfulness (image concerns and therapist responsiveness) may have unique characteristics based on

the experience of African American participants. A few participants expressed concern about the image they presented to the therapist as an African American. They imagined that the therapist could attribute general stereotypical attributes to all African Americans based how they presented their problem in the therapy. In exploring therapist responsiveness several participants described their apprehension of being understood in the context of culture. They relayed specific experiences where they believed that the dissimilarity between the therapist and their own race and ethnicity made some difference in the therapeutic process. These concerns included how language was used in the dialogue that occurred in treatment, issues surrounding the cultural competency of the therapist and some concern about institutional mistrust. This finding is consistent with the literature on the ethnic match hypothesis and selected studies that have identified preferences for "similar or like" therapists by ethnic minority populations. Additionally it supports the theory that the saliency of treatment fearfulness may be related to culture and ethnicity.

Moreover, there were several findings of concerns, apprehensions, and fears that were identified by participants that went beyond the five theory driven dimensions of treatment fearfulness. First, four prominent themes identified in the study were 1) concern with family protection 2) fear of attachment and dependency 3) the effect of family mental illness on the treatment seeker, and 4) how fears are experienced in the first therapy visit. Second, fears were identified that were specific to the exploration of how race and culture affected treatment apprehensions. Third, although not dominant themes, fears related to treatment stereotypes, fear of the discovery of the problem for which help

is sought and fears based on prior treatment experiences were also expressed by participants.

There may be several explanations regarding why all dimensions of treatment fearfulness explored in the study were found to be relevant. The literature indicates psychological distress is the most influential factor determining whether help-seeking will take place. In the present study the majority of participants were experiencing high levels of distress and (one half of the sample had thoughts of suicide at the time they first sought help). Deane and Chamberlain (1994) found that higher levels of psychological distress were associated with higher levels of treatment fears in a non-clinical population. Because of the nature of the study we are limited in our ability to quantify the degree or amount of fearfulness experienced by participants or define what can be considered as high level of fears in the sample. However, high levels of treatment fearfulness can also be interpreted by the number of dimensions that are relevant or salient in the population. In this regard, all five dimension of treatment fearfulness were found to be relevant in the sample, two dimensions were identified as salient and other treatment fears emerged from the data.

An opposing theory is that with a high degree of psychological distress, the distress an individual experiences becomes so dominant that treatment fears are diminished and are not strongly considered. In this case, an individual experiences such high levels of distress that seeking relief and feeling better is paramount. This is consistent with the approach avoidance theory and the dominance of psychological distress in motivating help-seeking . However, one might also speculate that something else occurs

with the presence of high psychological distress. Psychological distress, whether through depression, anxiety or other manifestations, may by its very nature also diminish the clarity with which someone is able to contemplate what might take place in the therapy. Therefore, treatment fears may also be born out of the emotional state that an individual experiences and is another explanation for high psychological distress being associated with high treatment fears.

Another explanation for the strong relevance of treatment fearfulness in this population may relate to the young age at which several participants sought help. No research has been done that specifically addresses treatment fearfulness in adolescent treatment seekers. It is possible that this population may experience higher levels of fears than treatment seekers that are older. In this study Angela, Fran, and Gayle sought help in high school, and Angela and Fran sought help without any direct assistance from a parent. A review of the dimensions that were relevant for these three women indicated that in addition to stigma and therapist responsiveness that were relevant for all eight participants, image concerns and self-concealment were also relevant for all three women. Therefore, two out of three participants who sought help in high school had experienced treatment fears on all five dimensions. For Fran, all of the dimensions were relevant to her experience except for coercion concerns.

The study lends support to other research that has conceptualized treatment fearfulness as a dynamic construct with individuals experiencing changing fears over time. For example, participants who had multiple treatment experiences were often unable to focus their responses on the first treatment-experience in this study. This may indicate

how prevalent fears are throughout the treatment-seeking experience. Prior to treatment, there are numerous factors that influence the initial fears that an individual may bring to therapy such as attitudes, beliefs, and characteristics of the problem (Sussman, Robins & Earl, 1987). The current literature focuses on these determinants. However, little is known about what occurs throughout the treatment process that both heightens and allays fears that are initially present. The experiences of the eight participants confirm that treatment fears can continue throughout the help-seeking process.

Although the data was not particularly clear in uncovering patterns of increasing and decreasing fearfulness, there was some understanding of this process in certain areas. For example, certain fears may be triggered by the therapy, as with the fear of attachment or dependency. Other fears may be easily dismissed or diminished by a positive experience in treatment or the realization that the fear does not exist in the reality of the treatment seeker. The first visit with the therapist was seen as a factor that allayed fears for three of the eight participants (Eve, Donna and Brenda). However, Carla experienced increasing fears during this session. Another example of how fears may diminish in the treatment process was illustrated by the data obtained in the exploration of stigma as a dimension of treatment fearfulness. Initially, few participants were able to disclose their plan to seek help to close friends or family members. However, after termination or in later stages of treatment-seeking all eight participants were able to share that they had received help. One possible explanation for this occurrence is that some of the other dimensions of treatment fearfulness (therapist responsiveness, image concerns, coercion concerns, self-concealment) may have lessened in the course of the therapy. As that

happened the issue of social stigma may also have become less of a concern. There is evidence in this study that for a few participants establishing a "connection" or "trusting relationship" with a therapist reduced concerns about therapist responsiveness.

The dynamic nature of the treatment fearfulness may also be influenced by techniques that are utilized by treatment seekers during the therapy. Treatment seekers may take positive steps to manage their fears and therefore we may see an increasing and decreasing of fears related to these actions. For example, Eve engaged in self-monitoring of what was presented in the therapy so that she was more assured of being understood by the therapist. This may have had the effect of reducing treatment fears associated with therapist responsiveness. Angela did things to ease the apprehensions of the therapist who she perceived to be "inexperienced and unable to guide me." She would provide the therapist with positive feedback so that the therapist would believe that she was making a difference for her. It is not clear how this action benefited Angela or influenced the individuals' internal process of experiencing fears. It is possible that an individual's fears may change as the treatment seeker takes these actions to improve what takes place in the therapeutic communication.

Relationships exist among the dimensions of treatment fearfulness that were explored in the study. Therapist responsiveness and image concerns both relate to the individual's experience with the therapist. In addition stigma and image concerns are both related to how an individual experiences judgment. In evaluating the experience of study participants, at times it appeared that the distinction between two dimensions might have been more imposed than was useful to understanding the experience. For example, the

discussions of the participant's experience of 'Am I Crazy' illustrates the blending of both concerns about being stigmatized (judgment by others) and also the worries that the participant had about how they view themselves in the therapy process (image concerns). Several participants did not want others to think that they were "crazy" but were equally concerned about how they were thinking about themselves. There can be benefits of looking at the combinations of selected dimension in identifying how certain fears are experienced.

A separate body of literature exists that indicates that self-concealment plays a role in the apprehension individuals have about seeking counseling. The data suggests that it could also be considered part of the multidimensional construct of treatment fearfulness. However, in this sample participants appeared to have the most difficulty talking about this concern in therapy. Responses to the question posed to participants about this dimension were sparse relative to responses about other dimensions. Therefore there is less of an understanding of this dimension. Although self-concealment was endorsed by five participants, it is possible that self-concealment is less of an issue than other dimensions explored in the study. However, it is also plausible that this dimension is more salient than the study results indicate. Apprehensions in discussing how "secrets" are concealed may have prevented participants from disclosure.

In understanding treatment fears relative to the external experience of the treatment seeker, differences were observed in the terminology that was used to describe the therapy experience. Although a few participants used the term "therapy" and "counseling" synonymously in talking about their experiences, it appeared that

participants usually had preferences or would use one term or another. For example, Angela, Brenda, Fran and Hope tended to use the term "counseling" and Carla, Donna, Eve and Gayle were more likely to use "therapy" in talking about their experience. There may be several explanations for these differences. For example, counseling may connote a broader range of services provided by various mental health professionals. However, another possibility exists in that the meaning that is associated with these terms is different for the treatment seeker with some individuals perceiving "counseling" to be associated with less stigma. During the participant recruitment phase of the study, community health center staff advised that I should use the term counseling in making the study known to potential participants because many people at their center do not want to use the term therapy. Additionally, one participant remarked during the interview that she used "counseling" to talk about her experience because she viewed it as a "softer" word and therefore more acceptable to others.

In the present study, family themes ran across several of the dimension of treatment fearfulness that were data and theory driven. Two themes that emerged in the exploration of treatment fearfulness related to the family experience of the treatment seeker and lend support to understanding that treatment can take place within the context of family. The results indicated that individuals who have family members suffering from mentally illness (especially if chronic mental illness exists), might experience heightened treatment fears because of the specific experiences they had with their family members. The second family-related theme was family protection. In this case, individuals were concerned about protecting family members from knowing about their problem and help-

seeking and consequently apprehensions were experienced. This may be more problematic for the treatment seeker who resides with family members that they are attempting to protect. For the four participants for whom family protection was relevant, all resided with family members or were away at school but nevertheless closely tied to their nuclear family. Because the treatment-seeker may be forced to cover-up the distress they experience or also engage in deception around the treatment-seeking, family protection may contribute to treatment apprehension or avoidance.

Two of the theory driven themes, stigma and self-concealment, have strong family elements. Stigma involves judgment by others including family. Self-concealment can take place when there are issues surrounding the disclosure of family matters or family secrets. These findings underscore what is already known in the literature about family systems, and the importance of recognizing that in many cases the individual does not receive treatment in isolation. Although beyond the scope of this study, it may be important to consider the importance of family related themes in treatment fearfulness. Are there implications for family support or lack of support having an important effect on the experience of treatment fears, or in what situations might family support heighten or allay fears? One might speculate that if there are relationships in this area than there could also be implications for how treatment fears are experienced by African Americans or other minority groups based on cultural differences in family systems.

The results of the study extend early findings related to the ethnic match hypothesis. The majority of participants expressed preferences for a therapist who was of a similar race, gender and ethnic group. However, it appeared that there were other

factors or attributes that were more important in the initial selection of a therapist. For example, the majority of participants had some thoughts or concerns about race and ethnicity during the first treatment experiences however no one sought out an African American therapist or a therapist of color. One explanation is that this was not a high level of concern for participants and therefore did not motivate a search for an African American therapist. Another explanation for this may be that participants perceived that they had limited access to psychotherapy and counseling services and that it was not possible to find an African American therapist. A few participants had to access services through their school, university or managed care plan and this may have narrowed the range of potential therapists they could realistically see. If these perceptions existed it is important to acknowledge that the literature supports the underrepresentation of ethnic minorities entering and practicing in the field.

It is also important to consider the distinctions that participants made between their experiences and what they believed to be the experiences of other African Americans. For the few participants who did not view race and ethnicity of the therapist to be an issue in their first treatment experience, all affirmed that they believed that it could be a general issue for other African Americans. Most participants believed that issues regarding race and discrimination could best be understood by a minority therapist. No participant had discussed this topic in therapy, although Angela expressed that she thought it would be helpful to discuss this topic with a therapist. Brenda relayed an experience where she was discriminated against in applying for a position at her university. She was told that no positions were available and then later that day her

roommate was hired for the position. Through legal services at the university Brenda was offered an opportunity to receive counseling regarding this experience. Brenda decided to decline this offer for professional help and also questioned whether it would have been useful to discuss something of this nature in therapy. It may be important to know to what extent do African Americans or other ethnic minorities want to talk about issues of racism or discrimination in therapy, as opposed to identifying other venues where these dialogues, support and interventions can take place.

The current study provided a rich view of the treatment-seeker's concerns, apprehensions, and fears that are experienced in psychotherapy. However, we do not know how representative the participants were of other African American treatment seekers and therefore are unable to generalize study results. Another limitation of the study was that all participants were women. We were unable to recruit African American male participants. It is possible that their experience of treatment fears may have been different and therefore would have contributed to and changed the overall findings of the study. The absence of male participation is consistent with the literature on help-seeking that identifies women as more likely to seek help than men. One might speculate that treatment fearfulness is also relevant to African American men, but that this construct may be so relevant as to play an inhibitory role even in research participation that addresses this issue.

Another limitation of the study is that participants varied in their ability to recollect their first treatment experience. Many participants were very descriptive about this experience and appeared to recall in great detail what they were experiencing at the

time that they sought help. Some of the differences in participant recollection may relate to the variation in time that had elapsed from the first treatment-seeking experience to the study participation. Some participants were remembering experiences that took place only a few months ago whereas other individuals where remembering back several years.

Lastly, it is also important to note that the majority of participants (six) were multiple treatment seekers, and therefore were recalling their experiences through lenses of multiple episodes of receiving professional help. These participants generally had more to express about their experiences because they had more to draw upon when questions were posed. However, beyond the broader range of experiences, it is also possible that the experience of treatment fears are affected by prior experiences in treatment and that this influenced the saliency of selected treatment fearfulness dimensions and the themes that emerged from the data.

Based on the results of the study there are several future research questions that would further our understanding of treatment fearfulness with African Americans, other ethnic minorities and the population at large. First, more work on the dynamic nature of treatment fearfulness in clinical populations could be fruitful, especially studies that specifically address the early stages of the help-seeking process. As we learn more about this important stage we may be more likely to understand the relationship treatment fearfulness has to premature termination, and what would be most useful in encouraging commitment to therapy based on the multiple fears that are experienced.

Second, in light of some of the findings of the present study, the investigation of treatment fearfulness in an adolescent population may also be an important area of study.

It appears that there may be special concerns that younger treatment-seekers experiences that affects their level of fears such as issues of accessibility and their ability to receive confidential treatment. Third, the saliency of family-related treatment fears suggests that a better understanding of how family relationships can both support or hinder an individual's apprehensions may also lead to learning about how treatment fears are experienced. This inquiry may have important implications for the kinds of interventions that may be effective in addressing fears for treatment seekers. Fourth, some participants in the present study had treatment experiences other than individual therapy. Group treatment may present unique treatment fears or there could be reasons why less fearfulness is experienced because of the benefits of peer relationships that are developed in the treatment process. Lastly, future studies should also look to determine if differences exist among ethnic minority or other cultural groups, and if any within group differences exist. For example, an investigation of gender, socioeconomic status and level of acculturation would all be worthy of exploration in this area. It is important that any research that is done in this area is designed with great sensitivity to the difficulties that African Americans and other ethnic minorities experience in disclosing personal information about their treatment-seeking. Special consideration should be given to developing research studies that encourage African American male participation.

In summary, treatment fearfulness as a multidimensional construct may be relevant to ethnic minority treatment seekers and specifically African Americans. Treatment fears is only one of many variables that may influence the initial decision to seek help and what happens for the help seeker during the therapeutic process. However,

it is an important area of study because as we increase our understanding of treatment fears and are able to address them with treatment seekers there is also a greater opportunity to improve the overall accessibility of needed mental health services to many individuals who fear seeking help, or decide to end their therapy before all the potential benefits of therapy have been realized.

APPENDIX A

PARTICIPANT CONSENT FORM

The purpose of the study is to learn more about what African Americans experience as they begin the process of counseling or psychotherapy services. We want to know your experiences in your own words and to know what are the issues that most concern you in seeking help. The study is being conducted by Aprile Maxie who is a doctoral student at the University of Massachusetts at Amherst.

If you decide to participate, you will be asked to complete several questionnaires and to participate in an interview. The interview will be informal and will be more like a discussion where you can express your thoughts and what you may be experiencing. It is anticipated that your participation will take approximately two hours. The interview will be audiotaped. Your participation in the study is voluntary, and you are free to withdraw at any time during the process. Also you are free to ask questions at any time. Although the study may take place at the Psychological Services Center at the University of Massachusetts your participation in the study is not a clinical visit and there is no association with the services that are received at the center.

Your participation in this study is confidential. Any information obtained from the study will be used for research purposes only. Names and identifying information will be removed from all study materials (transcripts and audiotapes) and will be identified by a number only. Only the researcher and supervisor will have access to this information.

I have read the above information and agree to participate in this study. I understand that I am free to withdraw my consent at any stage during the process.

_____ _____

Signature of Participant Date

_____ _____

Signature of Investigator Date

APPENDIX B

DEMOGRAPHIC-LIFE HISTORY QUESTIONNAIRE

The following is a brief list of questions that will help me in the discussion we will have by learning more about you and your experiences. Please take your time in answering the questions and feel free to ask questions if there are items you do not understand.

1. Age____
2. Gender? M F
3. Who lives with you? (Names are not required)

Name	Relation	Age
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____

4. Where do you live? (Please check the one that applies to you)

   _____ House

   _____ Room

   _____ Apartment

   _____ Other (please specify)

5. Significant Relationship Status (Please check the one that applies to you)

   _____Single

_____Engaged

_____Married

_____Separated

_____Divorced

_____Remarried

_____Committed Relationship

_____Widowed

For the one that you have checked please specify the number of years._____

6. Please circle the roles you have assumed and currently assume in your life

Today	**5 Years Ago**	**10 Years Ago**
Parent	Parent	Parent
Daughter / Son	Daughter / Son	Daughter / Son
Husband / Wife	Husband / Wife	Husband / Wife
Sister/ Brother	Sister/ Brother	Sister/ Brother
Aunt / Uncle	Aunt / Uncle	Aunt / Uncle
Niece /Nephew	Niece /Nephew	Niece /Nephew
Godparent	Godparent	Godparent
Godchild	Godchild	Godchild
Girlfriend /Boyfriend	Girlfriend /Boyfriend	Girlfriend /Boyfriend
Partner	Partner	Partner
Co-worker	Co-worker	Co-worker
Club Member	Club Member	Club Member
Church Member	Church Member	Church Member
Neighbor	Neighbor	Neighbor
Friend	Friend	Friend

7. What type of work do you do?

8. What was the most significant experience of your life? In addition, for the following periods of your life please identify other important life events or experiences.(If you need more room, just cross out the headings and write in your own.)

Early years: (1-12)

Adolescence: (12-19)

Early Adulthood: (20 –25)

Adulthood: (25-40)

Adulthood: (40-50)

Adulthood: (50-60)

Adulthood: (Over 60)

9. On the scale below please check the severity of the problem for which you decided to seek help.

____ mildly upsetting _____extremely severe

____ moderately severe _____totally incapacitating

____very severe

10. Generally speaking, list your three main fears, if any.

11. Specific to counseling and psychotherapy, list your three main fears, if any.

12. What is your religion, if any?

13. Are you a member of a church or religious organization?

14. Are you a member of any clubs or social organizations? If so please identify the kind of club or organization?

APPENDIX C

INTERVIEW QUESTIONS

The participants were given the following introduction prior to the interview starting.

> Most of the questions that I will ask you will relate back to the time when you initially decided to seek help. I will ask you to try to remember what you were thinking at the time. You may need to take time to reflect back to the time, especially if it is not recent. A few questions will also relate to your present day experiences or other experiences since your initial experience of help-seeking.
>
> After the interview was completed the participants were told the following.
>
> There could be further follow-up questions that I would like to ask after you have completed the two surveys. Some of these questions may relate to what we have already discussed or they may also be about things that we have not yet discussed.

1. Why did you decide to seek help at the time you started therapy?
2. Had you considered seeking help before that time? What prevented you from seeking care before that time? What had changed in your life that allowed you to come at that particular time?
3. What approaches had you used to deal with the difficulties you had been experiencing prior to starting therapy? What had worked for you? What had not worked for you?
4. Had you told anyone about your problem or seeking help? Who had you told? If no one, what has kept you from telling someone about this? What had you told them? Was it difficult for you to communicate this information?
5. Did you have concerns about receiving therapy? What were your concerns?
6. How did you imagine the therapy process to be? How was/is therapy different from what you imagined?
7. What did you think your therapist would be like? Can you recall what images you had of him or her? How have these past images compared with your actual experiences in therapy?
8. How did you feel about your initial contact with your therapist? Were there concerns that you had?
9. How is your current experience with therapy different from how it had been before?

10. How long do you anticipate being in therapy at the time that you started? Is that different now?

11. How did you think things would change for you as a result of therapy?

12. At the time you started therapy how did you imagine the most useful, positive experience in therapy. Is that different now?

13. Do you think there are particular concerns that African Americans have about seeking psychotherapy?

14. Are there other concerns that you have about seeking help, that we have not discussed?

APPENDIX D

THOUGHTS ABOUT PSYCHOTHERAPY SCALE

Please read each statement carefully and circle the number that indicates how concerned you are with the statement according to the following scale.

1. Not Concerned
2. Slightly Concerned
3. Moderately Concerned
4. Very Concerned
5. Extremely Concerned

1. Whether therapy is what I need to help me with my problem 1 2 3 4 5

2. Whether I'll be treated as a person in therapy. 1 2 3 4 5

3. Whether the therapist will be honest with me. 1 2 3 4 5

4. Whether the therapist will take my problem seriously. 1 2 3 4 5

5. Whether the therapist will share my values. 1 2 3 4 5

6. Whether everything I say in therapy will be kept confidential 1 2 3 4 5

7. Whether the therapist will think I'm a bad person if I talk about everything that I have been thinking and feeling. 1 2 3 4 5

8. Whether the therapist will understand my problem. 1 2 3 4 5

9. Whether my friends will think I'm abnormal for coming. 1 2 3 4 5

10. Whether the therapist will think I'm more disturbed than than I am. 1 2 3 4 5

11. Whether the therapist will find out things I don't want him or her to know about me and my life. 1 2 3 4 5

12. Whether I will learn things about myself I don't really want to know. 1 2 3 4 5

13. Whether I'll lose control of my emotions while in therapy. 1 2 3 4 5

14. Whether the therapist will be competent to address my problem. 1 2 3 4 5

15. Whether I will be pressured to do things in therapy I don't want to do. 1 2 3 4 5

16. Whether I will be pressured to make lifestyle changes that I feel unwilling or unable to make right now. 1 2 3 4 5

17. Whether I will be pressured into talking about things that I don't want to. 1 2 3 4 5

18. Whether I will end up changing the way I think or feel about things and the world in general. 1 2 3 4 5

19. The thought of seeing a therapist would cause me to worry, experience nervousness or feel fearful in general. 1 2 3 4 5

20. Whether seeking treatment would affect my job or job prospects if an employer found out about it. 1 2 3 4 5

21. Whether an employer will question my ability if he/she knows I'm attending therapy. 1 2 3 4 5

22. Whether attending therapy will create a psychiatric label that might stay with me. 1 2 3 4 5

23. Whether friends and family will see my future behavior as being attributable to my having had psychological therapy. 1 2 3 4 5

24. Whether some people will like or respect me less if I say I am receiving psychological treatment. 1 2 3 4 5

25. Whether people treat me differently if they know I have been receiving therapy. 1 2 3 4 5

26. Whether people will think me weak because I can't solve my own problems. 1 2 3 4 5

27. Whether I will lose my friends from seeing a therapist. 1 2 3 4 5

28. Whether being in therapy will affect my relationship with those closest to me (partner, family, close friends). 1 2 3 4 5

29. Whether those closest to me (my family, partner, close friends) will think less of me for seeing a therapist. 1 2 3 4 5

30. Whether those closest to me will feel guilty as a result of my seeking therapy 1 2 3 4 5

APPENDIX E

SELF-CONCEALMENT SCALE

Please read each of the following statements carefully and circle the number that indicates your level of agreement.

1. Strongly Disagree
2. Disagree
3. Neither Agree or Disagree
4. Agree
5. Strongly Agree

1. I have an important secret that I haven't shared with anyone.	1 2 3 4 5
2. If I share all my secrets with my friends, they'd like me less.	1 2 3 4 5
3. There are lots of things about me that I keep to myself.	1 2 3 4 5
4. When something bad happens to me, I tend to keep it to myself.	1 2 3 4 5
5. I'm often afraid that I'll reveal something I don't want to do.	1 2 3 4 5
6. Telling a secret often backfires and I wish I hadn't told it.	1 2 3 4 5
7. I have a secret that is so private I would lie if anybody asked me about it.	1 2 3 4 5
8. Some of my secrets really torment me.	1 2 3 4 5
9. My secrets are too embarrassing to share with others.	1 2 3 4 5
10. I have negative thoughts about myself that I never share with anyone.	1 2 3 4 5

BIBLIOGRAPHY

Acosta, F.X. (1980). Self-described reasons for premature termination of psychotherapy by Mexican American, Black American , and Anglo-American patients. Psychological reports, 47, 435-443.

Atkinson, D. R., Furlong, M.J., Poston, W.C. (1986). Afro-American Preferences for Counselor Characteristics. Journal of Counseling Psychology 33 (3) 326-330

Atkinson, D.R. & Gim, R.H. (1989). Asian-American cultural identity and attitudes toward mental health services. Journal of Counseling Psychology, 36 (2), 209-212

Berry, W.H. Trimble, J. & Olemedo, E. (1986). The assessment of acculturation. In W. Lonner & J. Berry (Eds.) Field methods in cross-cultural research.. Beverly Hills, CA: Sage

Carkhuff, R.R., & Pierce, R. (1967). Differential effects of therapist race and social class upon patient depth of self-exploration in the initial clinical interview. Journal of Consulting Psychology, 31, 632-634.

Comas-Diaz, L. (1992). The future of psychotherapy with ethnic minorities. Psychotherapy, 29 (1), 88-93.

Dadler, S., & Friedlander, M. L. (1982). Differential attitudes of international students toward seeking professional psychological help. Journal of Counseling Psychology,29, 335-338.

Deane, F.P., & Chamberlain, K. (1994). Treatment fearfulness and distress as predictors of professional psychological help-seeking. British Journal of Guidance and Counseling, 22 (2), 207-217.

Deane, F.P., & Todd, D.M. (1996). Attitudes and intentions to seek professional help for personal problems and suicidal thinking. Journal of College Student Psychotherapy, 10 (4), 45-59.

Dressler, W.W. (1991). Stress and adaptation in the context of culture: Depression in a southern community: New York: Albany State University of New York Press

Eaton, W.W. & Kessler, L.G. (Eds.). (1985). Epidemiologic field methods in psychiatry: The NIMH Epidemiologic Catchment Area Program. Orlando Florida: Academic Press

Fischer, E.H. & Turner, J.L. (1970). Orientations to seeking professional help: Development and research utility of an attitude scale. Journal of Consulting and Clinical Psychology, 35 (1), 79-90.

Gardner, G.G. & Hinton, R.M. (1980). Hypnosis with children. In G.D. Burrows & L Dennerstein (Eds), Handbook of hypnosis and psychosomatic medicine. New York: Elsevier

Gurin, G Veroff, J & Feld, S (1960). Americans view their mental health. New York: Basic Books.

Hatchett, S. J. Jackson, J.S. (1993). African American extended kin systems: An assessment. In H. P.McAdoo (Ed.) Family ethnicity: Strength in diversity. Newbury Park: CA: Sage

Heimberg, R.G. & Barlow, D.H. (1988). Psychosocial treatments for social phobia. Psychosomatics, 29 (1), 27-37.

Hill, C.E., Thompson, B.J. Cogar, M.C. & Denman, D.W. (1993). Beneath the surface of long term therapy: Therapist and client report of their own and each other's covert processes. Journal of Counseling Psychology, 40, 278-287.

Jones, E.E., & Thorne, A. (1987). Rediscovery of the subject: Intercultural approaches to clinical assessment. Journal of Consulting and Clinical Psychology, 55(4),488-495

Kelly, A.E., & Achter, J.A. (1995). Self-concealment and attitudes toward counseling in university students. Journal of Counseling Psychology, 42 (1), 40-46.

Kushner, M.G., & Sher, K.J. (1989). Fear of psychological treatment and its relation to mental health service avoidance. Professional Psychology: Research and Practice, 20 (4), 251-257.

Kushner, M.G., & Sher, K.J. (1991). The relation of treatment fearfulness and psychological service utilization: An overview. Professional Psychology: Researchand Practice, 22 (3), 196-203.

Kvale, S. (1987). Interpretation of the qualitative interview. In F.J. Van Zuuren, F.J. Wertz & B. Mook (Eds.). Advances in qualitative psychology: Themes and variations. Berwyn: Swets North America

Larson, D.G. & Chastain, R.L. (1990). Self-concealment: Conceptualization, measurement, and health implications. Journal of Social and Clinical Psychology, 9 (4), 439-455.

Leong, F.T.L., Wagner, N.S. & Tata, S.P. (1995). Racial and ethnic variations in help-seeking attitudes. In J.G. Ponterotto, J.M. Casas, L. A. Suzuki & C.M. Alexander (Eds.). Handbook of Multicultural Counseling (pp. 415-438) California: Sage

Lincoln, C.E. & Manyia, L.H. (1990).The Black church in the African American experience. Durham NC: Duke University Press

Marshall, C. & Rossman, G.B. (1989). Designing qualitative research. Newbury Park, CA:Sage

Mayer, J.B. & Timms, N. (1970). The client speaks. London: Routledge & Kegan Paul

Mays, V.M., Caldwell, C.H. & Jackson, J.S., (1996) Mental health symptoms and service utilization patterns of help-seeking among African American women. In H.W.Neighbors & J.S. Jackson (Eds.).Mental Health in Black America.. (pp.161-176.) California: Sage Publication.

Mechanic, D. (1975). Sociocultural and social psychological factors affecting personal responses of psychological disorder. Journal of Health and Social Behavior, 16 393-405.

Miller, N.E. (1944). Experimental studies of conflict. In J. McV. Hunt (Ed.). Personality and the behavior disorders. New York: Ronald Press

Neal, A.M. & Turner S.M. (1991). Anxiety disorders research with African American: Current status. Psychological Bulletin, 109 (3), 400-410.

Neighbors, H.W. & Jackson, J.S. (1996). Mental Health in Black America. California: Sage Publication.

Nickerson, K.J. Helms, J.E. & Terrell, F. (1994). Cultural mistrust, opinions about mental illness, and Black students attitudes toward seeking psychological help from white counselors. Journal of Counseling Psychology, 41 (3), 378-385.

Pennebaker, J.W, Kiecolt-Glaser, J.K.& Glaser, R. (1988). Disclosure of trauma and immune function: Health implications for psychotherapy. Journal of Consulting and Clinical Psychology, 56, 239-245

Peoples, V.Y. & Dell, D.M. (1975). Black and white student preferences for counselor roles. Journal of Counseling Psychology, 22 (6), 529-532.

Pipes, R.B., Schwartz, R., & Crouch, P. (1985). Brief reports. Journal of Counseling and Clinical Psychology, 53 (6), 933-934.

President's Commission on Mental Health (1978). Report to the President. Washington, D.C. U.S. Goverment Printing Office

Price, B.K., & Mc Neill, B.W. (1992). Cultural Commitment and attitudes toward Seeking counseling services in American Indian colege students. Professional Psychology: Research and Practice, 23 (5), 376-381.

Riccio, A.C., & Barnes, K.D. (1973). Counselor preferences of senior high school students. Counselor Education and Supervision, 13, 36-40

Rickwood, D. J., & Braitwaite, V.A (1994). Social-psychological factors affecting help-seeking for emotional problems. Social Science and Medicine, 39 (4), 563-572

Ridley, C.R. (1984). Clinical treatment of the nondisclosing black client: A therapeutic paradox. American Psychologist, 33, 1234-1244.

Robins, L.N., Helzer, J.E. Weissman, N.M., Orvaschel, H., Gruenberg, E., Burke, J.D., & Reiger, D.A. (1984). Lifetime prevalence of specific psychiatric disorders in three sites. Archives of General Psychiatry, 41, 949-958

Sanchez, A.R. & Atkinson, D.R. (1983). Mexican-American cultural commitment, preference for counselor ethnicity, and willingness to use counseling. Journal of Counseling Psychology, 30 (2), 215-220.

Silva De Crane R., & Spielberger, C. (1981). Attitudes of Hispanic, Black, and Caucasian university students toward mental illness. Hispanic Journal of Behavioral Sciences, 3, 241-255.

Sneider, I. (1987). The theory and practice of movie psychiatry. American Journal of Psychiatry, 4 (8), 996-1002.

Snowden, L.R. & Cheung, F.K. (1990). Use of inpatient mental health services by members of ethnic minority groups. American Psychologist, 45 (3), 347-355.

Socall, D.W., & Holtgraves, T. (1992). Attitudes toward the mentally ill: The effects of labels and beliefs. The Sociological Quarterly, 33 (3), 435-445.

Stefl, M.F., & Prosperi, D.C. (1985). Barriers to mental health service utilization. Community Mental Health Journal, 21(3), 167-177.

Stiles, W.B. (1993). Quality control in qualitative research. Clinical Psychology Review, 13, 593-618

Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. American Psychologist, 32,616-624.

Sue, S, Fujino, D.C., Hu, L., Takeuchi, D.T., & Zane, N.W.S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. Journal of Consulting and Clinical Psychology, 59 (4), 533-540.

Sue, D.W., Sue, D. (1977). Barriers to effective cross-cultural counseling. Journal of Counseling Psychology, 24 (5), 420-429.

Sussman, L.K., Robins, L.N. & Earls, F. (1987). Treatment-seeking for depression by Black and White Americans. Social Science and Medicine, 24 (3), 187-196.

Tata, S.P., & Leong F.T.L. (1994). Individualism-collectivism, social-network orientations, and acculturation as predictors of attitudes toward seeking professional psychological help among Chinese Americans. Journal of Counseling Psychology, 41 (3), 280-287.

Taylor, R.J., Hardinson, C.B. & Chatters, L.M., (1996). Kin and non-kin as sources of informal assistance. In H.W.Neighbors & J.S. Jackson (Eds.). Mental Health in Black America. (pp.130-145). California: Sage Publication.

Terrell, F., & Terrell, S. (1984). Race of counselor, client sex, cultural mistrust level and premature termination from counseling among Black clients. Journal of Counseling Psychology, 31 (3), 371-375.

Thompson, R.A. & Cimbolic P. (1978). Black students counselor preference and attitudes toward counseling center use. Journal of Counseling Psychology, 25 (6), 570-575.

Veronen, L.J. & Best, C.L. (1983). Assessment and treatment of rape induced fear and anxiety. Clinical Psychologist, 36, 99-101.

Vessey, J.T., & Howard, K.I. (1993). Who seeks psychotherapy? Psychotherapy, 30 (4), 546-553.

Webster, D.W. & Fretz, B.R. (1978). Asian American, Black and White college students' preferences for help-giving sources. Journal of Counseling Psychology,25 (2), 124-130

Weitzman, E.A. & Miles, M.B. (1995) Computer Programs for Qualitative Data Analysis California: Sage Publication.

Wood, W.D. & Sherrets, S.D. (1984). Requests for outpatient mental health Services: A comparison of Whites and Blacks. Comprehensive Psychiatry, 25 (3), 329-334

Yamamoto, J., James, D.& Palley, N. (1968). Cultural problems in psychiatric therapy .Archive of General Psychiatry, 29, 45-49