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Exploring the theoretical and philosophical frameworks that influence private practitioners' mental health treatment of middle-class African-American women

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ABSTRACT

SOCIAL WORK

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EXPLORING THE THEORETICAL AND PHILOSOPHICAL FRAMEWORKS THAT INFLUENCE PRIVATE PRACTITIONERS’ MENTAL HEALTH TREATMENT OF MIDDLE-CLASS AFRICAN-AMERICAN WOMEN

Committee Chair: Margaret Count-Spriggs, Ph.D.

Dissertation dated December 2010

The purpose of this qualitative study was to explore the theoretical/philosophical frameworks, treatment, engagement, and diagnostic approaches of private practice therapists who treat middle-class African-American women. This qualitative study consisted of eight in-depth interviews with private practitioners who were purposefully selected. The interviews took place over the course of three months and were the sole source of data for this study.

An analysis of the data revealed categories and properties related to the theoretical/philosophical framework employed by private practitioners and its influence when treating middle-class African-American women, the factors that impact the choice of interventions used, and what influences middle-class African-American women to seek treatment in the private sector. Grounded theory coding revealed a substantive level
theory explaining the dynamics of mental health treatment for middle class African-American women in the private sector.

Three general conclusions emerged from the findings: (a) Theory is not the sole influencer when approaching treatment with middle class African-American women; (b) A client-centered perspective which views the client as the expert as well as the development of a strong therapeutic relationship impacts the course of treatment; and (c) The intersection of race, class, and gender influences middle-class African-American women’s decision to seek services in the private sector. The findings, theory, and implications for social work policy, planning, and administration, and recommendations for future research were discussed.
EXPLORING THE THEORETICAL AND PHILOSOPHICAL FRAMEWORKS THAT INFLUENCE PRIVATE PRACTITIONERS’ MENTAL HEALTH TREATMENT OF MIDDLE-CLASS AFRICAN-AMERICAN WOMEN

A DISSERTATION
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

BY

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I first give thanks and honor to God for Blessing me with the strength, determination, and wisdom to complete this process. I have learned that your word is true and I can definitely do all things through Christ who strengthens me!

This dissertation is dedicated to my beautiful little girl! Thank you, Maile Ayanna, for sharing me with this process; you have been so gracious and understanding. Mommy loves you more than words can ever express. To my parents, thank you for being such an amazing support to me throughout this journey. Your love and support is appreciated more than you know. To my small but amazing circle of friends, thank you for believing in me.

To my committee and school family, thank you for your support, guidance, and for pushing me to my fullest potential. To all of the therapists who participated in my study, thank you for sharing your experiences, insights, and wisdom. It is within these kinds of exchanges that we create change.
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CHAPTER I

INTRODUCTION

The purpose of this study was to explore the theoretical/philosophical frameworks, treatment, engagement, and diagnostic approaches of private practice mental health therapists who treat middle-class African-American women seeking mental health services. This chapter presents the background of the problem by highlighting issues around mental health services and disparities as it relates to African Americans and specifically African-American women. This chapter also details the statement of the problem, the research questions, and the significance of this study. Chapter one concludes with a discussion of the theoretical framework and summary of the chapter.

Background of the Problem

Mental illness including suicide accounts for over 15% of the burden of diseases in established markets such as the United States. This is more than the disease burden for all cancers put together (National Institute of Mental Health [NIMH], 2008). When you couple this burden with disparities in care it becomes a huge problem for Americans. According to the Office of Minority Health and Health Disparities (OMH), health disparities refer to the difference between one population and another in regards to overall rates of disease incidence, prevalence, morbidity, mortality, or survival rates (OMH, 2008). Disparities in mental health services are institutional and societal problems that need to be addressed.
The Surgeon General’s report on the mental health supplement set out to probe deeper into mental health disparities affecting racial and ethnic minorities. The report concluded that racial and ethnic minorities have less access to and availability of mental health services, are less likely to receive needed services, are underrepresented in mental health research, and often receive a poorer quality of mental health care in treatment (Culture, Race, and Ethnicity, 2001). The report also indicated that some of the barriers to service include mistrust, insurance coverage, fear of treatment, and racism and discrimination (Surgeon General’s supplement, 2001; Ojeda & McGuire, 2006). It indicated that African Americans may use alternative therapies more than whites and that African Americans of all ages are underrepresented in outpatient services (Report of the Surgeon General supplement, 2001; Ojeda & McGuire, 2006).

Research also shows that social circumstances such as poverty and violence often contribute to the development of a mental illness. African Americans are disproportionately more likely to experience social circumstances that increase their chances of developing a mental illness (National Alliance on Mental Health [NAMH] Fact Sheet, 2008). They are also overrepresented in high need populations that are particularly at risk for mental illnesses. African Americans make up 40% of the homeless population, nearly 50% of all prisoners in the state and federal jurisdictions, 40% of juveniles in custody, 45% of children in the foster care system, and 50% of children waiting to be adopted (NAMH Fact Sheet, 2008). African Americans of all ages are more likely to be victims of serious violent crimes than non-Hispanic whites, also making them more vulnerable to mental illness (Surgeon General’s Report Fact Sheets, 1999). Due to
the mistrust of mental health professionals and prior experiences of misdiagnosis, inadequate treatment, and lack of cultural understanding, African Americans are less likely to receive treatment for their mental illness (NAMH Fact Sheet, 2008). However, mental illness is rampant in the African-American community. The Centers for Disease Control (CDC) concluded that African Americans are more likely to experience a mental health disorder than their white counterparts, less likely to seek treatment, and when they do seek treatment, they are more likely to use the emergency room for mental health care. They are also more likely than whites to receive inpatient care (CDC Fact Sheet, 2006). Somatization which is the manifestation of physical illnesses related to mental health occurs at a rate of 15% among African Americans and only 9% among Caucasian Americans (NAMG Fact Sheet, 2008). They also experience culture bound syndromes such as “isolated sleep paralysis,” and “fallen out.” According to the Report of the Surgeon General Supplement (2001), African Americans are diagnosed more frequently than their white counterparts (even when presenting with the same symptoms) with schizophrenia. They are also more likely to not receive needed medication and when they do, they are given higher doses resulting in more severe side effects (Surgeon General’s Report Fac: Sheets, 1999).

More specifically, African-American women are more vulnerable to the effects of mental health disparities than their male counterparts, especially related to depression. Statistics show that women in general, regardless of race and ethnic background experience depression in their lifetime at twice the rate of men. That is one in eight women (NAMI, 2008; Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007). Statistics also
show that by age 15, women are two times more likely to experience a major depressive episode than men. Contributors include relationships and work roles like single parenthood, caring for children and aging parents, reproductive events like pregnancy, menopause, and postpartum, and issues of abuse and poverty (NIMH, 2008; Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007). However, women of color face additional barriers related to utilizing mental health services including being uninsured or underinsured, limited time and competing priorities, loss of pay from missing work, child care, transportation, and inconvenient clinic location and hours (Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007).

Additionally, African-American women experience some unique disparities related to depression. The National Institute of Mental Health (2008) found that African-American women are diagnosed less with major depression and dysthymia than Hispanic and Caucasian women. They indicate the possible differences in symptom presentation as a contributing factor. African-American women are more likely to report somatic symptoms like appetite change and body aches and pains (NIMH, 2008). Also, African-American women are usually an under diagnosed and under treated population for psychiatric disorders. When African-American women do seek treatment for depressive symptoms, they are less likely to see mental health professionals and more likely than African-American men to seek help from a minister (Jackson, 2006).

Problem Statement and Purpose

The information stated above suggest that there is a huge disparity in the diagnosis and treatment of mental illness among African Americans resulting in the need
for research to identify the reasons, possible solutions, and magnitude of this issue. African-American women in general are even more vulnerable however, very little is known about middle-class African-American women and their help seeking and utilization behaviors in the private sector of mental health services. Most of the literature looks at lower-class women who are receiving some kind of public entitlement. A study done by Smith and Wermeling (2007) noted that approximately 10% of blacks are members of the upper class, 40% are middle-class, and 50% belong to the lower class. One of the advantages of black middle-class is access to health care, for example, in 2003, 53.9% of African Americans used employer sponsored health insurance (Smith & Wermeling, 2007). Middle-class African-American women face a significant degree of stress related to their position of upward mobility. They face a complex and discouraging reality which include racism, sexism, and the stress of balancing occupational, family, and community responsibilities. This combination of stressors increase their vulnerability to physical and mental health problems like conflicts in self-esteem, depression, anxiety, addictive behaviors, and other stress related reactions (Smith & Wermeling, 2007). Middle-class African Americans have seldom been the focus of social research. Most of the mental health research focus on the most disadvantaged within the group. However, middle-class African-American women are beginning to use counseling more frequently. Within group differences like income, education, occupational status can no longer be ignored (Jackson & Stewart, 2003; Smith & Wermeling, 2007).
Additionally, once African-American women are diagnosed with a mental disorder, determining a promising form of treatment is a process that must be determined carefully because of gender and racial/ethnic differences (Jackson, 2006). This leads to the question of how mental health practitioners whether in the private sector arrive at treatment decisions and approaches when treating African-American women.

Traditionally, theoretical orientation or frameworks usually guide how practitioners make treatment decisions. A theoretical orientation refers to a set of assumptions that provides a framework for generating hypothesis, guiding interventions, and conceptualizing the counseling process (Minton & Myers, 2008; Poznanski & Mclennan, 2003). The development of a theoretical orientation to therapy can be a complex process. Factors like clinical experiences, graduate and post graduate training, supervisors orientation, therapist personality, and personal philosophy and values all play a role in that process (Bitar, Bean, & Bermudez, 2007). However, no single theory can be used to treat all clients and some may argue that traditional counseling theories may not be applicable to people of color due to the ingrained racism and cultural bias (Minton & Meyers, 2008; Norcross, Karipak, & Lister, 2005; Jackson, 1977).

Current research suggest that many counselors identify as eclectic, choose to integrate orientations, and may use various techniques and interventions based on the needs of a client at a given point in time of the counseling process (Minton & Meyers, 2008; Norcross, Karipak, & Lister, 2005). A study done by Norcross, Karpiak, and Lister (2005) examined the views and practices of self-identified eclectic and integrative psychologist. The studied defined three essential terms: (a) theoretical integration is
defined as a synthesis of multiple theories, (b) technical eclecticism is defined as the use of various techniques without regard to the theories it derived from, and (c), assimilative integration, is defined as the selection and incorporation of techniques and concepts from different orientations into a single preferred theory. The clinical psychologists in their study did not feel that there was a single theory that could address the needs of clients in its entirety and although most therapists are trained in a single approach, they begin to incorporate other approaches once they discover the limitations of their original approach (Norcross, Karipak, & Lister, 2005).

Another study done by Poznanski and Mclennan (2003) interviewed 103 Australian psychologist about factors associated with their choice of a theoretical orientation. They found that factors like age, personality characteristics, personal therapy, and university training influenced the selection of a theoretical framework. However, depending on the theoretical framework the counselors identified with, those factors had varying importance. For example, university training was an important factor for cognitive behavioral therapists but not other theoretical orientations.

The studies mentioned above all focused on the decision making process and factors that influence a therapist development, choice, and allegiance to a particular theoretical orientation as opposed to how that theoretical orientation influences their treatment practices as it relates to a particular group or population. This is important especially as it relates to mental health disparities and vulnerable populations. As the surveillance data indicated, many African Americans and more specifically African-American women underutilize mental health services despite their overwhelming need
(Culture, Race, and Ethnicity, 2001). A lot of the factors relate to the position of and interaction with the provider, factors like mistrust based on prior experiences of racism and discrimination, misdiagnosis, services that lack cultural relevance, and the attitudes and beliefs of the provider (Report of the Surgeon General supplement, 2001; Carrasco, 2004). The research clearly links a therapist worldview, personal and professional values, and personality to their choice and use of a theoretical framework, exploring that specified framework(s) influence on treatment approaches and decisions when serving middle-class black women becomes vital as it relates to mental health disparities (Bitar, Bean, & Bermudez, 2007). Middle-class African-American women are utilizing counseling services more frequently than before and some practitioners’ often become personally invested in their theoretical orientation and remain committed to it even in the face of opposing research (Smith & Wermeling, 2007; Murray, 2009). Therefore, the purpose of this study was to explore the theoretical/philosophical frameworks that influence the treatment, engagement, and diagnostic approaches of private practice therapists who treat middle-class African-American women.

Significance of the Study

The surveillance data and existing literature highlight the issues of mistrust, stigma, and cultural incongruence as utilization issues for African Americans in the public sector. Although very little is known about middle-class African-American women’s help seeking behavior and utilization patterns, we do know that due to their socioeconomic status they tend to have an increased risk for mental health issues, insurance coverage to assist in accessing services, and an increase in the use of services
(Smith & Wermeling, 2007). We also know that issues with mental health treatment go beyond the social circumstances of the woman served and lie within the realm of the practitioner. Factors like competence, skill base, theoretical orientation, cultural bias and worldviews all play a role (Report of the Surgeon General Supplement, 2001; Carrasco, 2004; Bitar, Bean, & Bermudez, 2007).

This study is significant because it explores the mental health treatment of middle-class African-American women in the private sector from the practitioner/therapists perspective. This viewpoint and position in the arena of mental health disparities tackles the issue from the practitioners’ perspective. Research usually focuses on the barriers that black women face like stigma within their community as well as her preference of pastoral counseling over traditional counseling. However, looking at the issue from the practitioner’s perspective highlights their role and responsibility in assisting in the elimination of mental health disparities and the adequate treatment of middle-class African-American women which in turn would assist in the elimination of mental health disparities. Research shows that competent therapist and theoretical understanding is an essential component of effective therapy (Hanson, 2006). Counselors must adjust their clinical decision making processes to accommodate the needs of a more diverse clientele. For example, the research indicates a prevalence of misdiagnosis among ethnic minorities and speculates that it is partially due to practitioners’ cultural bias. Some practitioners rely on racial, ethnic, and gender stereotypes in clinical decision making and tend to view symptoms more negatively leading to more severe diagnosis (Hays, Prosek, & Mcleod, 2010). Even when practitioners’ are subscribing to and
utilizing a theoretical orientation as a guide to counseling, the question of cultural relevance within the existing theoretical frameworks arise. Jackson (1977) argues that counseling professionals operate from a deficit model when working with black people. They believe that black people have underlying genetic and social deficiencies and as a result do not consider psychosocial factors contributing to the issues brought to counseling. With the increase of African-American women using counseling service the exploration of practitioners’ perspectives as it relates to theoretical orientation and clinical decision making becomes vital.

This study explores from a qualitative standpoint the philosophical undercurrents of private practitioners who treat middle-class African-American women and how those undercurrents impact treatment and engagement. Since my area of inquiry is a different way of looking at mental health disparities and focuses on increased understanding and meaning of this issue, the researcher felt it was necessary to explore this phenomenon using a grounded theory qualitative research approach.

**Research Questions**

This study explores the following qualitatively posed questions:

RQ1: How does the theoretical/philosophical framework employed by private practitioners influence their approach to treating middle-class African-American women?

RQ2: In their opinion and experience, what influences middle-class African-American women to seek treatment in the private sector?
RQ3: What factors impact the choice of interventions used when treating middle-class African-American women?

**Definitions**

Several conceptual definitions are provided to clarify relevant constructs.

*Mental Disorder (Mental Illness):* The diagnostic and statistical manual of mental disorders, fourth edition (DSM-IV) defines mental disorder as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with an significantly increased risk of suffering death, pain, disability, or an important loss of freedom (American Psychiatric Association, 2000).

*Private Practitioner* means to offer or to render for a fee any service involving the application of principles, methods, or procedures of professional counseling, social work, or marriage and family therapy (Professional Counseling, Social workers, Marriage and Family Therapist Licensing Law, 1984).

*Middle-class:* A woman whose income falls within the range of $25,000 to $49,000 a year (U. S. Census Bureau, 2008).

*Theoretical Orientation/Framework* refers to a set of assumptions that provides a framework for generating hypothesis, guiding interventions, and conceptualizing the counseling process (Minton & Myers, 2008; Poznanski & McLennan, 2003)

**Grounded Theory: A Theoretical Framework**

Grounded theory was developed and introduced by Barney Glaser and Anselm Strauss in 1967 in their study of the interactions of hospital staff with dying patients
They believed that some of the theories used in research did not fit the phenomenon under study. Grounded theory is rooted in social science and the symbolic interaction tradition of social psychology. Symbolic interaction is a theory about human behavior and places an emphasis on meaning and the symbols used to convey those meanings (Eaves, 2001). Symbolic interaction rests on the following core principles, social reality and action is based on the meaning we apply to people and objects, symbols and language are the source of meaning, and our thoughts modify and interpret those meanings (Skeat & Perry, 2008). The influence symbolic interaction has on grounded theory is in its emphasis on social processes and interactions and our role in constructing meaning. The notion that people who share a common circumstance will also share some common meanings that they attach to that circumstance and this shared sense of meaning will be revealed during data analysis and development of core categories of concern for the group being studied. This commonality serves as the bases for theory development which is the central goal of grounded theory (Skeat & Perry, 2008).

There are many approaches to grounded theory. However, the two major modes come from the original founders after their split due to disagreeing on the meaning and procedures of grounded theory (Creswell, 2007). This study uses the Strauss approach to grounded theory. This approach focuses on the development of a theory that allows for the understanding and management of a problem. It seeks to develop theory that explains a process, action, or interaction on a topic (Skeat & Perry, 2008; Creswell, 2007). The area of focus and broad research questions are identified prior to the study which comes out of a review of the literature, personal experience, and dialogue with colleagues. This
is very different from Glaser’s approach which believes that the literature review should come after data collection and the core category of concern is developed (Skeat & Perry, 2008). Strauss believes that the literature review is conducted prior to the study to increase awareness of existing knowledge and identify gaps. He believed that literature review could stimulate theoretical sensitivity, provide a secondary source of data, stimulate questions, direct theoretical sampling, and provide supplementary validity. The review of literature during data analysis is to support theory development (McGhee, Marland, & Atkinson, 2007; Skeat & Perry, 2008).

The data analysis is more prescriptive in Strauss approach and consists of three overlapping phases which is discussed in chapter three. The primary result of a grounded theory approach is a theoretical model that can be used to explain the area of study (Patton, 2002; Skeat & Perry, 2008). This is referred to as substantial level theory, which is theory that evolves from the study of a phenomenon in a particular situational context (Creswell, 2007; Eaves, 2001). There are four basic premises associated with grounded theory that you can find across approaches and they include (McCallin, 2003):

2. The theories should be grounded in empirical reality (McCallin, 2003).
3. The researcher is open minded (McCallin, 2003).
4. The use of theoretical sampling which is when the researcher chooses participants based on the need to discover more about emerging categories, properties, and theory from the data (Skeat & Perry, 2008).
Grounded theory is an interpretative research method that is used widely by social science researchers who seek to uncover the underlying social processes guiding interaction. It is used to generate knowledge about the behavioral patterns of a particular group and explains what is actually happening at a particular time as opposed to what should happen (McCallen, 2003). One cannot separate the methodological approach of grounded theory from its potential to serve as a theoretical framework because the two are intertwined and the theory emerges from the data (Skeat & Perry, 2008; Chiovitti & Piran (2003). Grounded theory is useful in explaining clinical practices that are not well understood and it emphasizes explaining the social processes involved and the core concerns of the participants.

A couple of studies have used grounded theory to explore clinical decision making among practitioners, granted none of those studies are looking at the theoretical orientation of private practitioners’ and its influence on the treatment of middle-class African-American women, the topics are similar enough to be compared. A study conducted by McGinnis, Hack, Nixon-Cave, and Michlovitz (2009) looked at factors that influence the clinical decision making of physical therapist in choosing a balance assessment approach. They used grounded theory to explore decision making during examination of patients with balance deficits, to understand the selection and use of assessment methods from the clinician’s perspective, and explore why specific methods were selected. Another study used grounded theory to gain insight into how physical therapists use reflection to inform clinical decision making (Wainwright, Shepard, & Harman, 2010). Additionally, a study done by Bitar, Bean, and Bermudez (2007) used
grounded theory to establish a model of the influences and processes that are involved in the theoretical orientation development of licensed marriage and family therapist. The findings lead to a theoretical model that involves two main contextual factors, personal and professional, that influence the theoretical orientation development of Licensed Marriage and Family Therapists [LMFT] (Bitar, Bean, & Bermudez, 2007).

Grounded theory is considered to be appropriate when a phenomenon has not been adequately described, few theories exist to explain it, and when there is a social process under investigation (Skeat & Perry, 2008). With those three components in mind and the studies referenced above, grounded theory appears to be the most appropriate theory to use in this study. The purpose of this study was to explore the theoretical/philosophical frameworks that influence the treatment, engagement, and diagnostic approaches employed by private practice mental health therapists who treat middle-class African-American women seeking mental health services. By using a grounded theory approach to exploring this phenomenon, a substantial level theory was developed regarding that process and interaction.

Summary

This chapter presented an introduction to the study including its purpose and significance. Additionally, this chapter presented the theoretical framework that guided this study. The chapter two discusses the literature related to African-American women and mental health treatment and disparities.
CHAPTER II

LITERATURE REVIEW

The purpose of this study was to explore the theoretical/philosophical frameworks that influence the treatment, engagement, and diagnostic approaches employed by private practice mental health therapists who treat middle-class African-American women seeking mental health services. This chapter starts with the limitations of the literature first as to set the stage for what is missing regarding this topic. The chapter then gives a historical overview, discusses mental health disparities, race, class, and gender issues, counseling theories, and appropriate treatment modalities. The chapter concludes with a discussion of the literature reviewed and its limitations.

Limitations of the Literature

The mental health utilization of African Americans in general has been a longstanding topic of concern and numerous studies have been completed to seek the answer. Literature has been written on African-American women and the various reasons they do not utilize services, trust the mental health profession, and have a higher prevalence of mental health disorders, specifically depression (Surgeon General’s Report Fact Sheets, 1999; National Alliance of Mental Illness [NAMI], 2008). However, very few studies have looked at African-American middle-class women and their help seeking and utilization behaviors in the private sector of mental health services. Most of the
literature looks at lower-class women who are receiving some kind of public entitlement. Additionally there is no existing literature regarding the efficacy of the treatment they receive in the private sector. Although there is research regarding the development and decision making process and factors that influence a therapist development, choice, and allegiance to a particular theoretical orientation there is little known on how those theoretical frameworks influence the treatment of middle-class African-American women. The literature reviewed in this chapter provides a foundation that lays out the following:

1. African Americans distrustful relationship with the health and mental health system dates back to slavery;
2. Mental health disparities are real and relevant when discussing mental health utilization and treatment of African-American women;
3. The importance of cultural competence in treatment;
4. Appropriate treatment modalities when serving African-American women;
5. The need for this very kind of research.

**Historical Overview**

African Americans have a long history both in and out of America. The institution of slavery served as a breeding ground for fear, cruelty, mistrust, and physical and mental maltreatment. The after effect of slavery has long reaching implications especially as it relates to the mental health of African Americans.
Medical Experimentation

Historically, medical experimentation using human subjects have resulted in medical advancements and procedures across the world. However, the subjects of these experiments are usually poor and vulnerable. African Americans endured a huge and disproportionate burden and suffered the most brutal, invasive, and dangerous of the medical experiments (Washington, 2008). In order to get a full and in depth understanding of why the above statement is true, you must start with the enslaved African. The medical experimentation on enslaved Africans and African Americans is seldom discussed; however, the evidence of numerous accounts are embedded in historical documents and speeches made by physicians. The experimental tormenting of African Americans has manifested in many ways which includes fear, profound deception, psychological trauma, pain, injection with lethal agents, disfigurement, crippling chronic illness, undignified display, intractable pain, stolen fertility, and death (Washington, 2008).

One infamous account of medical experimentation on enslaved Africans is the work of Dr. James Marian Sims. In the 1840s, Dr. Sims dedicated his career to the care and cure of women’s disorders and perfected his surgical techniques by practicing on enslaved African women. He performed as many as thirty surgeries within a four year period without anesthesia on slave women who suffered injuries during childbirth (Lederer, 2005; Washington, 2008). These women were forced to be human subjects and submit to very invasive and harmful surgeries. In Washington’s book, Medical Apartheid, she describes the operating scene as follows:
Each naked, unanesthetized slave woman had to be forcibly restrained by the other physicians through her shrieks of agony as Sims determinedly sliced, then sutured her genitalia. The other doctors, who could, fled when they could bear the horrific scene no longer. It then fell to the other women to restrain one another. (p. 2)

Dr. Sims also surgically treated enslaved infants who suffered from neonatal tetanus, a disease that took countless lives of enslaved infants. He set up a hospital with 8 beds that later expanded to 16 beds to treat enslaved Africans and further his surgical abilities and knowledge. Dr. Sims stated, “There was never a time that I could not, at any day, have had a subject for operation” (Kenny, 2007, p. 228). He was not alone in his interest and use of enslaved Africans to explore, develop, and practice various medical procedures. There were a number of “slave hospitals” that were used as experimental facilities to further both individual reputations and medical knowledge (Kenny, 2007). Dr. T. Stillman’s medical infirmary for diseases of the skin published the following advertisement in the Charleston Mercury in October 1838:

To planters and others—wanted 50 Negroes. Any person having sick negroes considered incurable by their respective physicians, and wishing to dispose of them, Drs will pay cash for negroes affected with scrofula kings evil, confirmed hypocondriasm, apoplexy, diseases of the liver, kidneys, spleen, stomach and intestines, bladder, and its appendages, diarrhea, dysentery, and C. The highest cash price will be paid on application as above. (Kenny, 2007, p. 229)
As one can see, the use of enslaved Africans for medical experimentation was a common and public practice.

The south played the most significant role in the maltreatment and medical experimentation of enslaved Africans. It is also important to note that the actual medical treatment of slaves were also discriminatory in nature and quite cruel at times. Medical interventions like bloodletting (removal of blood from the body), induced vomiting, induction of diarrhea, and the whipping of slaves accused of malingering (faking illness) demonstrated the harsh and experimental nature of southern medicine during that time (Washington, 2008). Physicians and scientist of the slavery era and eras to follow were very vocal in their support of slavery, medical experimentation, and the inferiority of slaves and African Americans. In 1891, Dr. V.A. McIntosh addressed the South Carolina medical association with “the future of the Negro race.” His remarks were as follows: “Negroes flourished in slavery and received the “the best medical skill money could command, careful feeding and nursing” (Hammer, 1997, p. 36). In 1960, Dr. Harry Bailey delivered a speech at Tulane medical school and stated: “It was cheaper to use niggers than cats because they were everywhere and cheap experimental animals” (p. 10). Also, as recent as 1995, radiation scientist Clarence Lushbaugh, MD, explained that he and his partner, Eugene Saenger, MD, chose “slum” patients as radiation subjects because “these persons don’t have any money and they’re poorly washed” (Washington, 2008, p. 10). The worldview of enslaved Africans and African Americans has continued to be derogatory and unfounded as it relates to healthcare and mental health.
Those same perspectives contribute to the adverse relationship that African Americans have with the healthcare (including mental health) system.

Dangerous and involuntary medical experimentation has been practiced widely even after the institution of slavery was abolished. Harriet Washington documents the investigative actions of the Office for Protection from Research Risk (OPRR) due to alleged abuse at more than sixty research centers ranging from scientific fraud to experimentation related deaths (Washington, 2008). Other documented medical experiments perpetrated against people of African descent include the Donovanosis study and Tuskegee experiment. Between 1918 and the early 1950s, African-American men and women were purposely injected with the disease causing agent Donovanosis (a genital ulcer disease) in a variety of experimental settings. This disease can lead to genital disfiguration and can be a debilitating disease (Hammer, 1997). The infamous Tuskegee experiment studied the effects of advanced syphilis (sexually transmitted disease) on 400 African-American men living in rural Macon county Alabama from 1932-1972. The investigators believed that the best way to understand the disease was to explore its impact on the body after death through autopsies. They recruited poor African-American men by promising free treatment and performed countless unnecessary diagnostic tests (i.e., spinal puncture) in lieu of actual treatment (Lederer, 2005). As one can see, the unjust medical experimentation of African Americans dates back to the beginning of slavery and plays a significant role in their journey within this country. Events like the ones discussed above continue to fuel the distrust that African Americans have of all major systems in this country, especially healthcare.
African Americans and Mental Health

Most of the literature focus on African Americans treatment in mental health institutions but do not discuss in great detail the medical experimentation of enslaved or free African Americans as it related to mental health. However, racist and discriminatory beliefs and actions were evident in mental health during and after slavery. Most of the leaders in psychiatry and mental health were focused on building asylums and supporting the institution of slavery through producing “knowledge” regarding the mental inferiority of enslaved and free Africans (Washington, 2008; Jackson, 2001). In 1851, Dr. Samuel Cartwright defined two forms of mental illness unique to African Americans, Drapetomania (disease causing Negroes to run away) and Dyathesia Aethiopica (hebetude of the mind) (Jackson, 2001). Dr. Peter Bryce, superintendent of the Alabama insane hospital believed freedom caused African Americans great psychological pressure because they had to care for themselves when they did not posses neither the intelligence nor the judgment to do so which resulted in madness (Washington, 2008). Philosophies such as the ones stated above were perpetuated through so called scientific research even when such research was purposely falsified. For example, the sixth U.S. Census (1840) for the first time counted the “insane and idiots.” When completed, it reported 17 million Americans of whom 3 million were black. The report indicated that free blacks suffered worse health, especially mental health than those enslaved.

The census attempted to provide statistical data to support the institution of slavery by showing health disparities based on freedom and slavery. This was published in 1841 and showed alarming differences such as 1 out of 1,558 blacks in the south was
an "idiot and insane," but 1 out of 144 northern blacks had similar mental problems. Thus mental defects were 11 times more common among free blacks than enslaved blacks. They said blacks lacked the mature judgment of whites, unable to resist liquor, indiscriminate sex, constant dancing, and frequent fighting. The Census also noted that blacks bodies were deficient and were more vulnerable to disease that whites did not get such as Cachexia Africana (pica) and hebetude which is dullness of mind (Washington, 2008). It was not until Dr. Edward Javis, a physician specially trained both in mental illness and in statistics found numerous statistical errors in the census data did the validity of the census even come into question. Dr. Javis noted that the original investigators counted insane Negroes in northern towns that did not have a black population (i.e. Scarborough and Worcester, MA) (Washington, 2008). This set the stage for the unfair mental health treatment and mistrust of the mental health system by African Americans.

Historically African Americans connection to the mental health system was directly related to the concepts of freedom, proper conduct, and discriminate beliefs. The mental health of African Americans have always been grounded in the social, political, and economic influences of this world as opposed to the needs and desires of that population. Scientific research and assessment was manipulated to support the views of that time (Washington, 2008; Jackson, 2001).

In Vanessa Jackson’s Monograph, In Our Own Voice: African American stories of Oppression, Survival, and Recovery in Mental Health Systems, she tells the historical story of African Americans who were institutionalized in psychiatric hospitals. She specifically discusses seven state mental hospitals established solely for the treatment of
African Americans, Central State Hospital (West Virginia), Goldsboro Hospital for the Colored Insane (North Carolina), Lakin State Hospital (West Virginia), Mount Vernon Hospital for the Colored Insane (Alabama), Taft State Hospital (Oklahoma), State Farm Division/Palmetto State Hospital (South Carolina), and Crownsville State Hospital (Maryland) (Jackson, 2001).

Treatment practices among the hospitals were discriminatory and unjust. For example, Central State Hospital used interventions like occupational therapy which is basically labor and the lending out for a day to work in the homes of hospital staff, confinement to overcrowded day rooms, wet packs, needle showers, metrazol shock, insulin coma, hydrotherapy, wrapping wet towels around their necks, lobotomies, and electro convulsive therapy. Patients were also sexually abuse and female patients who had more than two children while institutionalized were sterilized by the facility. Goldsboro Hospital for the Colored Insane would house manic patients in a large iron cage and lease other patients to local white farmers to pick cotton and other crops (Jackson, 2001). Many African Americans faced a new kind of enslavement that was justified by measuring their “sanity.” This definition or measurement was based on the kind of behavior that slave minded individuals expected from African Americans, docile, agreeable, and obedient behavior. African Americans were diagnosed with mania and paranoia when they did not display “appropriate” behavior and were confined to institutions to serve as laborers, subjects, and servants (Jackson, 2001). The relationship between African Americans and mental health has always been fueled with mistrust, fear,
and oppression as clearly demonstrated through the inhumane and unjust confinement and treatment in psychiatric institutions.

A history of racial discrimination in medical research and the healthcare system has been linked to a low level of trust in medical research and medical care among African Americans. A study conducted by Boulware, Cooper, Ratner, and Laveist (2003), found that Non-Hispanic black respondents were less likely to trust their health insurance plans and were more likely than Non-Hispanic whites to be concerned about personal privacy and the potential harmful experimentation in hospitals. They also noted that trust is a vital component of the therapeutic process and can impact a person's help seeking behavior, continuation of treatment, and medication compliance. Race impacts the level of trust in various components of the healthcare system and those differences may be influenced by cultural experiences and expectations for care. Provider racism and patient awareness of negative historical events such as the experiments on slaves have contributed to the lack of access, knowledge, trust and participation in clinical trials (King, 2003).

**Mental Health Disparities**

**Influence of Social Circumstances**

Research also shows that social circumstances often contribute to the development of a mental illness. Many African Americans still live in poor segregated neighborhoods which have few resources. Children and youth in these environments are often exposed to violence, more likely to suffer the loss of a loved one, to be victimized, to attend subsidized schools, and to suffer from abuse and neglect. Members of minority
groups are also overrepresented among the uninsured, employees at jobs with higher rates of occupational hazards, and the economically disadvantaged. All of the above mentioned social circumstances can contribute to the development of mental health issues and contribute negatively to the maintenance of mental health (Carrasco, 2004; Beancourt, Green, Carrillo, & Ananeh-Firempong, 2003).

Policies like managed care and privatization of public services can also impact the effectiveness or even use of culturally competent services/treatment. In 1997, Nightingale and Pindus explained the concept of privatization in their article entitled Privatization of Public Social Services. They defined privatization as the provision of publicly-funded services and activities by nongovernmental entities (Nightingale & Pindus, 1997). They stated in their article that:

The real issue is not so much public vs. private—it is monopoly vs. competition.

A key issue in the current trend towards what is commonly referred to as ‘privatization’ is the introduction of competition (e.g., public-public competition, public-private competition, competition between public-private ventures, public-nonprofit competition) to increase efficiency, reduce costs, and improve quality and customer satisfaction. (p. 1)

The authors also draw a connection between The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and privatization of state social services. They argue that the law removes the restrictions that prevented states from using managed care models in the past. The authors also point out that privatization is not inherently good or bad but dependent on implementation (Nightingale & Pindus, 1997).
Some of the problems noted in behavioral health organizations that indicated a need for managed care included disorganized services, redundant services, no comprehensive tracking or evaluative system, and outdated grant and aid mechanism of funding services (Godbole, Temkin, & Cradock, 1998). Managed Behavioral Healthcare (MBHC) became dominant in the 1990s and now almost all mental health care is privatized in both the public and private sectors. The management of behavioral health care reduces impatient length of stay, reduced cost, made specialty mental health services more accessible, and reduced the intensity of service without reducing quality. It appears that mental illness is less stigmatized and the use of mental health services has increased however, quality of services is lacking especially in regards to evidence based practice (Mechanic, 2007). Managed care organizations also have the potential to exacerbate existing problems with minority mental health service utilization by reducing benefits, relocating services, and engaging service providers who are not familiar with cultural values (Switzer, Scholle, Johnson, & Kelleher, 1998). Also, one study showed that private practice clinicians did not perceive themselves as having the requisite skills to interact effectively with managed care organizations (MCO) to ensure that the care they are rendering is certified (authorized) and follows best practice guidelines (Hall & Keefe, 2006).

As Nightingale and Pindus (1997), privatization is not inherently good or bad but contingent on implementation. Therefore, managed care which is a manifestation of privatization depending on implementation has the potential to reduce high intense mental health services and contribute to existing issues with minority mental health
(Nightingale & Pindus, 1997; Switzer, Scholle, Johnson, & Kelleher, 1998; Mechanic, 2007).

**African Americans and Help Seeking Behaviors**

Research examining pathways to care among African Americans with recent onset psychosis is limited, but suggests that African Americans have more complex and less desirable routes into care compared to whites. Some of the cultural and ethnic factors that contribute to help seeking behavior are strong endorsement of folk, supernatural, and spiritual beliefs as causes of mental illness which is associated with lower rates of service use, are less likely to see themselves as having mental health problems, and more fearful of mental health treatment (Merritt-Davis & Keshavan, 2006). African Americans also tend to have more stigmatizing attitudes towards individuals with mental illness which impacts the help seeking behaviors of those in African-American communities (Anglin, Link, & Phelan, 2006).

Some African Americans have a negative perspective and relationship with mental health services and the factors contributing to mental health disparities are very clear. Researchers need to explore ways to utilize the cultural and ethnic behaviors to encourage treatment and approach the treatment of African Americans in a different way.

**International Perspective**

Interestingly enough, America is not the only part of the world struggling with disparities in mental health as it relates to ethnic and racial minorities. In London, one study on the ethnic differences in Compulsory Psychiatric Admissions found that black patients are significantly more likely to be admitted to a psychiatric intensive care facility
or prison. Black Caribbean and black African patients are more likely to be involuntarily detained and this differential contact with mental health services may set up a viscous cycle (Davies, Thornicroft, Lesse, Higgingbotham, & Phelan, 1996). Another study in London found that fear negatively impacts on the interactions between black people and mental health services. It delays help seeking and results in blacks presenting with more severe states of crisis which results in more police involvement (Keating & Robertson, 2004). The study also indicated that families and care givers are reluctant to become involved in care because of stigma and shame that is more acute because of a history of racism (Keating & Robertson, 2004).

A study conducted in Canada explored how black West Indian Canadian women manage their depression. A basic social process was discovered (being strong), that the women used to manage their depression. Being strong occurs within the overlapping areas of social contexts: the cultural stigma of depression, male and female relationships and roles, and belief in Christian doctrine. All of those social contexts are set against the backdrop of being a visible minority in a Eurocentric society (Schreiber, Stern, & Wilson, 1998).

As demonstrated above, people of African decent struggle with mental health services regardless of their geographical location. Issues of mistrust, fear, stigma, racism and discriminatory treatment is a common theme globally.
Race, Gender, and Mental Health

Race and Gender

A study done by Utsey, Ponterotto, Reynolds, and Cancelli (2000) explored whether African Americans use different types of coping strategies to manage stress associated with different types of racism. The sample consisted of 213 participants, 137 women and 76 men from New York, Louisiana, and North Carolina. The ages ranged from 17-60 and participants were recruited exclusively from college and university campuses. The study found that black women preferred avoidance coping for racism experienced on a personal level. This is relevant because by avoiding the fact that the experience took place, black women are more likely to internalize that experience which plays a negative role in their self-esteem and psychological well-being.

Avalon and Young (2005) found that blacks are less likely to use psychological services than whites and they found that when access to services are equal, blacks still were less likely to use services. The question is why? African Americans face all kind of social ills including racial discrimination; all of these social ills impact the mental health of this group. Various studies have been conducted in the late 1980s and 1990s that acknowledges a connection between the various social ills African Americans face and their psychological well-being or mental health status. Those of most relevance to this research are those that speak to the relationship between racism, racial identity, and mental health (Pyant & Yanico, 1991) looked at how William Cross’s Racial Identity Development Model has impacted African-American women’s mental health. The sample consisted of 143 adult black women, 78 were black female college students from
a predominately black University in North Carolina. The other 65 black female non-student participants consisted of 19 enlisted U.S. army personnel in Alabama, 30 employees of a social work agency in Missouri, and 16 employees of a university medical hospital in North Carolina. Pyant and Yanico used a short demographic questionnaire and five standard instruments, the Racial Identity Assessment Scale, the Attitudes Toward Women Scale, Well-Being Scale, Beck Depression Inventory, and the Rosenberg Self-Esteem Scale. They found that the more women in the study endorsed pro-white/anti-black attitudes, the more psychological and physical symptoms they reported. They also reported a lower self-esteem. In the nonstudent sample, preencounter (Euro-American world view) attitudes were positively related to depressive symptoms. Racial identity attitudes played a larger role in predicting mental health variables for the older, nonstudent woman than for the college students. For the college students, preencounter attitudes were the only racial identity attitudes related to mental health. In the nonstudent sample, encounter (identity confusion) attitudes along with preencounter attitudes indicated a lower degree of wellbeing, lower self-esteem, and more depressive symptoms (Pyant & Yanico, 1991). Pyant and Yanico found that racial identity not gender roles were predictive of mental health for black woman. A study done by Carter and Parks (1996) explored the relationship between Helm’s womanist identity attitudes and the mental health of black and white women. The findings are consistent with the findings of Pyant and Yanico.

A study conducted by Miranda, Siddique, Belin, and Kohn-Wood (2005) examined the differences in mental health between U.S. born, Caribbean born, and
African born black women who seek county entitlements. They found lower rates of depression among immigrant black women than U.S. born black women. The authors suggest the following reasons for these findings: lower rates of depression among immigrant black women could be due to diagnostic criteria being driven by western psychiatry and U.S. born black women may be somewhat more deprived than their immigrant counterparts, and may be exposed to more chronic stressors.

This body of literature indicates the importance of African-American women's identity and race related stress in regard to mental health and psychological well being. It is therefore important to view black women's mental health issues and needs in a context that considers not only their gender but their race and ethnicity. This dynamic could potentially impact the course of treatment when serving African-American women.

Women in the Spotlight

Due to the lack of empirical literature focused on women above the poverty line, three well known women who fall way above low income status and have experienced traumatic events that impacted their mental health were reviewed.

Waris Dirie was born in 1965 in the Somali near the border of Ethiopia. She survived the inhumane procedure of genital mutilation when she was five years old and at the age of thirteen she fled her father’s home to escape an arranged marriage to a much older man. She was illiterate and improvised and faced many challenges while growing up in Somalia. During the time she traveled through Africa she was almost raped by a man she met on a truck she hitched a ride with and escaped by beating the man with a brick. She also was assaulted by her cousin when she lived in London with her relatives
(Dire & Miller, 1998). In her book, *Desert Flower*, she describes her experience of genital mutilation which was a common practice in her country. She talked about the agony and pain she experienced as her genital was sliced and sewed up at the young age of five. She described the long and painful healing process that most girls did not survive. She talked of not caring if she lived or died because the pain was so unbearable (Dire & Miller, 1997).

Dire also experienced various traumatic events in her adult life, an attack by a stalker, kidnapping by a taxi driver, and various attempted rapes (Fox News, 2008). Despite her experiences with trauma, Waris went on to be a successful international model and bestselling author of four books, *Desert Flower, Desert Dawn, Letters to my Mother,* and *Desert Children* (Waris-Dirie Foundation, 2009).

Waris endured a significant amount of trauma growing up in Somalia specifically undergoing female genital mutilation however; there is no documentation of Waris ever receiving professional mental health treatment. It appears as though Waris has dealt with her experiences with trauma by dedicating her life to the eradication of female genital mutilation. She became a United Nations ambassador in 1997 for the elimination of female genital mutilation. In 2002, she founded the Waris Dirie Foundation whose mission states:

Female Genital Mutilation (FGM) concerns us all. It is a crime that is being committed in many countries. With my worldwide campaign I want to raise awareness of this cruel practice. I want to contribute all I can to make it possible to finally eradicate FGM worldwide. (p. 1)
She also co-founded the PPR Foundation for Women’s Dignity and Rights and the Desert Dawn Foundation which raises money for schools and clinics in Somalia (Waris-Dirie Foundation, 2009). It is through the giving back to her community and the fighting back of the most traumatic event in her life that she deals with her past.

In her book, *I know why the caged Bird Sings*, Maya Angelou (1997) gives a compelling account of her life. She was born in 1928 in St. Louis Missouri and was raised both in St. Louis and Arkansas. Maya Angelou experienced racism and poverty in her childhood which are both significant social circumstances that can contribute to mental illness. Maya also experienced sexual assault when she was raped by her mother’s boyfriend when she was eight years old. She recounts how much pain she experienced when she was assaulted and after the traumatic event. She recounts the threats made by her aggressor, threats to kill her and her brother if she told (Angelou, 1997). The man who attacked her was eventually prosecuted and later killed however; the events of the assault impacted her for years to come. Maya Angelou was deeply impacted by the rape and death of her attacker that she did not speak to anyone but her brother until the age of thirteen. Maya Angelou went on to become a very successful writer, actor, and activist despite her past experiences. It appears as though her way of dealing with the trauma was to succeed and write about it in her autobiography.

Oprah Winfrey grew up in poverty and was moved around between her mother, grandmother, and fathers house a lot. She was sexually abused by her 19 year old cousin, a family friend, and an uncle for many years of her life. That abuse caused her to act out in her teenage years by skipping school, stealing from her mother, and breaking curfew.
Oprah also became pregnant at age 14 and gave birth to a premature boy who died within two weeks of his birth. Oprah, like the other two women, discussed deals with her traumatic history by giving back to her community and speaking publicly of her abuse and hardships. She donates millions of dollars to various organizations and continuously brings light to issues facing abused and improvised women and girls (Academy of Achievement, 2009).

All of the women discussed have endured poverty, hardships, and abuse; however, they have overcome all of the trials they faced. They are all very successful, award winning, and cause driven African-American women who did not use the traditional mental health system to deal with their issues. What is interesting and similar about all three of these women is the healing they receive in being public with their abuse and giving back to their communities. Maybe it is having a voice to express their pain, contributing to their communities, or using their resources to fight abuse and victimization that contributes to their healing. Oprah Winfrey was empowered by reading Maya Angelou’s autobiography because she could relate to her experiences of poverty and abuse (Academy of Achievement, 2009). Regardless of the reason, the success and healing that these women experience need to be commended and explored. Could there be healing in the telling of your story or giving back?

**Cultural Competence/Cultural Relevant Services**

As outlined earlier, disparities in mental health treatment is not a new phenomenon and definitely has contributed to the emergence of the term “culturally competent and culturally relevant services/treatment.” The Report of the Surgeon
General Supplement (2001) clearly points out the significance of culture on the outcomes of mental health treatment. The executive summary indicated that culture and society play a vital role in mental health services and understanding culture allows the mental health field to construct and deliver services that are more responsive to racial and ethnic minorities, in other words, cultural competent services (Surgeon General Supplement, 2001; Beancourt, Green, Carrillo, & Ananeh-Firempong, 2003). The report noted that the clinicians’ culture is an important factor in the dynamics of mental health services and can at times become barriers for the person receiving services. When a clinician and mental health system is absorbed in their own culture without acknowledging the difference and diversity in the people they serve, they can at times negatively impact the delivery of services (Surgeon General Supplement, 2001). In April 2002, President George W. Bush established the presidents New Freedom Commission on Mental Health Care. The Commission was charged with identifying policies to improve public mental health systems at federal, state, and local levels. The goal was to maximize existing resources, improve the coordination of treatment and services and promote the successful integration of Americans with mental health (Carrasco, 2004). The commission published a final report entitled Achieving the Promise, Transforming Mental Health Care in America. The commission found America’s mental health system to be in “shambles” (Carrasco, 2004). The findings resulted in six goals; however, goal number three is the most relevant to this topic: “Disparities in Mental Health Services Eliminated.” This goal was established because the commission found that significant barriers still exist in regards to access, quality, and outcomes of care for racially and
ethnically diverse people. They also noted that this barrier or higher burden does not come from a higher prevalence or severity of mental illness but due to the poor quality of services provided (Carrasco, 2004).

Cultural Competence on the Micro, Mezzo, and Macro Levels

In Diller’s (2007) book, Cultural Diversity, he talks about cross’s five basic skill areas needed for cultural competent services and they are as follows:

1. Awareness and acceptance of differences—this skill area requires a social worker to acknowledge and accept the cultural differences and realities of the clients they serve. This skill also allows the practitioner to use the knowledge of the differences to creatively treat the diverse clients they serve.

2. Self-Awareness—Social workers need to be aware of their own cultural influences, bias, and how they impact the consumers they serve.

3. Dynamics of difference—Social workers need to be aware of the differences between them and their clients and anticipate ways to minimize the differences that may pose as barriers (i.e. language).

4. Knowledge of client’s culture—continued commitment to the understanding and seeking of information in regards to cultures and populations they serve.

5. Adaptation of skills—social workers need to be able to adjust and modify traditional ways of providing care to diverse clients.

It is imperative that social workers who practice direct care take the time to ensure competence in the culture and lived experiences of African-American women. The
competence has to span to all groups these women may identify with, African Americans, women, socioeconomic status, and religious beliefs.

Culturally competent healthcare systems have been defined as one that acknowledges and incorporates at all levels, the importance of culture, assessments of cross-cultural relations, vigilance toward dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs (Beancourt, Green, Carrillo, & Ananeh-Firempong, 2003). There are ways healthcare organizations can ensure or develop an environment of cultural competence. Examples include the following:

1. Ensure minority/racial groups are reflected in the leadership and staffing of the organization;

2. Evaluate policies and practices that govern services (i.e. clinic hours, intake process, etc) to eliminate bureaucratic practices that may negatively impact minority service utilization;

3. Secure resources that can enhance service utilization for minority groups (i.e. interpreters, culturally relevant health material);

4. Continuous quality improvement and evaluation (i.e. quality measures, data collection, service evaluations).

It is imperative for organizations to create and maintain service environments that are considerate and supportive of communities and people of color. In doing so, cultural competence can be achieved at the mezzo level.
Cultural Democracy

Akinyela and Aldridge (2003) discuss the concept of cultural democracy as a step beyond cultural competence. They define cultural democracy as a philosophy of practice that recognizes the destructive and oppressive nature of cultural domination and marginalization. It recognizes the importance of insuring cultural self-determination and integrity for each oppressed community as a precondition for multicultural unity. Cultural democracy recognizes and promotes the importance of emphasizing and understanding the relationship between power, culture, and other forms of oppression particularly class and gender oppression (Akinyela & Aldridge, 2003). This is extremely important when serving African American women. The dynamics of race, class and gender all play a role in African American women’s mental health needs, utilization, and disparities (Pyant & Yanico, 1991; Smith & Wermeling, 2007; Avalon & Young, 2005; Utsey, Ponterotto, Reynolds, & Cancelli, 2000). One of the unique features of cultural democracy includes the desire to empower a group and assist in giving voice to an oppressed group and/or community. It moves beyond simply obtaining and acquiring knowledge of a cultural group and focuses on shifting the power relationships between individuals, communities, and cultural groups with the dominant society (Akinyela & Aldridge, 2003). It is important to understand that values, ideas, and mannerisms are culturally driven and when the dominant culture interacts with other ethnic/cultural groups who do not exhibit their values and social norms, they tend to pathologize that group or culture (Akinyela & Aldridge, 2003). To combat this pathologizing of behavior
social workers must center the questions they ask in the context of that individual/culture that challenge Eurocentric models.

It is extremely important to obtain the basic skills to begin the journey of cultural competent service delivery especially when working with African-American women. More importantly, social work practitioners need to be committed to challenging the power dynamics and various forms of oppression African-American women face. Whether practicing on the micro (individual), mezzo (community), or macro (society/policy) level, social work practitioners have to be committed to giving voice to those they serve and assisting them in challenging the power dynamics that negatively impact their mental health.

National Association of Social Workers (NASW)

The National Association of Social Workers (NASW) also stresses the importance of cultural competent practice as a way to combat disparities in health care. The code of ethics section 1.05 Cultural Competence and Social Diversity clearly states the following: (a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures; (b) Social workers should have a knowledge base of their clients’ cultures and be able to demonstrate competence in the provision of services that are sensitive to clients’ cultures and to differences among people and cultural groups; and (c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical
disability (NASW, 1999). Cultural groups are distinguished by their unique socialization process. Members of a social cultural group may share a sense of history. In mental health care services culturally different clients have often been misunderstood by professionals that have resulted in misdiagnosis and inappropriate treatment (Ka’opua, 1998). Practitioners may experience a lot of anxiety when working with diverse clients however, the balance lies in understanding the culture of the person being served and the great amount of difference within that culture (Ka’opua, 1998). Culture continues to affect the incidence, prevalence, severity, course, and treatment of mental health problems resulting in the continued need for competent services, clinicians, systems and policies.

**Appropriate Treatment Modalities**

African-American women hold a great need for mental health services but receive effective treatment the least. Most therapeutic approaches correspond with western individualistic terms, values, and beliefs. However, African Americans often tend to be more group-centered, more sensitive to interpersonal matters, and tend to value cooperation more than middle-class Europeans (Smith & Wermeling, 2007).

In Saggese’s (2005) article, “Maximizing Treatment Effectiveness in Clinical Practice: An Outcome-Informed, Collaborative Approach”, he discussed the issues surrounding uniformity in diagnosing mental illness. He also discussed a comparison of four therapeutic modalities as it related to the treatment of depression. Those four approaches included Becks cognitive behavioral therapy, antidepressant medication, placebo, and interpersonal therapy. The findings revealed no significant difference as it
relates to clinical outcomes between the four, diagnosis did not help in treatment planning or selection, and diagnosis provides no meaningful information to a therapist about how to proceed with care. Therefore, the significance placed on the labeling (diagnosing) of consumers may not always be as useful as one may think. Saleebey (1994) noted a contradictory relationship between the DSM-IV as it relates to the accurate diagnosing of a consumer. He noted that the DSM-IV relies partially on consumer narrative of symptoms and issues but is qualified by the practitioner’s interpretation/perspective of those issues, symptoms and narrative which then overrides the consumer’s story. This tension and labeling can contribute to African-American women’s reluctance to seek services. It is imperative when treating African-American women not to listen and engage in dialogue solely to box them into a diagnostic label because this has the potential to be just as damaging as a stereotype or racial slur (Saleebey, 1994). Diagnosis is usually the starting point of therapeutic interventions, for some practitioners this actually drives the direction of treatment or at the very least the selection of treatment modalities especially within the new managed care environment. Consideration to race, class, and gender must be given when selecting an appropriate diagnosis and treatment modality.

**Narrative Therapy**

Narrative therapy is a form of psychotherapy that centers itself in the culture and empowerment of the individual being served. This requires the practitioner to establish a link between individual constructions and the larger environment of social institutions and culture as well as examine how a theory of practice is also a symbolic construction or
story (Saleebey, 1994). This assists the practitioner in understanding that people position themselves in the world by creating meaning which is viewed through their culture lens. Narrative therapy is a way to bridge a practitioner’s theoretical framework and consumer’s story and culture. This is effective when serving African American women because they are members of two oppressed groups (African Americans and women) that rarely get the opportunity to tell their stories from their perspective assigning their meaning (Saleebey, 1994). Take all three of the successful women discussed earlier, they all seem to get a certain level of healing by telling their stories of abuse from their perspectives and assigning their own meaning to the experiences. Saleeby notes that as more women tell their own story and as stories are told about women they then begin to construct their own self meaning and create more opportunities to tell their stories of oppression, poverty, and abuse. Oprah Winfrey’s comment about Maya Angelou’s book is a great example of the previous statement. When she read of Maya Angelou’s victimization it assisted her in her own healing because there was a woman she could relate to, a story she could inform and tell as well. When a practitioner uses narrative therapy, he/she is giving voice to the woman and allowing her to tell her story, symptoms, issues, goals, and desires as she sees relevant through her cultural and gendered perspective. By doing so, treatment can be tailored to work on the things she sees important for her recovery in a way that is comfortable with her position in her community and family and consistent with her cultural beliefs. By giving voice, a practitioner can also empower women to challenge the power dynamics she may face in her everyday life (i.e. racism, male-female relationships, etc). This form of intervention
also appears to be consistent with the concepts of cultural competence and cultural
democracy.

**Feminist Therapy**

Feminist therapy is the infusion of cognitive behavioral techniques, women’s
psychology, social activism, and developmental research. Feminist therapy’s basic
premise is that political is personal; you cannot ignore the social, cultural, economical,
and political influences and circumstances of a person’s life and have lasting change
(Evans, Kincade, Marbley, & Seem, 2005). This model emphasizes the following
(Rhodes & Johnson, 1997):

1. A woman’s vulnerable position within the larger society;
2. Shifts focus from internal deficits to environmental issues as a source of stress;
3. Recognition of oppression and its effects;
4. Recognition of the complex intersection of race, class, and gender;
5. Acknowledges the full and holistic context of a woman’s life and the roles she
   plays within her family, community, and society as a whole;
6. Addresses the effects of internalizing external sources of stress;
7. Centering therapy in the lived experiences of the women;
8. infuses empowerment and strengths based perspectives;
9. challenges power dynamics;

Feminist therapy approaches assessment and diagnosis differently than traditional
approaches. For example when considering a diagnosis derived from the DSM IV, the
therapist critically thinks about the diagnosis and questions the origins and embedded assumptions as well as its social implications for the consumer. Feminist assessment looks at women’s symptoms as an expression of her life experiences and attempts to deal with oppression. It reframes women’s symptoms as (Evans, Kincade, Marbley, & Seem, 2005):

1. The experience of role conflict;
2. Coping strategies for surviving oppression;
3. Deviation from traditional gender roles resulting in labeling.

Feminist therapy is more of a collaborative approach to treatment and recovery and diffuses the power dynamics found in traditional approaches. Consumers are considered valid contributors to the direction of therapy and play a role in the decision making of treatment (Evans, Kincade, Marbley, & Seem, 2005).

Feminist and Narrative therapy are appropriate for treatment of African-American women because it centers the treatment in the lived experiences of the women as it relates to gender, race, and class. It is used as a tool of empowerment and social change which recognizes the multiplicity of African-American women. Both approaches rely on and relate to the cultural grounding of the individual and honors what the woman brings to the therapeutic process. It is this theoretical foundation that can serve as a springboard for effective mental health treatment.

There are a number of treatment modalities that are used within numerous therapeutic approaches. Those modalities include individual counseling, family counseling, and group therapy. Some therapist use insight oriented approaches, skill
focused, and/or behavioral change interventions just to name a few. However, the actual modality used is not as important as the philosophical and therapeutic foundation on which they are laid. What is the purpose of the group session? To change the individual based on western knowledge or provide a venue for women to come together and share their stories and give voice to each other as it relates to depression, abuse, or race, etc. Are gender, class, and race being considered? Is the social, economical, cultural, and political context being considered? What power dynamics are being challenged? Are you providing cognitive behavioral therapy to women and assisting her with reframing her thinking and then sending her out into a social world that oppresses her? Or are you assisting her in telling and reframing her story as an African-American woman in a world that opposes her gender and race? Are you giving her a voice to change and challenge her status in this world? Those are the questions that need to guide treatment for African American women.

Conclusion/Discussion

The medical experimentation and psychiatric treatment of enslaved Africans and African Americans have a profound influence on the levels of trust, respect, and use of the health and mental healthcare system by African Americans. Knowledge of their history of racial discrimination has been associated with the reluctance to participate in medical and clinical research, to trust researchers and clinicians, and influences their help seeking behavior (King, 2003). The underlying causes of health and mental disparities are multifaceted and societal issues like institutionalized racism, discrimination, socioeconomic issues, and poor access to health care and community resources play a
significant role in the disparities (Piescia, Herrick, & Chavis, 2008). When one couples the historical context of African Americans and all they have endured within this country with social circumstances like poverty, poor quality of education, discriminatory policies and practices, and discrimination and racism, it fosters a volatile relationship between healthcare systems and this cultural group. Although the acknowledgement of disparities and social circumstances has stimulated a response from mental health professionals to include cultural competence and culturally relevant services, the overall system can sometimes institute policies and programs that function as barriers to implement those practices such as managed care. It is imperative that culture continues to play a significant role in the understanding, research, service development and delivery when addressing the mental health needs and help seeking behavior of African Americans.

Practitioners need to be aware of the historical context that impacts the mental health of African Americans, specifically African-American women. This historical perspective includes the knowledge of the medical experimentation of African Americans (dating back to slavery), the treatment and interaction with psychiatric institutions and systems, and how those cultural experiences inform help seeking behaviors of African Americans (Jackson, 2001). It is also vital that clinicians who treat African-American women in the mental health sector be well versed in the body of literature that documents the mental health disparities facing African-American women.

The literature reviewed clearly outlines various topics related to the mental health treatment of African Americans and African-American women. Topics like mistrust and fear, access, prevalence of mental health issues, the cultural barriers to treatment, the
need for cultural competence, and finally appropriate treatment modalities. However, three gaps exist in the literature: (a) class differential, very little research focus on middle-class African-American women as it relates to mental health treatment, (b) the private sector of mental health services, and (c) the theoretical framework(s) of private practitioners that guide the treatment specifically for middle-class African-American women. Additionally, the use of qualitative methodology when exploring the issue of mental health treatment for middle-class African-American women is limited.
CHAPTER III

METHODOLOGY

The purpose of this chapter is to layout in detail the methodology proposed to explore the theoretical/philosophical frameworks, treatment, engagement, and diagnostic approaches of private practice therapists who treat middle class African-American women. This research study seeks to gain understanding of the following research questions:

RQ1: How does the theoretical/philosophical framework employed by private practitioners influence their approach to treating middle-class African-American women?

RQ2: In their opinion and experience, what influences middle-class African-American women to seek treatment in the private sector?

RQ3: What factors impact the choice of interventions used when treating middle-class African-American women?

This chapter discusses the research design and its appropriateness for exploring this phenomenon. The population is presented along with the sampling and data collection procedures, a description of the proposed data analysis, and methods used to ensure the validity and reliability of this study. Finally, this chapter concludes with a discussion of the study’s limitations and researcher’s bias.
Qualitative Design

Qualitative inquiry seeks to learn how and why people think, behave, and make meaning the way they do as opposed to focusing on what people do. This type of inquiry falls within the context of discovery and its appropriateness is determined by the nature of the social phenomenon being explored (Ambert, Adler, Adler, & Detzner, 1995; Morgan & Smircich, 1980). Creswell (2007) defines Qualitative research in the following manner:

Qualitative research begins with assumptions, a worldview, the possible use of theoretical lens, and the study of research problems inquiring into the meanings individuals or groups ascribe to a social or human problem. To study this problem, qualitative researchers use an emerging qualitative approach to inquiry, the collection of data in a natural setting sensitive to the people and places under study, and data analysis that is inductive and establishes patterns of themes. The final written report or presentation includes the voices of participants, the reflexivity of the researcher, and a complex description and interpretation of the problem and it extends the literature or signals a call for action. (p. 37)

Creswell also identifies nine characteristics of Qualitative Research Natural Setting: the researcher collects the data in the participants setting as opposed to bringing the participant into a "lab" or sending the instrument to them. The researcher has face to face interaction with participants and is able to observe the participants in their own environment.
1. Researcher as a key instrument—the researcher actually gathers the information by conducting interviews, observing, and reviewing documents.

2. Multiple sources of data—data are collected through observation, interviews, and documents.

3. Inductive data analysis—the researcher builds his/her patterns and themes from the bottom up.

4. Participants meaning—the focus and importance is placed on the meaning the participants give to an issue not the researchers meaning.

5. Emergent design—all phases of the process may shift based on findings at the various stages.

6. Theoretical lens—having a theoretical framework in which to view the study.

7. Interpretive inquiry—researchers interpret what they see, hear, and observe.

8. Holistic account—charged with reporting and interpreting multiple perspectives and factors. They are also charged with showing the bigger picture.

**Qualitative Approaches and Methods**

There are several approaches to qualitative research however; Creswell (2007) notes five major approaches:

- **Narrative Research**—This approach focuses on the lived experiences of individuals that are communicated through their written or verbal stories of a particular event or events;
- Phenomenological Research—Describes the meaning for several individuals of their lived experiences of a concept or a phenomenon (p. 57). The focus is to understand the essence of a particular issue (i.e. trauma);

- Grounded Theory—Moves beyond description and to generate or discover a theory, an abstract analytical schema of a process (p. 63). The theory is found in the data collected and has the potential to explain a practice or provide a framework for further research;

- Ethnographic Research—This approach is used to study a group's values, beliefs, language, and behavior that are bound by the sharing of culture;

- Case Study—Involves the study of an issue explored through one or more cases within a bounded system. (p. 73)

Creswell indicated that grounded theory is useful in approaching qualitative inquiry that does not have an available theory or model to explain the process or the available theories do not adequately capture the focus of the current study; a theory is needed to explain how a phenomenon or process is experienced by an individual or group; and/or questions asked of the participants focus on understanding how the process is experienced. This study used a grounded theory approach to qualitative research in efforts to explore the theoretical frameworks that influence the approach employed by private practitioners when treating African-American middle-class women. Although there are not many studies that look at theoretical frameworks/orientation from the perspectives of practitioners as it relates to the treatment of African-American women, the majority of studies that look at any kind of phenomenon from a practitioners or
therapist perspective usually used a grounded theory approach (Olmstead, Blick, & Mills, 2009; Chang, Buranosky, Dado, Cluss, Hawker, Rothe, et al., 2009; Wainwright, Shepard, Harman, & Stephens, 2010; Rober, Elliott, Buysse, Loots, De Corte, 2008). For example, a study conducted by Olmstead, Blick, and Mills (2009), explored how therapists treat infidelity and work towards forgiveness with couples presenting with extramarital involvement from a therapist perspective. The grounded theory methods of open, axial, and selective coding were used. Another study that looked at health professionals comfort level in dealing with intimate partner violence used a grounded theory approach to explore this issue from the health professionals’ perspective (Chang et al., 2009). Additionally, a study that looked at physical therapist perspectives on the clinical decision making process used a grounded theory approach to explore those concepts and generate theory (Wainwright et al., 2010). This study’s goal was to understand the role theoretical frameworks play in the decision making of private practitioners as it relates to treatment steps, approaches, and interventions used when treating a very vulnerable population (middle-class African-American women).

A grounded theory qualitative approach was chosen for this study because it is well suited for addressing topics that have little empirical research, allows for a very detailed understanding of a complex issue, and is appropriate approach to research when meaning and understanding is the desired outcome (Turner, Wallace, Anderson, & Bird, 2004; Creswell, 2007). This topic has not been explored from the provider’s perspective and I wanted to generate specific and detailed data in regards to their perspectives of the middle class African-American women they treat, their theoretical/philosophical
undercurrents, the approaches they use, and their evaluation of the women’s help seeking behavior. Quantitative methods would not capture the depth of those issues; the amount of detail needed, or give meaning to the findings. There may be a story that these practitioners hold and or an approach that can be captured in the interviews that were conducted. Additionally, the literature does not provide a theoretical framework other than grounded theory that can serve as a guide for exploration of this phenomenon.

**Sample Selection**

According to Patton (2002), sampling approaches exemplifies the difference between qualitative and quantitative methods better than anything else. Qualitative samples are typically small and focus more on depth than breadth, whereas quantitative sampling depends on randomly selected larger samples (Patton, 2002). Randomized sampling controls for sampling bias and provides a statistical representation that allows for generalizing the findings to the larger population. However, in qualitative sampling, a more purposeful approach provides more in rich information that allows for an in depth understanding of the topic at hand versus empirical generalizations (Patton, 2002).

There are various sample selection methods and traditionally, when using a grounded theory approach, theoretical sampling is employed. Theoretical sampling is when a researcher selects a sample based on the input they can provide to the development of a theory (Creswell, 2007; Patton, 2002). The sample selection method used for this study was a combination of theoretical sampling and what Creswell and Patton calls a purposeful sampling strategy in that the participants used informed the research problem/questions at hand (Creswell, 2007; Patton, 2002; Byrne, 2001). In this
research, the private practitioners selected for the sample hold a specific set of information, perspective, and knowledge about the middle class African-American women they treat and the theoretical frameworks that drive their treatment approach when serving them. They also contributed to the development of a theory as it relates to the influence of their theoretical frameworks on treatment approaches to the specified population.

Although there are numerous sampling strategies used in qualitative research, this study employed a combination of snowballing and criterion sampling strategies. Snowballing is the technique of securing additional participants from the recommendations of current participants (Byrne, 2001). By asking current participants to refer other people who meet the sample criterion the sample increased in information rich data. As the snowballing technique was used, the theoretical sampling strategy emerged as well.

Criterion sampling is identifying potential participants based on predetermined characteristics (Patton, 2002). In this study, the licensure and professional status of the private practitioners is a predetermined criterion that is vital to research questions. Therefore, advertising to the three major professional organizations Georgia chapters (Georgia Association for Marriage and Family Therapy, Georgia Society for Clinical Social Work, and Licensed Professional Counselors Association of Georgia) was a good place to look for viable participants.
Sample Criterion

Statistical generalization was not the goal of this study or qualitative research for that matter; therefore, purposeful sampling was most appropriate. Additionally, the findings of this study are not generalizable to the larger population; however, they are detailed enough to begin the exploration of the influence theoretical frameworks have on private practitioners’ approach to treating middle-class African-American women. The sample criteria that assisted this researcher in selecting this sample that held the particular information relevant to this study was vital. To participate in this study, all participants meet three criteria:

- Be a fully licensed private practitioner;
- Have at least five years clinical experience;
- Serve or have served middle-class African-American women within the last five years.

A license is permission given by a competent authority to practice or render a certain service (Webster, 2010). In order to receive a license in social work, professional counseling, marriage and family therapy, or psychology; a certain amount of education and training needs to be obtained. Also, a candidate must pass a written exam. The acquisition of a license (i.e. Licensed Clinical Social Worker [LCSW], Licensed Professional Counselor [LPC], Licensed Marriage and Family Therapist [LMFT]) relays to the general public that you have received and demonstrated the training necessary to provide counseling. This criterion is directly related to the ability to provide therapeutic
services to African-American women as well as demonstrates a working knowledge of theoretical perspectives related to counseling.

The second selection criteria of at least five years experience was established based on licensure standards of supervision. All of the disciplines standards for clinical supervision require three to five years of post licensure experience to qualify as knowledgeable and competent to teach clinical standards. When you couple the three to five years post experience with the three to four years experience needed to qualify for licensure you reach a total of six to nine years of clinical practice. General competence to provide counseling services and experience is needed to explore the theoretical undercurrents that influence the treatment approaches of private practitioners. Therefore, the same expectations of competence applied to licensure supervision were applied for the purpose of this study.

The third sample criterion directly relates to the population affected by the theoretical frameworks employed by the practitioners. It would not be beneficial to explore this phenomenon with practitioners who have never served or haven’t recently (within five years) served middle class African-American women.

Sample Procedures

An email was constructed and sent to the three major professional organization’s Georgia chapters as well as participants already identified through the snowballing effect. The email contained the following (see Appendix A):

1. Introduction of the researcher
2. Purpose of the email
3. Brief description of the study and its purpose

4. Eligibility requirements for participation

5. Expectations for participants

6. Contact information

Participants began responding to the email solicitation in April 2010. Upon initial contact, participants who responded were screened for eligibility by confirming there alignment with the three sample criterion. Upon confirmation of eligibility, participants were informed that participation is voluntary and they have the right to end participation at any time throughout the study. Each participant committed to a one-time 60 to 90-minute interview and a time and location was confirmed. The researcher continued recruitment of participants until the point of saturation in data collection was reached.

**Research Site and Sample Size**

All of the interviews were conducted within the state of Georgia and more specifically in a location convenient for and identified by the participant. The state of Georgia currently has 4,034 Licensed Professional Counselors, 2,713 Licensed Clinical Social Workers, and 655 Licensed Marriage and Family Therapist (GA composite board, 2010). Therefore, the potential sample pool totaled 7,402. However, Patton (2002) explains that there are no rules for sample size in qualitative research. Sample size is driven by the purpose of the inquiry and what will be useful, as well as available time and resources. This study sample size consisted of eight participants who meet sample criterion. It is important to keep in mind sample size as it relates to qualitative inquiry and the desire for in-depth rich information as opposed to statistical representation and
generalization. This study did not seek to generalize but rather collect rich in depth information.

**Data Collection Strategy**

Qualitative research generates various forms of data which can be grouped into four categories, observation, documents, audiovisual material, and interviews (Creswell, 2007). Regardless of the form of data collected, the goal is to express someone’s perspective or experience (Patton 2002). The primary source of data collection for this study was a one-on-one in-depth semistructured individual interview with participants. Qualitative interviewing is designed to discover the interviewees’ framework of meanings and open up many new areas of research that is relevant to clinical practice (Britten, 1995). I was interested in the practitioners’ descriptions and meanings of the theoretical frameworks used and its influence on treatment approach and choices when treating middle-class African-American women. The purpose of interviewing participants was to discover and explore their perspectives and to gather their stories (Patton, 2002).

There are three types of interviews (Britten, 1995):

1. Structured interviews consist of administering structured questionnaires in a standardized manner.

2. Semistructured interviews are conducted in a loose manner consisting of open ended questions that define the area to be explored. An interviewer may diverge in order to explore a topic in more detail.
3. In-Depth interviews are less structured and may only cover one or two issues in great detail.

One-on-one in-depth semistructured interview was chosen as the primary data collection method because interviews afford the following benefits (Creswell, 2003):

1. Useful when participants cannot be observed directly;
2. Allow for open and honest communication without external influences;
3. Gives the researcher the opportunity to ask additional questions based on responses;
4. Allows the participant to attach meaning to the phenomenon in question;
5. Allows the researcher to observe body language and the context in which statements are made;
6. Allows for depth of the issue to be explored.

The researcher was interested in the practitioners' descriptions and meaning they place on theoretical frameworks used when serving the specified population as well as how it influences the treatment approach. Also, grounded theory inquiry is usually gathered through in-depth interviews (Creswell, 2007).

**Data Collection Procedures**

This study used a qualitative methodology consisting of in-depth semistructured one-on-one individual interviews. Additional demographic data was collected via a survey. This researcher prepared to conduct the interviews by purchasing a digital recorder, securing a transcription service, and developing and using an interview guide.
An interview guide outlines topic areas that the researcher can explore and helps to use
the limited time available in the best possible manner (Patton, 2002).

During the one-on-one interview, the written informed consent was presented to
the participants and upon comprehension of consent; the form was be signed by the
participant and collected by the researcher. Issues of confidentiality, as they related to
data analysis and storage, were discussed with each participant as well. Participants were
then asked to complete a short 12-item demographic survey which captured education
level, race, gender, years of practice, population served, insurance accepted, service
pricing, and the names and contact information of recommended participants (see
Appendices B, C, and D). Prior to beginning the interview, each participant was asked to
pick a first name other than their own to be used as a pseudonym to enhance
confidentiality and to be used for data representation within the findings chapter.
Throughout the interview, this researcher took notes and documented nonverbal as well
as my overall perception of the interview.

Upon completion of the survey, the 60 to 90-minute audio recorded interview
began. The researcher used an interview guide that consisted of the following questions
and probes:

1. Theoretical/philosophical orientation and training
   a. Tell me about your training on counseling theories
   b. Which theory do you see fitting for your work in mental health? Why?
   c. Which theory do you see fitting when serving middle class African-American women?
d. Describe the factors that contributed to the development of your theoretical orientation.

e. What value do you place on your theoretical orientation as it relates to your treatment choices and outcomes?

2. Theoretical/philosophical framework employed when serving middle-class African-American women

a. Walk me through the treatment of a middle class African-American woman you have served.

b. Did race, gender, or both influence your treatment choices? Why or Why Not?

c. Describe the connection of your theoretical orientation and treatment choices used with the scenario you described?

3. Explain how your theoretical/philosophical framework influence the following when serving middle-class African-American women:

a. treatment approach

b. treatment decisions

c. interventions used

4. From your perspective, what factors impact the middle-class African-women you serve to seek mental health services in the private sector?

a. From the women you have served, what factors appear to be unique to middle class African American women seeking your services?
b. In your opinion, which factor appears to be the most influential in their decision to seek services?

c. Why do you think they choose mental health services in the private sector?

d. What factors impact their willingness to continue mental health treatment with you?

e. Is treatment successful? Why or why not?

f. What would you want a therapist to know who has never worked with middle class African American women?

5. Housekeeping questions

a. Are you willing to participate in a member check to ensure the information I collected today adequately represents your perspectives?

At the conclusion of the interviews, participants were thanked for their time.

Data Analysis

Data analysis in qualitative research is the process of translating the data into findings. Although there are directions and guides to the process of qualitative analysis, no particular formula exists. Unlike quantitative data analysis, qualitative data analysis occurs simultaneously. However, qualitative researchers are obligated to monitor and document the analytical procedures completely and truthfully (Patton, 2002). The analytical process used by a qualitative researcher will be influenced by the theoretical framework used in the study. Therefore, grounded theory heavily shapes the proposed analysis for this study.
Grounded theory analysis does not prescribe particular data collection techniques; however, analytical strategies are usually employed. Strategies like simultaneous data collection and analysis, constant comparative analysis, coding, memoing, and development of the theoretical framework (Ward, 2005; Creswell, 2007). All of the previously mentioned strategies were used in this study.

Constant comparative analysis is dissecting the data line by line into meaningful units of analysis and comparing those units or categories to the emerging data in order to develop and saturate the category (Creswell, 2007). Prior to receiving the transcript and engaging in comparative analysis, the researcher conducted a preliminary analysis after each interview which consisted of listening to the interview, adding to the notes and memoing while listening, and typing up the finalized notes from that interview. The first phase of constant comparative analysis began with open coding, upon receipt of the transcript, the researcher read it a couple of times while listening to the recorded interview and made corrections to the transcript and additional notes. The researcher then examined each transcript line by line and made notes and identified categories. The researcher also made a theoretical note after analyzing each transcript. This phase allowed the researcher to discover and describe the activities and events of the phenomenon from the practitioners' perspective (Ward, 2005; Creswell, 2007). The next phase of analysis is axial coding, in which this researcher identified a central category and then looked to the data to see what caused this phenomenon to happen, in what context, and what resulted from this process. Basically this researcher connected categories of information to the central category. This process continued for each piece
of data and in turn this researcher became familiar enough with the data to recognize when saturation was reached. The final phase of coding was selective coding. In this phase, the researcher took the central phenomenon and explored its relationship to other categories and subcategories in order to generate statements of relationship that was used for substantial level theory development (Creswell, 2007). Substantial level theory is a theory developed to explain a particular situation or context and lacks the kind of abstraction and applicability found in more formal theories (Creswell, 2007). The process of memoing assisted me in the development of the emerging theory. Throughout the data collection and analysis process, the researcher documented (memoing) the information learned, reflective thoughts, ideas, insights, and theoretical development (Ward, 2005; Creswell, 2007). Based on the emerging themes and theory found in the data, various questions may be added to the subsequent interviews to better inform and explore those theoretical categories or content (Ward, 2005; Creswell, 2007). This process continued until the sample size of 15 was reached or saturation. Saturation is the point in the process where no new information is being generated. Once saturation was obtained, which was the point in which no new information was generated from the interviews, the developing theory was integrated into a model (Ward, 2005; Creswell, 2007).

The interviews produced an abundance of information. However, all of it was not relevant to the research questions in this study. Additionally, some of the information was important to the study but was not preponderant so that information was included in
the participant descriptions and discussion. This researcher presents the preponderance of data in the findings chapter.

**Trustworthiness**

Qualitative research although very different from quantitative inquiry is still a methodological way of looking at phenomenon therefore issues of rigor are equally important. Discussions on what to call rigour and how to evaluate it in qualitative research are heavily documented and depending on your philosophical approach or standpoint, rigor can be judged differently in qualitative research (Patton, 2002; Creswell, 2007). Validity and reliability are terms used in quantitative research and refer to the accuracy and the ability to generalize the findings to other populations, settings, and samples (Creswell, 2003). Although, generalizing findings in qualitative research is rarely a goal, accurate representation of your findings, research process of data collection, procedures, etc are very important. Creswell defines validation in qualitative research as “an attempt to assess ‘accuracy’ of the findings” (Creswell, 2007, p. 206). He also notes that validation validity is an important factor in qualitative research and accepted strategies should be used to ensure the accuracy of the findings (Creswell, 2007). Validation and reliability strategies are addressed in the following sections.

**Internal Validity**

Patton explains that the creditability (internal validity) of qualitative research depends on three elements, rigorous methods that pay attention to detail and uses a systematic approach to analysis, the credibility of the researcher which is influenced by
experience, training, status, and self presentation throughout the study, and finally, the philosophical belief in the value of qualitative inquiry (Patton, 2002).

This researcher used three strategies to ensure the validity of this study, analyst triangulation, member checking, and peer review. Analyst triangulation is the use of two or more analysts to review the data and findings in this study, the emerging categories, and theory to corroborate and double check the accuracy of the findings (Patton, 2002). Using this validation strategy reduces the bias in data collection. For this study, a committee member who served as my methodologist also served as the second reviewer of the collected data.

Member checks refer to the process of taking findings back to participants to determine the accuracy of the interpretations identified by the researcher (Creswell, 2007; Patton, 2002). The researcher selected two participants to provide a member check for this study. Both of the participants felt that their perspectives were accurately conveyed in the interviews. Only one of the participants added a clarification to one of the statements made during the interview. This process was used to corroborate the findings and substantiate the creditability of the study.

Peer review or debriefing consist of the researcher and a peer (s) discussing the research, findings, and researcher’s feelings. The peer asks “the hard questions about methods, meaning, and interpretations” (Creswell, 2007, p. 208). This researcher used a peer who is experienced and knowledgeable in qualitative methods to serve as a reviewer for this study. We met on three separate occasions throughout the data collection and
analysis process and discussed the processes, analysis, theory, and interpretations of the data.

**Reliability**

Dependability (reliability) emphasizes the need for the researcher to account for the ever-changing context within which research occurs (Trochim, 2006). The validation strategies that were used in this study also add to the reliability of the study. Additionally, the researcher kept an audit trail that documented the memos, clarified bias by clearly stating the researcher’s position, assumptions, and experiences that have shaped the approach to this research. The researcher also gave detailed descriptions when reporting the findings of the study (Creswell, 2007). Reliability was also addressed by this researcher with the use of audio recorded interviews and transcription to ensure accuracy of information shared.

**Confidentiality**

Confidentiality and proper storage of data is important. The data generated during the data collection process were memos and field notes both written and typed, transcripts from the transcribed interview, consent forms, and digital recording of the interviews. The digitally recorded interviews were kept in a folder on the researcher's personal password protected laptop. All hardcopy documents mentioned above was stored in a locked file cabinet in this researcher’s home. Only the researcher, committee members, and peer reviewer had access to the various forms of data. Additionally to ensure confidentiality of participants, pseudonyms were used in lieu of real names. The
data collected will be kept by this researcher for three to five years after completion of the interviews and after the specified timeframe all data will be destroyed.

**Researcher’s Bias and Assumptions**

It is important to acknowledge the inherited bias the researcher brings to the research, both professionally and personally. Professionally, the researcher is a Licensed Master Social Worker (LMSW) and has clinical experience in providing direct counseling service. The researcher currently works as an auditor trainer and quality improvement coordinator for a company in which the researcher evaluates behavioral health agencies to ensure adequate service provision to consumers of mental health. This influences the researcher’s perspective because of the “standards” of quality expected as it relates to the provision of mental health services.

This researcher is an African-American woman with cultural and historical ties to the population in which this inquiry is grounded. The researcher also knows several middle-class African-American women who deal with mental health issues like depression and anxiety but are reluctant to seek services in the traditional mental health arena. The friends who do choose private therapist do so because it is “undocumented care.” The researcher’s place in this world as an African-American woman and all that this position means, have helped to shape the researcher’s interest in black women who have reached a certain economic status in this country.

This dynamic places the researcher at an insider outsider position. As a professional therapist the researcher has ideas about theoretical frameworks and there use in therapy. The researcher also has ideas about the issues impacting mental health
disparities. Additionally, as an African-American woman, the researcher has ideas regarding the barriers to seeking treatment, the reasons for choosing private practitioners, and how a therapist should approach treatment. All of these experiences and perspectives come together to create bias. This researcher is unable to eliminate bias; however, they can be minimized by making them transparent and the use of memoing.

**Summary**

This chapter presented the methodology used in this study. It included a discussion of the designed used, sample selected, data collection and procedures, as well as issues of validity and reliability. Additionally this researcher’s bias and assumptions were discussed as well. Chapter four presents an in-depth description of the study participants as well as the findings of this study.
CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

The purpose of this qualitative study was to explore the theoretical/philosophical frameworks, treatment, engagement, and diagnostic approaches of private practice therapists who treat middle-class African-American women. This research study seeks to gain an understanding of the following research questions:

RQ1: How does the theoretical/philosophical framework employed by private practitioners influence their approach to treating middle-class African-American women?

RQ2: In their opinion and experience, what influences middle-class African-American women to seek treatment in the private sector?

RQ3: What factors impact the choice of interventions used when treating middle-class African-American women?

This study used a grounded theory qualitative approach and was conducted from April 2010 to July 2010. Prior to the collection of data, Institutional Review Board (IRB) approval was received from the Clark Atlanta University Institutional Review Board. Upon receipt of approval, private practitioners who met the sample criterion were recruited using an email circulated through Georgia’s three major professional organizations and the snowballing method. Eight private practitioners were selected and
interviewed for 15 to 77 minutes. Seven of the interviews were conducted in the private offices of the participants and one
interview was conducted at a local Starbucks coffee shop. All of the interviews were
digitally recorded and professionally transcribed. Additionally, all participants reviewed
and signed a consent form and completed a demographic survey.

Four of the eight participants were asked to participate in a members check and all
agreed. Each of the four members were sent their completed transcribed interview via
email and asked to review prior to our discussion. Two of the participants were able to
complete the members check via telephone as a face to face follow up could not be
conducted due to scheduling conflicts. Both of the participants who completed the
member check felt that the transcript accurately reflected their perspectives on the topic
and questions asked. One participant provided additionally insight and clarification on a
couple of her statements. Her additions were noted and typed directly into the transcript
for analysis.

This chapter began with a detailed description of each participant in the order in
which they were interviewed as well as a description of the setting in which the
interviews took place. Following the individual descriptions, I provide the findings
reached through grounded theory analysis including the data to support the core
categories and properties. According to (Charmaz, 2009), memos are an important part
of grounded theory analysis (site someone here) therefore, I have included excerpts from
memos I wrote during the analytical process. This chapter concludes with a summary.

Participants Demographics

Eight private practitioners who were fully licensed as a Licensed Clinical Social
Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, and
Licensed Psychologist participated in face-to-face interviews that lasted 15 to 75 minutes each. Additionally, these participants met the sample criterion which included being fully licensed, having at least five years of clinical experience, and was serving or have served middle class African-American women within the last five years.

There were five females and three males, with ages ranging from 35 to 66. All of the five women and two of the three men identified as an African American with the last male identifying as Caucasian. Four of the participants do not accept private insurance but self-pay only, two participants only accept private insurance, and two participants accept both private insurance and self-pay. All participants had a masters degree or higher. The professional breakdown of the sample is as follows:

- Two Licensed Clinical Social Workers (LCSW) who were licensed for 15 years or more and had over 20 years of experience serving middle-class African-American women.

- Three Licensed Professional Counselors (LPC) who were licensed for 5 years or more and had 10 years or more of experience serving middle-class African-American women. It is important to note that one of the participants who is licensed as a LPC is also licensed as a marriage and family therapist. However, he was grouped with the LPCs.

- Two licensed psychologist, one who was licensed for at least five years and has served middle-class African-American women for those five years. The other participant has been licensed and serving middle-class African-American women for over 20 years.
One participant was a Licensed Marriage and Family Therapist who has been licensed for at least 15 years and has experience serving middle-class African-American women for more than 10 years.

Following is a detailed description of each participant. Confidentiality was protected through the selection of a pseudonym chosen by each participant. All information presented related to a particular participant use the pseudonym chosen by that individual. Direct quotes are used where appropriate.

Paul

The interview with Paul lasted 15 minutes and was conducted in his office at a university. Paul sat behind his desk and I sat across from him. The environment was quiet, private and appeared to be comfortable to the participant. He was very open and answered all of the questions posed by this interviewer. Paul is a 50 year old African-American man who practices counseling in the state of Georgia. His highest degree obtained is a doctorate and he is currently licensed as a Licensed Professional Counselor (LPC). Paul has served middle-class African-American women in private practice for 10 years and has been licensed for almost 15 years. In his practice, he only accepts self pay clients.

Paul described his training on counseling theories as follows: "my doctoral training and my master training at North Carolina State University, and any other training I got after that at conferences" (Paul, Personal communication, April 22, 2010). He identified Cognitive Behavioral Therapy as fitting when serving middle-class African-American women because of:
the behavioral component. I believe that sometimes you have to use a behavioral component on some clients. It depends on their situation. And once they get to a certain point in their therapy, you could switch to a more cognitive aspect. So the combination of the two seems to work best for most of the disorders that I deal with. (Paul, Personal communication, April 22, 2010)

When asked to describe the factors that contributed to the development of his theoretical orientation, his response was:

The factors—well, I developed that while I was in school, going through my masters program. In my undergrad, we dealt a lot with the behavioral approach and the cognitive approach separately. But in the masters program, we combined those two, and I saw that the cognitive behavioral approach gave me both aspects of those two theories. And research has shown that that theory alone helps more patients than probably any other theory out there. (Paul, Personal communication, April 22, 2010)

Additionally, Paul felt that his theoretical framework plays a significant role in his treatment approach when serving middle-class African-American women although it is not the sole factor.

Jack

The interview with Jack lasted 48 minutes. The interview took place at Jack’s practice in his waiting room. We were the only two people present during the interview and Jack answered all of the questions posed by this interviewer. The setting of the interview was very relaxing and conducive to a conversation. Jack appeared to be very
comfortable and open with this interviewer. Jack is a 46 year old Caucasian man who
practices counseling in the state of Georgia. His highest degree obtained is a Masters and
he is currently a Licensed Professional Counselor (LPC) and a Licensed Marriage and
Family Therapist (LMFT) in the state of Georgia. Jack has served middle-class African-
American women in private practice for more than ten years and he has been licensed for
at least five years. In his practice, he accepts private insurance and self pay.

Jack’s training on counseling theories consisted of “A program at Georgia State
University and Psychological Studies Institute that was dedicated to integrating
psychology and theology from the Adlerian perspective. So I’m trained as an Adlerian”
(Jack, Personal communication, May 7, 2010). When asked what theory he saw fitting
when serving middle-class African-American women his response was “it’s an
integration of Adlerian, solution-focused and an integration of a Christian understanding
of behavior modification, what promotes change, what’s curative from a Christian
perspective” (Jack, Personal communication, May 7, 2010). The previous noted response
prompted this researcher to ask can you define a Christian perspective? His response
was:

Yes. I would begin with, from a psychological perspective, in terms of how it
works out in practice, it’s an affirmation of resilience that comes from a faith
informed by the Bible, the inherent word of God and I don’t like the word dogma,
but in this case it applies, that there are beliefs that emerge from a Christian
understanding, and that’s the client’s understanding and my understanding, and
the negotiation of that. But ultimately, it’s summed up in Jesus’ words to love
God with all your heart, mind, soul and spirit and love your neighbor as yourself.

(Jack, Personal communication, May 7, 2010)

Jack places “a high value” on his theoretical framework as it relates to his treatment approach.

Toby

The interview with Toby lasted 46 minutes and took place in his private office. The environment was calm, welcoming, and appeared to be comfortable for the participant. Toby is a 56 year old African-American man who practices counseling in the state of Georgia. His highest degree obtained is a doctorate and he is currently licensed as a Licensed Marriage and Family Therapist. Toby has been licensed for over 15 years and has served middle-class African-American women for more than 10 years. Toby only accepts self pay clients. When asked about his training on counseling theories, Toby’s response was:

Well, I went to school in the 80s at a time when systemic or systems theory was very much in vogue for family therapists in particular. Bowenian Theory was very much in vogue, so I started out particularly with knowledge of systems. As I continued my work and did my research, I became personally interested in dialogical work, particularly influenced by Paulo Freire, and I later began to focus on discursive therapies; narrative therapy, solution-focused, and, I began developing my own ideas in terms of the relationship between discursive therapy and cultural issues, African-centered issues. My practice now is around what I call testimony therapy, which is related to other discursive therapies, such as
narrative therapy, solution-focused therapy. (Toby, Personal communication, May 14, 2010)

When asked what theory he saw fitting when serving African-American women, his response was, “This is my own practice, the work that I write about, and teach about, testimony therapy” (Toby, Personal communication, May 14, 2010). Interestingly, Toby only places fifteen percent value on theory as it relates to his approach to treatment.

Ester

The interview with Ester lasted 46 minutes and took place in her private office. The environment was soothing, cozy, and relaxing. Ester is a 66 year old woman who practices counseling in the state of Georgia. Her highest degree obtained is a masters and she is currently licensed as a Licensed Clinical Social Worker. Ester has been licensed for over twenty years and has served middle-class African-American women for more than 20 years. Ester accepts private insurance and self pay clients.

Ester described her training on counseling theories as follows: “I began my career in a predominantly psychoanalytic format, and over the years I’ve spent time through continuing education and just in in-depth exploration of different things. I don’t use any particular set theoretical formulation” (Ester, Personal communication, May 14, 2010).

When asked what theory she saw fitting when serving African-American women, her response was, “I don’t approach therapy that way to say that anything is—I begin where the client is, and I have the capability to adapt whatever my treatment approach is
to what I think is most appropriate to the needs of the client” (Ester, Personal communication, May 14, 2010).

**Patricia**

The interview with Patricia lasted 51 minutes and took place in a local Starbucks coffee shop. We secured a quiet table on the outside corner of the shop to minimize noise and secure privacy. Patricia was very open throughout the interview. Patricia is a 35 year old African-American woman who practices counseling in the state of Georgia. Her highest degree obtained is a doctorate and she is currently a Licensed Psychologist. Patricia has been licensed for at least five years and has served middle-class African-American women for five years as well. Patricia only accepts private insurance. Patricia described her training on counseling theories as follows:

This was in two parts in the Masters program and Ph.D. program and had actually kind of limited time, I guess, or focus, so it was actually one quarter in the Masters program, one semester, and talked about different theories such as cognitive behavioral therapy, rational emotive therapy, Ellis’s therapy that kind of fits somewhat with Beck’s college of cognitive behavioral systems theory; might have had family systems, Adlerian, client-centered, human-centered, existential. So those were the areas that were covered, probably more in depth in the Ph.D. program as far as what it would actually look like with a client. (Patricia, Personal communication, May 21, 2010)

When asked what theory she saw fitting when serving middle-class African-American women her response was:
Most often it’s probably systems and/or cognitive behavioral, and a big part of that is kind of doing somewhat of an assessment of the level of functioning of the client to see what would probably work best based on their diagnoses, their level of functioning, intellectual capacity, and who all is involved, who all is involved, because even though they may be the only person presenting, there are other people to consider as well as certain behaviors or patterns. (Patricia, Personal communication, May 21, 2010)

Patricia felt the significance of theory was based more on what the client brought to the table and therefore was different for each person.

**Diana**

The interview with Diana lasted 30 minutes and took place in her private office. The environment was quiet, private and appeared to be comfortable for Diana. Diana is a 57 year old African-American woman who practices counseling in the state of Georgia. Her highest degree obtained is a masters and she is currently licensed as a Licensed Professional Counselor. Diana has been licensed for over ten years and has served middle-class African-American women for five years as well. Diana only accepts private insurance.

Diana’s training on counseling theories consists of “mostly graduate work, counseling theories, and that was the first half of my masters degree program. We went over the counseling theories and perspectives. That’s about it” (Diana, Personal communication, June 4, 2010). When asked what theory she saw fitting when serving middle-class African-American women, her response was:
The humanistic side, the side where they can begin to do some real introspection and talking about self. And I think it's because a lot of the women I see, their root issue is around self-esteem, and so to me that works well because there are a lot of self-esteem, self-worth, deservability kinds of issues that come up, not really knowing how to love oneself and nurturing. Not that they're not good nurturers, they're great nurturers, except when it comes to nurturing self. So I get a lot of that. (Diana, Personal communication, June 4, 2010)

Additionally, Diana felt like theory was significant because there is value in the knowledge, not necessarily to approach treatment.

Sarah

The interview with Sarah lasted 77 minutes and took place at her private office. The environment was quiet, private and inviting. Sarah is a 49 year old African-American woman who practices counseling in the state of Georgia. Her highest degree obtained is a doctorate and she is currently licensed as a Licensed Clinical Social Worker. Sarah has been licensed for over five years and has served middle-class African-American women for more than 20 years. Sarah only accepts self-pay clients.

When asked about her training on counseling theories, Sarah's response was:

I have a master's degree in social work, which actually is a little unusual because my actual degree is in Women’s Issues and Social and Economic Development. I did most of my clinical work in my undergraduate—which was a pure sort of counseling program at the University—what’s now the University of Illinois, and probably more humanistic sort of counseling at that time. It was back in the 80s,
which was—that was cutting edge. In terms of ongoing training and just development is probably most informed by Family Systems work, sort of in the tradition of Monica McGoldrick, who does a lot of work around ethnicity and families, and narrative therapy, sort of coming out of the Michae. White school of work. Then sort of co-creating some stuff, pulling all that together with basic—what I like to believe is common sense, is working with people like Makungu Akinyela and Vanessa Moore around what we call sort of testimony therapy, which is sort of narrative therapy for black folks that looks at people very much in the context of their environment and how that impinges upon them. (Sarah, Personal communication, June 28, 2010)

When asked what theory she saw fitting when serving middle-class African-American women, her response was:

Testimony theory, which is just a derivative of narrative therapy. It’s because it sort of positions the person as the expert, it values their telling of the story and the themes that are important to them, and sort of, for me, checks the therapist, quite frankly, on who gets to define what the problem is. (Sarah, Personal communication, June 28, 2010)

Sarah did not feel that theory plays a significant role in her approach to treating middle-class African-American women.

Carey

The interview with Carey lasted 43 minutes and took place in her private office. Carey is a 66 year old African-American woman who practices counseling in the state of
Georgia. Her highest degree obtained is a doctorate and she is currently a Licensed Psychologist. Carey has been licensed for over twenty years and has served middle-class African-American women for over 20 years as well. Carey only accepts private insurance. When asked about her training on counseling theories, Carey’s response was:

I had been trained at the masters’ level as Transactional Analyst and Gestaltist, and combined the two. Then I went through a series of other trainings and modalities in the context of both the masters program and the doctoral program. The masters program was to be a Masters in Psychotherapy and Social Change in the 70s, and because it was through Loon Mountain College in California, they called it a Masters in Clinical Psychology and put Psychotherapy and Social Change as a subtitle. The doctoral program I went to was at Wright State. I was in the charter class of their Psy.D. program. So it focused on the applications of the study of human behavior, and we were required to work the entire time that we went to class. (Carey, Personal communication, June 28, 2010)

Carey believed redecision therapy was fitting for serving African-American women as well and she placed value on theory. Table 1 summarizes the individual interview participants’ information.
Table 1

Summary of Individual Interview Participants’ Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Race</th>
<th>Age</th>
<th>Sex</th>
<th>Licensure</th>
<th>Years Licensed</th>
<th>Years Serving</th>
<th>MC AA</th>
<th>Payment Accepted</th>
<th>Women</th>
<th>Payment Accepted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul</td>
<td>African American</td>
<td>50</td>
<td>Male</td>
<td>LPC</td>
<td>5-15</td>
<td>0-10</td>
<td></td>
<td>Private Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jack</td>
<td>Caucasian</td>
<td>46</td>
<td>Male</td>
<td>LPC/LMFT</td>
<td>5-15</td>
<td>11-20</td>
<td></td>
<td>Private Insurance &amp; Self-Pay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toby</td>
<td>African American</td>
<td>56</td>
<td>Male</td>
<td>LMFT</td>
<td>15-20</td>
<td>11-20</td>
<td></td>
<td>Self-Pay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ester</td>
<td>African American</td>
<td>66</td>
<td>Female</td>
<td>LCSW</td>
<td>21+</td>
<td>21+</td>
<td></td>
<td>Private Insurance &amp; Self-Pay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patricia</td>
<td>African American</td>
<td>35</td>
<td>Female</td>
<td>Licensed</td>
<td>5-15</td>
<td>0-10</td>
<td></td>
<td>Private Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diana</td>
<td>African American</td>
<td>57</td>
<td>Female</td>
<td>LPC</td>
<td>5-15</td>
<td>11-20</td>
<td></td>
<td>Private Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sarah</td>
<td>African American</td>
<td>49</td>
<td>Female</td>
<td>LCSW</td>
<td>5-15</td>
<td>21+</td>
<td></td>
<td>Self-Pay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carey</td>
<td>African American</td>
<td>66</td>
<td>Female</td>
<td>Licensed</td>
<td>21+</td>
<td>21+</td>
<td></td>
<td>Self-Pay</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Overview of Properties and Categories

The purpose of this study was to explore the theoretical/philosophical frameworks, treatment, engagement, and diagnostic approaches of private practice.
therapists who treat middle-class African-American women. Through grounded theory analysis, a model emerged which is called dynamics of mental health treatment, which displays this exploration (see Figure 1).

\[
\text{Figure 1. Dynamics of Mental Health Treatment}
\]

Analysis revealed that a knowledge and identification of a theory coupled with other contributing factors influences how therapists approach treatment. However, a client centered focus is the key component when developing and providing interventions to middle-class African-American women. Additionally, an understanding of why middle-class African-American women seek treatment in the private sector, (i.e. access, resources, and privacy) and the unique factors they bring to the table (i.e. Strength, resilience, strong black women syndrome), provide an atmosphere for successful treatment. Table 2 provides an outline of the research questions and categories.
Table 2

*Categories and Properties*

<table>
<thead>
<tr>
<th>Research Questions</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>RQ1: How does the theoretical/philosophical framework employed by private practitioners influence their approach to treating middle-class African-American women?</td>
<td>KNOWLEDGE AND IDENTIFICATION OF THEORY</td>
</tr>
<tr>
<td>RQ2: In their opinion and experience, what influences middle-class African-American women to seek treatment in the private sector?</td>
<td>OTHER CONTRIBUTING FACTORS</td>
</tr>
<tr>
<td>RQ3: What factors impact the choice of interventions used when treating middle-class African-American women?</td>
<td>INTERSECTION OF RACE, CLASS, AND GENDER RQ3: What factors impact the choice of interventions used when treating middle-class African-American women?</td>
</tr>
<tr>
<td></td>
<td>ACCESS, RESOURCES, AND PRIVACY</td>
</tr>
</tbody>
</table>

**Interview Question:** How does the theoretical/philosophical framework employed by private practitioners influence their approach to treating middle-class African-American women?

A variety of questions were asked in order to explore the theoretical/philosophical frameworks used by private practitioners and its influence, if any on how they approach
treatment with African-American women. The participants’ responses generated two core categories, knowledge and identification of a theory and other contributing factors.

**Knowledge and Identification of Theory**

All participants received training in their educational programs on counseling theories, identified a theory, and have acquired additional knowledge throughout their professional journey. The various theories or approaches noted by the participants were Cognitive Behavioral therapy, Testimony therapy, Redecision therapy, Humanistic approach, Eclectic approach, and Christian counseling. Theory appeared to be more of a guide, compass, or foundation for the therapist and although important, not the sole influence on their approach to treatment. Toby, an African-American Licensed Marriage and Family Therapist identified testimony therapy as his theory of choice when serving middle-class African-American women. Toby put the use of theory in perspective when he stated the following:

> The treatment mode, for the most part, is the compass for the therapist. I don’t believe that some particular treatment has some scientific proof because every few years, every 25 years or so, somebody comes up with a scientific proof that a particular approach is better than another. But it is important to have a theory. That’s why, when I’m doing supervision or teaching a therapist, I don’t accept young therapists who say, ‘Well, I’m kind of eclectic.’ No. That’s the lazy way out of having to learn your work. It’s important to know your theory. It’s important to have something to guide you. It’s for you. It’s your compass.

(Toby, Personal communication, May 14, 2010)
Jack, a Caucasian Licensed Professional Counselor and Licensed Marriage and Family Therapist identified a hybrid of theories or approaches that he uses, something he calls: “An integration of Adlerian, solution-focused and an integration of a Christian understanding of behavior modification, what promotes change, what’s curative from a Christian perspective” (Jack, Personal communication, May 7, 2010)

He went on, just like Toby, to discuss the importance of theory in the context of a compass or guide. Interestingly, he expressed the importance of theory as something that “serves him well.” This is illustrated below:

Well, I place a high value on it because it’s something – it guides my mission in the process, and many times, it promotes healing for my clients, as they define it, not as I define it. It’s understanding the process of—each individual’s process for growth and healing, for helping the client apply solutions. So are they getting well? And many times, I think my theoretical orientation, my approach promotes their well-being according to their assessment and so I find value in it. I think it’s something that has served me well in my understanding of the world. (Jack, Personal communication, May 7, 2010)

Diana, an African-American Licensed Professional Counselor felt like knowledge of theory is important but does not really influence her approach. When I asked her if she valued theory her response was, “I value the knowledge. However, I think my approach is not based on a particular theory” (Diana, Personal communication, June 4, 2010). Additionally, when I responded to a statement she made and indicated that it sounds like theory is more for her than her clients she responded, “Definitely; for me it is.” She
went on to explain what she meant: “I can’t say, ‘Well, today I’m going to use cognitive behavioral,’ or ‘I feel like I’m going to use so-and-so.’ No. No. It’s more about, yeah, I know that stuff” (Diana, Personal communication, June 24, 2010).

Diana’s perspective on theory was similar to Jack and Toby, they all indicated that theory’s place in treatment is more of a guide, compass, or valued knowledge for the therapist.

Carey explained that her theory of choice which is reddecision therapy, is useful when serving African-American women, she stated, “The answer is yes. I find it to be useful in my head” (Carey, Personal communication, June 28, 2010). Like Diana, Carey’s sentiment is in line with other participants’ perspective on the role of therapy. Theory is a guide, compass, useful knowledge for the therapist. Even Ester who found it difficult to respond to the questions regarding theory because as she stated, “I don’t approach my work from ‘I do a certain type of therapy,’ identified a theory. Ester stated, “I’m more cognitively based. I’m more brief solutions-oriented. But I’m very eclectic in my—I don’t have—I wouldn’t say I specialize in any specific therapy” (Ester, Personal communication, May 14, 2010) Her statements indicated she values the knowledge those theories offer however, she does not approach therapy based on a particular theory. Sarah also described theory as a guide when she mentioned, “It’s a guide for me,” her perspective fell right in line with the other participants mentioned.

Generally participants possessed a knowledge and understanding of theory that developed through educational training and experience. However, that theory alone does
not influence treatment choices or approach but interacts with various factors that culminate to serve as a guide for understanding and interacting with their clients.

Table 3

*Memo on Theory*

<table>
<thead>
<tr>
<th>Date</th>
<th>Theory</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 28, 2010</td>
<td>Theory is more of a “guide” or “compass” for the therapist. It really has nothing to do with the client and everything to do with the therapist. It appears to be strongly formed and based on how the therapist positions herself in the world which is influenced by many variables (i.e. race, gender, experiences, privilege, and upbringing). Maybe the therapists in my sample do not see theory as a big influencer because they do not define their approach as theory but as a piece of who they are, of their worldview, even if the theory reflects that worldview</td>
</tr>
</tbody>
</table>

**Other Contributing Factors**

Although many of the participants felt like theory was not a huge influencer, they did appear to select a theory based on their personal and professional experiences, upbringing, and worldview. Those same factors that influence the choice of a theory also influence treatment approach. For example, Sarah explained the following:
"Oh, I think that—probably another influence for me, though, is that I did research on African-American psychiatric history, which then made me immediately question just about everything that’s done in the mental health field because it is based on oppression and trauma. So I had to sort of think about a new way of relating to people that didn’t have that sort of power abuse that’s inherent in mental health in America. So narrative therapy sort of emerged for me at that time as a form of therapy that, one, looked at the person in their environment in a way that my social work training invites me to look at people anyway, and how their environment fits with who they are, and how that impinges upon them. (Sarah, Personal communication, June 28, 2010)

Sarah also discussed her racial and gender position as an influence:

I think it’s one, just being a black woman, being an activist, primarily, so I do sort of identify as an activist therapist with the activist first for a reason. Sort of coming out of the tradition of black women’s health activism . . . which is also a self-help model, which again, sort of influences how I think about things. (Sarah, Personal communication, June 28, 2010)

Sarah’s position in the world as a black woman and an activist strongly influenced her adoption of a theory and approach to treatment. Jack’s influence was very similar to Sarah in that his position in the world, upbringing, and personal experiences served as a contributing factor or influencer of his approach. He explained:

Certainly, my own experience. I grew up in a single parent home with a—well, my father was an alcoholic and my parents were divorced at an early age. And I
developed a lot of difficulties, challenges as an adolescent in terms of adjusting and adapting, just development milestones as a kid, and struggled. And then when I was 22, I had a dramatic conversion to faith, to Christianity, and along with that conversion came a commitment to living well, living healthy, living spiritually and so I think that that’s a framework from which my story interacts with my client’s story and certainly my narrative informs what I believe about what promotes change, what is resilience, how was I able to overcome challenges in my early adolescence, late adolescence and early adulthood, which formed in me a commitment and a mission to serve others. So that’s really where I began. It begins a missional perspective. (Jack, Personal communication, May 7, 2010)

Patricia, an African-American licensed psychologist explained how her professional experiences serve as an influencer:

Partly seeing a lot of—a pattern of most of my clients really needing to restructure some of their thoughts and some of their patterns, one just even coming to counseling in the first place. So what does that mean, and how do you define what that means about you and your level of ego strength, if you will? And the family systems piece is probably just working primarily with underrepresented groups and diverse populations in general, and recognizing that you’re very seldom operating with just one individual, that person who you see in front of you, and needing to look more comprehensively as far as their resources and who all is impacted or in connection with them. (Patricia, Personal communication, May 21, 2010)
Ester’s perspective, an African-American Licensed Clinical Social Worker who has over 20 years of experience, was similar to Patricia in that experience was an influence. Ester felt like experience was the biggest influencer; this sentiment is reflected in the following comment:

Well, I feel capable of adapting my work to what the client needs and what I think is most appropriate, too. The other thing is, I think that after you’ve been in the field for a number of years, you’re able to see that as pretty much underlying the theory about human functioning and human emotional systems. It’s the same thing; it’s just different concepts for how you get to the best outcome for your client. (Ester, Personal communication, May 14, 2010)

Like Ester and Patricia, Diana also felt like experience or practice as she put it was a contributing factor. Her similar sentiments were expressed when she stated, “Practice, Practice, I guess just working with clients” (Diana, Personal communication, June 24, 2010).

Comments made by Toby, an African-American Licensed Marriage and Family Therapist explain why from his perspective, other factors in therapy influence treatment. He summarized this theme concisely:

Within common factor research, it says that 40% of what works in all therapies, whatever the type of therapy it is, is what we call extra-therapeutic experience. So that’s what happens outside of the therapy room—watching Oprah, reading a book, talking to a relative, talking to a friend, That’s the bulk of what creates change in people’s experience, and so a good therapist learns to listen for what is
going on outside of the therapy room that is impacting change in a person’s life.

Thirty percent of what impacts change in the therapeutic process is the relationship between the therapist and the client based on the, the client’s assessment of a good relationship. Fifteen percent of what works in therapy is the theory of the therapist, so whether it’s cognitive behavioral theory or systems theory or narrative, or whatever your particular theory that you hang your practice on, 15% that goes toward the actual change that is going on and that means that that theory is more for the therapist than it is for the client. And then finally, 15% of what impacts change is what we call placebo, or the hope factor, and so a really important skill for a therapist is to be able to instill hopefulness in their client that change can happen. (Toby, Personal communication, May 14, 2010)

Similar to Sarah and Jack, the other factors that contributed to Carey’s adoption of a theory and treatment approach are far more personal. When the question regarding what other factors, other than education contributed to her theoretical framework her response was:

Oh, absolutely, because none of those classes had anything to do with it. I was hired by Duke University to run a preschool in what was a settlement house when I moved south. I got married and moved south. That led to my directing the center in which the preschool was in for four or five, maybe six, I don’t know, several years. I was approaching burn-out from political change activities and from delivering social services in a community that had both the Panthers and the Klan living in that region, which also contributes to my work with diversity a lot.
I was so young and over-hired. So when I met some people, a couple of friends, actually, who were faculty at Duke who had gone to a workshop for the Institute for Racial and Economical Equality, they suggested I attend that workshop which was moving from Lynchburg, Virginia, to Chapel Hill, which is where I lived. When I went to that workshop, their frame of reference was Redecision Therapy, and they were working with people who worked for political change, as well as counseling. I went there for a month-long workshop and essentially I never left. In that workshop, I decided it was important to live and not set myself up for harm. I also had two young children, and I decided to quit. Well, I quit the job and I continued to do seminars at this institute that used TA and Gestalt. And then they hired me, so I didn’t leave. That’s how I got into it. I didn’t know what I was getting into until I signed up for it, and then they had some articles and some recommended readings. That was it. (Carey, Personal communication, June 28, 2010)

The personal and professional experiences of the participants played a significant role in their adoption of a theory and how they approach treatment. All of the participants described factors other than education as contributing to their approach to treatment and theory of choice. Whether it was experience, a conversion of faith, their own position in life and society (i.e. race, class, gender), or an “ahh ha” moment (i.e. political climate, activism, awareness of oppression), those factors weigh heavily when treating middle-class African-American women.
**Interview Question:** What factors impact the choice of interventions used when treating middle class African-American women?

Participants were asked a series of questions regarding the factors that impact their choice of interventions when treating middle class African-American women. It was overwhelmingly evident that all of the participants felt like a client centered or focused perspective greatly influenced the choice of interventions used. They relied heavily on the woman’s expertise of her issues and life. This also impacted the success of treatment as well. Some of the therapist, regardless of the particular theory that they subscribed to or had knowledge of, relied heavily on the relationship built with the woman to foster the client centered focus.

**Client-Centered/Focused Perspective**

All of the participants talked about approaching treatment from a client centered/focused perspective. They were clear in explaining that they are not the expert on what is wrong in their clients’ life or what it will take to make it right. They also talked about understanding what the client brings to treatment and starting where the client is. Jack stated:

The beginning point is to identify the problem from their perspective, so I will listen very carefully to understand what prompted them to come in, how they identified the problem, and I usually explained to them that the first couple of sessions, depending upon the complexity of their issue, will be focused on understanding the problem from their perspective. It’s a phenomenological approach. I am looking for their perceptions, and so I’m identifying what they
identify as their stress responses, such as depression, anxiety, health problems or whatever their issues are as they define them. They identify the problem. I don’t. And I listen very carefully. (Jack, Personal communication, May 7, 2010)

Jack also talked about empowering the women he serves to be the expert and share their story, he expressed this when he stated:

I empower them by indicating that they’re the consumer, that they’re going to make a decision about their health and they will answer the question whether or not this process will be useful to them. Then I explain to them how the process works. My approach is respectful, encouraging, supportive and phenomenological. I want to understand this person’s story and I don’t seek to impose my worldview, my understanding of the problem on the client. (Jack, Personal communication, May 7, 2010)

Toby’s response was in line with other participants as well. He also talked about being client centered and understanding that he is not the expert in this person’s life. This point is illustrated in the following statement:

Again, that becomes important because what we’re saying is you are an expert in your life. I’m not the expert in your life. I’m not the one who can tell you what you need. How the hell do I know? I can only be an expert in the work that I do, but not in your life . . . As opposed to trying to be an expert in someone’s life and telling them what to do, collaborate. I believe very strongly in client-centered and client-directed work where, as the therapist, I’m not trying to be the expert in somebody’s life and tell them where to go. I’m making space for that person to
tell me where it is they need to go to get to the place that they want to go; so that they can have the testimony about their life. (Toby, Personal communication, May 14, 2010)

He went on to explain:

So we’re giving a person a chance to put forth their theory of change, which then allows me, as a therapist, to collaborate with them from their theory of change. What is it that you need to heal? ‘Well, I need my husband to apologize to me’ or ‘I need to forgive my husband.’ ‘I need an opportunity to at least try to reconcile.’ ‘I need to understand what it is that I did that made this happen.’

There might be a number of answers that might come to this. They’re all a part of that theory of change. This also then gives me, as a therapist, a sense of, okay, these are things that we can point toward, we can work on. (Toby, Personal communication, May 14, 2010)

Diana illustrated her shared belief that the client is the expert in the following statement:

I guess just working with clients. Like I said, I kind of work with the person around who they are, what they’re bringing to the table. And my first—in my general conversation with them when we initially meet, I always let the person know that you have all the answers for yourself, okay, and I’m just here to help you facilitate that, or organize them in some way, or come up with a best plan for you, and so we kind of work with that. (Diana, Personal communication, June 4, 2010)
Paul’s agreement with other participants perspectives were expressed in the following when discussing the importance of starting where the client is: “It depends on what they come to the table with; their problems, their ability, their social skills, their problem-solving skills. So you have to take all of that into account” (Paul, Personal communication, April 22, 2010). Both Ester and Carey expressed their perspective of the client as the expert when Ester stated, “I don’t know what else it could be other than what they bring. It’s not my story” and Carey expressed, “I don’t come as the expert on their experience” (Ester, Personal communication, May 14, 2010; Carey, Personal communication, June 28, 2010)

During Carey’s interview, she mentioned only using historical data that is relevant to the change they want to make, when asked why she stated:

I want to communicate that they are the expert on their experience and what’s relevant in their perception and all that. The other is I want to avoid any inclination on my part to make assumptions based on somebody else’s diagnosis.

(Carey, Personal communication, June 28, 2010)

Sarah spent a lot of time explaining her perspective on the clients’ expertise in treatment when discussing testimony therapy as her therapeutic approach. Her perspective really illustrates the concept of a client centered/focused approach to treatment:

It’s because it sort of positions the person as the expert, it values their telling of the story and the themes that are important to them, and sort of, for me, checks the therapist, quite frankly, on who gets to define what the problem is. People may
come to me and say, 'Well, tell me what's wrong with me,' and I tend not to work very long with those kind of people because if you want me to be the expert for you, that's probably not going to work for me because I think that a lot of times the healing for black women is that it's being able to define yourself, and that's something that a lot of times we've been cut off for in other areas of our lives, so I want to make sure that therapy is a place where there's a constant invitation to tell me what you think about that. I can offer you perspectives, I can offer you some feedback, I can tell you sort of, in the scheme of larger women's issues, and black women much like you, sort of what they might be experiencing or some recurrent themes, but always trying to stay clear with like, 'What's your perspective on it? Does this feel true to you?' A lot of times I'll say, 'How does that fit for you?' and people can say, 'Well, that doesn't fit for me.' 'Well, that's good. Tell me what fits for you. It's okay if you don't know in the moment, but part of the work here is where you tease that out so that whatever time you work with me you get some skills, that you go out and you live your life.' (Sarah, Personal communication, June 28, 2010)

Some of the participants described the importance of the therapeutic relationship in order to foster an environment of sharing. This is important because in order for the woman to share her expertise and story she needs to feel safe and connected. For example, Jack illustrated this point when he stated, "I think it's the therapeutic bond, that she feels safe and that she gets her needs met . . ." Jack also mentioned the importance of safety when developing the therapeutic relationship in the following statement: "It
begins with creating a sense of safety by explaining the limits of confidentiality and helping them recognize that this is a safe place to share their thoughts, feelings and concern” (Jack, Personal communication, May 7, 2010).

In Toby’s discussion of common factors he also mentioned the importance of the therapeutic relationship when he stated: “A therapist who knows how to build a strong relationship, a good relationship with their client, is in a much better stead, whatever they’re doing, whatever their theory, than another therapist” (Toby, Personal communication, May 14, 2010). When discussing how this therapeutic relationship is fostered, respect and safety always came up. For example, Toby used the historical concept of a brush harbor to illustrate his point:

I call my therapeutic space—a metaphor that I use for it is brush arbor. Brush arbor, during days of slavery, were safe places that enslaved Africans could go to worship. It’s where Africans went and worshiped in the way that they wanted to worship, because generally, the law was that black people could only have worship experiences if there was a white person present. In other words, there had to be a white person there for them to have church, or whatever. But what black people had was the brush arbor, where they’d go back in the woods and they’d create a cleared space, cut down space and what not, and create basically a covering that they could worship in secret. In that brush arbor, you could say, do and be who you wanted to be. For me, that metaphor is really appropriate for black people in therapy. This is a brush arbor experience where you can say what you need to say... What I work really hard for is to create real transparency within
the therapeutic space; transparency about issues of gender, sexuality, color, ethnicity, so that it is a safe space to have those conversations in ways that are not stilted. (Toby, Personal communication, May 14, 2010)

Just like Toby and Jack, Ester also shared the perspective on the importance of a therapeutic relationship, she also mentioned using respect as a tool to develop the relationship. She stated:

I do what I can to create an environment that is respectful and where people will feel comfortable. I think coming into a space where you’re going to share your most intimate life story should be in an environment that is inviting. So I start with that. I start with creating an environment that is peaceful, that is respectful. I believe that for every person who comes to tell their story, there’s a level of respect. There’s a level of respect in honoring their story, and that it is an, if you will, sacred experience. And so the pain that a person is sharing, the time that they’re taking to come in and ask for me to be with them in their experience, I want them to feel that I’m on the journey with them, and so that, to me, is why the relationship piece is so critical . . . I make a point of being very personal and building the relationship. . . Relationship is a big part of the process. (Ester, Personal communication, May 14, 2010)

Patricia also felt like the therapeutic relationship is important even more so than theory, this sentiment was evident when she stated: ‘There are other factors that contribute, and sometimes they outweigh theory, like the spirituality, the therapeutic relationship, those kind of things” (Patricia, Personal communication, May 21, 2010).
In summary, all of the therapists demonstrated through their comments that the client is the driver of treatment. What they bring to the treatment table is vital and impacts how treatment is rendered (i.e. interventions used, duration, and issues targeted for change) regardless of the theory of choice. All of the participants made it clear that the client is the expert. The therapeutic relationship fosters an environment that promotes change and assist with the selection of interventions as well. It also helps to foster a safe and respectful environment in which the women can share their story and expertise.

**Interview Question:** In your opinion and experience, what influences middle-class African-American women to seek treatment in the private sector?

When questioned about what influences middle-class African-American women to seek treatment in the private sector was explored, participants focused on two distinct sides to that perspective. On one hand they focused on the unique factors that contribute to discomfort, conflict, and emotional pain for middle-class African-American women. On the other hand they discussed issues of resources, access and privacy. As a result of the aforementioned, two themes emerged, the intersection of race, class, and gender and access, resources, and privacy.

**The Intersection of Race, Class, and Gender**

All of the participants discussed race, class, and gender at some point in their interview. All of the participants felt all three were important however for different reasons. Some participants talked more about the importance or impact of their race and gender as it relates to treatment. Others talked more about the women they serve and the
dynamics of their race, gender, and class. For example, Patricia expressed the following as it related to race, class, and gender:

There's a different twist probably with women of color, because oftentimes that's a block or why it might have taken them longer to come in. I mean, some of the issues that they face have been going on for decades or generations. And so we probably spend more time on it, and it's probably interwoven throughout the therapy process a little differently than maybe with clients who are not African American. I think, and this is probably also somewhat historically, but we constantly hear or have witnessed about women being the rock or the foundation, and so I think some women celebrate that. At the same time, they want a break too, and that could be either the married woman or the single woman, in whatever way she is single, that they get tired of carrying all of the weight, all the responsibility. And so I think I hear more of an egalitarian relationship, and this might be just what they disclose, from the Caucasian American clients, for example. But the African American ones, I think they just feel so overwhelmed. 'It's good and I can do better by myself, but sometimes Mama needs a break.' I hear that pretty consistently, like they're just overwhelmed, overwhelmed and would love to—just need to share some of the responsibility or get a different perspective on it so it can be more doable. If they've been in this position of being so strong and they can do everything and they can handle everything, blah, blah, and they're often—and this is probably one thing I often do hear, 'I'm the person everybody comes to. Even though I'm the youngest, or I'm the
middle, grandmama, auntie, uncle, younger so-and-so, they come to me for money. They come to me for advice. They come to me to babysit their kids, blah, blah, blah. And so being in a place where I’m asking for help is very odd or uncomfortable for me. I’ve wanted to, but I’ve had no place to go. So I would have gone to somebody in my immediate circle, but I don’t have anybody because they all come to me.’ So that’s probably—and they’re like, ‘What is this that I have to come to somebody who I don’t even know? But I have all these people around me, but I can’t go to them because they need me,’ and so that’s probably another thing. (Patricia, Personal communication, May 21, 2010)

Patricia also discussed the unique role spirituality plays when serving middle class African-American women. She stated:

What I’ve found is just that with this population, you’ve got to be really, really careful to explore the role of spirituality and religion and differentiating the two, because again, it can often be the source of why they haven’t come before, or getting criticism about coming to therapy in the first place, because you should rely on God more. (Patricia, Personal communication, May 21, 2010)

Toby had the following to say about the dynamics of race, class, and gender:

First of all, she is a woman sitting here having a conversation with a man about problems with a man, and I have to be aware of that; aware of what does that mean, what does that look like, you know, which means, for me, it becomes important to always be considering things like what gender things—how it’s important to make transparent the gender issues. I’m very much aware of the
discourses about gender, and to question them; things about what men are supposed to do, what women are supposed to do, and to raise questions about those. ‘Well, where did you hear that?’ So the question of gender becomes very important, and not only the question of gender as it relates to, say, that woman and some man in her life, but also the relationship between the two of us. What does that mean? Issues of power. It becomes very important as a therapist that I be aware of the power relationships between myself and my client that I’m not inappropriately relying on some kind of power that I may or may not have in that relationship, or perceived power that might be going on between us. It becomes important to be critically aware of that thing going on. What I work really hard for is to create real transparency within the therapeutic space; transparency about issues of gender, sexuality, color, ethnicity, so that it is a safe space to have those conversations in ways that are not stilted. (Toby, Personal communication, May 14, 2010)

Additionally, Toby discussed issues of race as it relates to treatment:

The things that you may not say if you had a white therapist, the things that you might not say, even with a black therapist who does not explicitly make that an open space. Often, sometimes people will go to a black therapist, and if that black therapist is not being transparent about questions of color, questions of race, questions of gender and sexuality—there’s a lot of silencing that goes on. So a lot will not get said; even questions of spirituality or religion. If the black therapist is
presenting from a context of whiteness, the black person is not certain what they can say safely in that space. (Toby, Personal communication, May 14, 2010)

Diana commented on the dynamics of gender during her interview, her comments were similar to Patricia in that she discussed the load and stresses African-American women face. She stated:

For women, I find that women tend to express themselves. They're not afraid to talk about any kind of emotional feelings, whether it's a positive or a negative. It's a little easier. I think that's historic. Nowadays it's becoming to be—not only is it historic, but the stresses are even more so, because a lot of African-American women I see are raising kids by themselves, or working two and three jobs, or they're in school and working. So it just—they're trying to take care of parents, or helping brothers and sisters in school. The stresses seem to be getting more in today's climate than ever before. (Diana, Personal communication, June 4, 2010)

During the interview with Sarah, she had a lot to say about race, class and gender. Just like Toby, she spoke about being aware of the power dynamics when working with middle-class African-Americans, she stated:

Just because I'm black doesn't mean I understand her experience. I'm a black therapist who came out of a working class background and still strongly identifies as a working class woman, so I also have to be open to middle class women, especially middle-class women—multi-generational middle class black women who have a different experience from me. That's why I think it makes so much more sense for me to really stay clear about the power, and knowledge, and
expertise of the person sitting next to me, because I don’t know where you’ve been. I can guess. I can empathize in ways, sort of know what that might feel like, but the truest test is for you to tell me how you experienced that, what impact it has had on you, what happened. (Sarah, Personal communication, June 28, 2010)

She continued to expound on the dynamics of class, race, and gender as it relates to middle-class African-American women in her statement below:

“I think especially with middle-class women—black women—there is a standard about what they’re trying to get to, and it’s like, and that’s fine, but you need to be real clear about the standard, that one, the standard is yours, that you’ll know when you got there, and that you like it when you get there... When you see, especially in middle-class black women, who I think are often times really trying to sort of have a foot in both worlds—both their racial world and the thing about where they came from, and that’s why I think the genogram can be very helpful if people are also making class shifts while they’re doing their career development, and so they have experiences, and loyalties, and vulnerabilities that may come from growing up poor or working class, their class status now is maybe solidly middle class, or even upper middle class, but they’re dealing with all the things that come with that, whether it’s finding partners who are of their social class—I’m sure. Then you’ve got women, of course, who are middle class women who are with same sex partners who are not only having to deal with the sexism and
the racism, they’re having to deal with massive homophobia. (Sarah, Personal communication, June 28, 2010)

Sarah also talked about safety in therapy as a woman and then when you add another layer such as a black woman, safety becomes even more distant. She illustrated her point in the statement below: She explained:

White women had to work a long time to make therapy sort of safe for them. It’s not fully safe for white women, so if it’s not fully safe for white women we can be pretty much sure that colorful women still got some work to do. I think it’s still normed on men. Sort of what’s normal, and what’s considered healthy sort of emotional identity, or mental health is still very much normed on what’s – on men’s behavior. At the same time, being a woman is not a fundamental problem and flawed, and the goal is not to be like a man. (Sarah, Personal communication, June 28, 2010)

Additionally, Sarah gave an in-depth description of how she feels race plays a role in the mental health treatment of middle-class African-American women. Her sentiments are clearly illustrated in the following comment:

I just think there is still a lot of stuff out there, and more conversation happening around the legacy of slavery. I think there is something about multi-generational transmission of trauma, which is very profound. Black people were not considered to be capable of depression because it was like saying the cow was depressed. I think in some ways in slavery and sharecropper times, and right up into the 50s, it’s like JoJo the dog is more likely to be, JoJo looks kind of bumbled
out today. The black woman over there, she’s got no problems. Yet she’s being raped at work and all this kind of stuff, but they don’t have the capacity. So I think there is the one legacy, I think, is that since that plays out in that sense that black people don’t want to go to therapy, black people don’t talk, black people are stark raving crazy, is that it was a sense of our feelings were so unimportant to so many people for so long that it is just in this generation—the last couple of generations where there’s a sense that somebody wants to hear that story.

Sometimes when the story comes out it’s very hostile, or very confused, or crazy. Almost like, ‘Why are you mad like that? I don’t get why you’re mad like that.’ It’s not just because they’re mad about this, it’s about the whole thing. It’s almost like all of this ancestral stuff coming through in many ways. So that’s a piece of the therapy too, and they might come in for conflicts at work, or depression, or relationship stuff, and if they choose to do the work there may be this other thing they get to say about you’re dealing with a legacy you didn’t create, but you’ve got to live it out. You want to clear it up so you don’t, so your kids don’t have to do it. (Sarah, Personal communication, June 28, 2010)

Like Sarah, Carey also had a lot to say about cultural and racial trauma impacting the women she serves. Sarah gave an example during her interview regarding African-American child rearing practices mimicking the braking of a slave as a way to protect your child from death: “I think there’s been a lot of discussion around some of the physical discipline in the black community that some of it is very likened to the breaking of slaves” (Sarah, Personal communication, June 28, 2010). Interestingly, Carey also
referenced child rearing practices to demonstrate the internal oppression she sees in some of her clients. She stated the following: “The survival strategies that are manifest in African-American child-rearing practices often have the impact of internalized oppression” (Carey, Personal communication, June 28, 2010). Carey went on to use one of her clients as an additional example to demonstrate how cultural oppression can look like pathology. She illustrated her point in the following statement:

So for instance, with the person I just talked about, the woman I just talked about, some of what could be seen as traditional pathology were a result of the oppression that comes with internalizing how one should be in relationship to a corporate husband. That’s a white model. So when I’m working with white women, it’s much the same, but it’s not a result of cultural oppression. It’s a result of the models that they’re trying to follow. But we’re trying to follow not only the traditional roles, but we’re trying to follow them like white women that do the superwoman garbage. (Carey, Personal communication, June 28, 2010)

Paul and Jack discussed race and gender more as it related to the impact of their race or gender not necessarily the clients. For example, Paul stated:

Some women would rather have a man therapist than a female therapist for various reasons, and they’d rather have a black therapist than a white therapist, because probably through their history, they have found that a lot of white therapists didn’t understand where they coming from, or tried to place them in a box, or tried to stereotype them. And what I’ve been told is that the therapists just don’t understand them. As far as the gender, there’s a lot of situations where any
woman would want to go to another female, but there’s also other situations where an African-American woman would want to go to a male, especially if there are older sons involved that she has some questions about, and if the father figure is not there. (Paul, Personal communication, April 22, 2010)

When asked if race, gender, or both influences his treatment choices, Jack’s response was:

No. I don’t approach my... I do customize the process to every client based on what they identify as the problem and they identify as potential solutions, and what they respond to as potential solutions. But I don’t alter my theoretical approach based upon the consumer’s race or gender because I really can’t. That would be altering who I am, and to me, my experience is, and I think that’s part of my success. I think part of my success is I bring my person to the process and I have to be true to myself in the sense that—and I make it clear what the process is with the consumer before they engage. (Jack, Personal communication, May 7, 2010)

However, Jack did express the following as it relates to his race and gender:

Just like my cultural, my upbringing, every experience that I’ve had forms who I am and it contributes to my unique perception of the world, my biases and I take responsibility for them. I own them as much as I can. I try to be aware of what they are. (Jack, Personal communication, May 7, 2010)
Since Jack is the only participant who, in regards to gender and race, is the most different from the women he serves, the question of barriers this difference may pose was raised in his interview. His response was:

I do ask that question. There are times when the process unfolds in such a way that the question doesn’t arise. By that, I mean the rapport comes so naturally that it doesn’t feel like the question seems irrelevant. But what I’m looking for is am I building rapport with this client? Are they getting to know me? Am I getting to know them? Are there barriers to the process? And that’s really what I’m most concerned about is, are they engaging in a process that will be helpful to them. Is it curative? Is it promoting their well-being. And so in many cases, I will ask the question, how do you feel about working with, I usually try to introduce some humor by saying, ‘How do you feel about working with a pink, bald therapist?’ I try to highlight there’s a difference there, and then I ask the question directly, ‘Do you feel comfortable working with a white therapist,’ especially if there’s a history of trauma related to race, and there are many times when that will come up naturally or I will ask the question directly in assessment related to a trauma history and I also work with interracial couples and that’s a question that begs to be asked. How do you manage the tension of being an interracial couple? (Jack, Personal communication, May 7, 2010)

Like Patricia, Jack discussed spirituality. However, Jack noted spirituality as a connection point or common ground for the middle-class African-American women he serves. This common ground was described by Jack in the following statement:
Typically, spiritually or faith is one of the things I’m assessing for in terms of a coping resource, along with social support and psychological resiliency. Do they have competence in their ability to manage challenges in life? What is their core strength? How do they perceive their strength? Many times, in my work with African-American women, faith is the core of that strength. It’s not always the case, but in many cases it is. I work well with people of faith, and a lot of my African-American clients have either a cultural or a personal exposure to biblical principles. So it offers a shared language and a platform for treatment planning and that kind of stuff. (Jack, Personal communication, May 7, 2010)

When discussing race, some of the participants also discussed ethnic matching.

Patricia discussed it in the following statement:

So that’s why it’s very important for them to have a lot of different psychiatrists in the area who also look like them or are of color, because the trust goes up even more when they’re relatively close and they look like them. Typically I think with someone who’s gone through some of the same experiences, and you can assume, though it’s a huge assumption to make just because we look alike that we have the same experiences, but it does decrease some of the anxiety about just coming to counseling. So if you’ve already got a certain level of depression or stress, anxiety, whatever this may be, they often feel like it would come down a bit if there was somebody who I thought may be able to relate. But when you’re coming and talking to somebody completely new, a stranger, about your business, there’s a certain level of familiarity with someone who almost looks like you,
because you almost feel like this is kinfolk. You can tell that. You can kind of
tell that in their eyes that they're just kind of like, okay, you know. Yeah, it's a
huge, huge relief. And I think it's just a comfort level, because they think that—
it's an assumption, but they think that there's certain things that you already
know, I experience on a day to day that I won't have to say or I won't mind
expounding on because you already have an understanding, but I'm not going to
have to teach you. I think it adds an extra layer to it, but most of them kind of
know what they're looking for. When they're going through a search or when
they talk to another therapist and they need somebody who's a little bit closer to
where they work or live, if they've been referred word of mouth, they will say,
“I'm looking for an African-American female therapist”. And so they kind of—
so they come in knowing, but I think it's all those different pieces. (Patricia,
Personal communication, May 21, 2010)

Diana also spoke on the issue of ethnic matching in her comment below:

Even here, it makes a big difference when I'm seeing mostly African-American
and they're not used to having African-American therapists. They may have been
in therapy a couple of times, and people will say, 'It's such a difference. I feel
like I can talk to you.' It's not that they couldn't talk to the other person; it's
about their perception or preconceived notion that I'm going to hear it differently
than anybody else of another race. (Diana, Personal communication, June 4,
2010)
Some of the participants also talked about the use of personal disclosure and the use of touch as an important tool when working with middle-class African-American women. Patricia explained the following:

We’re taught in Western society not to disclose too much about your personal life, but it’s easy for somebody to see if your name is hyphenated or not, or if you have on a wedding ring or not, or certain things that people kind of are more attuned to that tell them a little bit more about you. So it’s certain things, whether I say, they may not know that I have a son and a stepdaughter who’s 17. They might not know that. That may never come up at all. But sometimes with our culture, self-disclosure in particularly African-American women, it helps a lot. You don’t have to have the same exact experience, but sometimes it gives you a certain level of credibility. And so, yeah, that gender piece adds to it quite a bit. (Patricia, Personal communication, May 21, 2010)

Toby used one of his supervisees to express his perspective on disclosure:

For instance, one of the things I had with one of my supervisees, a young woman who was always very formal and straight with her clients. I talked to her about the idea of befriending her clients. She said, ‘I can’t be a friend of my clients.’ That was the whole thing. You’re supposed to avoid the slippery slope, which becomes a cultural issue. But again, within a relationship between black people, a comfortable relationship this very formal, interviewing type relationship can feel very off-putting. So it’s not the thing of being the friend that’s going out and partying with somebody and what-not, but it’s about befriending, creating that
sense of friendship between the client and the therapist, so there's a level of comfort. A person who's going strictly by the book that we learned in those classes that we take, which don't take black people into consideration except for that week that you talk about so-called multiculturalism, or that chapter or that paragraph from the chapter on multiculturalism, where you've gone through every ethnic group that the author could think of, and to tell you basically what black people do or don't do. It's this very stilted relationship. (Toby, Personal communication, May 14, 2010)

Ester also discussed the importance of being personal, she stated:

I make a point of being very personal and building the relationship. I’m a hugger. I find that many, many, many, in terms of ethics, they say don’t do it, but I think that there are too many people who don’t get hugs ever, and that I give a hug if they want a hug. I ask; I don’t just jump up and hug somebody. I ask, or sometimes they ask. A lot of times people before they leave ask for a hug. (Ester, Personal communication, May 14, 2010)

Ester, Paul, and Carey, just like Sarah, discussed more specifically, the dynamic of class and race and the unique experience of some middle-class African-American women. For example, Ester stated the following:

You have first-time middle class. You have people who are the first person in their family to have achieved a certain level of education and income, and the other members of the family think they're rich, and so they want to borrow money, and they don’t understand. And colleagues don’t understand that this
person might have a brother in prison, an uncle who’s a junkie, a mother who is crazy. There’s just realities about coming from either an urban center or a small Southern town or wherever, of growing up in the projects and getting a Masters degree or a Ph.D. and being confused, being very confused. Then they talk about the stress of moving into a white neighborhood, the rejection of the white folks, and the attitude of the black people from the community saying you think you’re better than them and you want to be white. And there’s the stress of when you’re being employed and all the self-imposed ideas about what it takes to succeed, and then the ideas that people from all the different races bring into the workplace about black people, their lack of diversity issues, issues of diversity. (Ester, Personal communication, May 14, 2010)

Paul also talked about what middle class means for some African-American women, he stated:

When a lot of African-American middle-class women come to the table, even though they’re middle class, a lot of their extended family are not, and a lot of them have the same problems as women who are in the lower class income. Middle class just means that they were able to find them a better job and move up the ladder, in many cases. It’s not always the case that they came from an upper class or a middle class family without a lot of the stressors involved. But you still are connected emotionally, socially, to a lot of the African-American family who are not as well off or in your position, and you have to deal with those stressors. Believe it or not, a lot of even middle class African-American women have an
issue with self-esteem. They have an issue with depression. And you can understand, a lot of times, they have a lot of pressure on them. They’re the ones that the family had looked up to who were different, who didn’t have the problems, who were supposed to be the 100% person. And when they’re not, they beat themselves up a lot. A lot of the family members, when they look at them, they don’t look at them as having self-esteem issues because they look at them as having a decent job, a house to live, and maybe a husband. But those factors are not the contributing factors to a healthy and whole life. There’s a lot of other aspects. But a lot of times, with the middle class African-American woman, it’s the stressors around her, and she still has the same stressors as the lower income women. So there’s not a lot of difference between the two, other than she’s able to remove herself from a lot of the situations that lower income African-American women don’t have the resources to use to do that. (Paul, Personal communication, April 22, 2010)

Carey’s statements regarding class and race were in line with Paul and Ester, she stated the following:

Well, let me just say what’s unique is that they’re a member of two target groups, and sometimes three. One is African American, the other is gender, and the other is the variable of class. Very few are second generation middle class. Most are first. (Carey, Personal communication, June 28, 2010)
Sarah also spoke more specifically about the impact of class combined with being the go to person of the family on African-American women and how it can serve as pressure and be a curse and a blessing at the same time. She stated:

So they’ve got lots of multiple pressures, including pressures of—and what I see some coming in now, and it shows up a lot of couples stuff, is in the economic crisis people often times women slip the money out of their purses, and their ATMs to give to family members, and they’re not talking with partners about that. They’re trying to be this bridge for the family to sort of—and they’re really feeling the pressure, and they can no longer afford to do that, but they’ve got this role in the family, especially if there’s been a class shift. Or middle class black women whose parents were middle class, and whose parents are now starting to age, but their parents have been horrible with money . . . so money is both a gift, and then it becomes a huge sort of curse because there’s also still not clear money conversations. It’s being able to talk about class, and I don’t think that we talk about class very well. I think that gender and race get talked about—get talked about with much more openness than class. (Sarah, Personal communication, June 28, 2010)

When the participants were faced with the question of what they would want a therapist to know before working with middle-class African-American women, almost all of the responses were related to race, class and gender. Paul stated:

And if it’s a white therapist—first you have to understand the culture and just don’t put that middle-class African-American woman in some type of category,
because you don’t know. That middle-class African-American woman can be in a category of an upper-class African-American or European woman, and she can carry herself that way and totally disassociate herself with all of the stressors that lower income people have. Or she can be right of the box of a lower income class African-American woman. So what that says is that there is a broad range. You can’t stereotype them. You have to treat them with a blank slate and then you get your information from them, just realizing no matter which area they come from, they still are tied to the African-American race because this culture will not allow anything but that; so just to say you have to use a broad range of therapeutic approach with them and not restrict yourself to just one or two types of approaches. Definitely don’t go in with a framework in mind of how you’re going to do with this with this woman without leaving because you just don’t know what you’re going to get into. You meet them and do the background information check. (Paul, Personal communication, April 22, 2010)

Ester expressed the following when asked this question:

I wouldn't want anybody to go into treatment with any black person unsupervised, black or white. I just think that, not just black people, but that our training is primarily based upon assumptions about white middle-class Americans, not even poor white Americans, but white middle-class Americans. And so what I tell my students, and I guess that’s the place I would go to answer that question, is to ask a lot of questions, and be clear about what the person is telling you, and to not have any assumptions without checking them out. Therapists tend to assume.
think therapists in Atlanta probably not as much, because there’s so many well-educated black people in Atlanta that it would be hard to be in practice and not experience meeting people who are well educated. But there’s a tendency in our field to put a low-income frame on a black person sitting in the room, and make some assumptions from that multi-problem, deprived, disadvantaged perspective as a way of thinking about and listening to them. (Ester, Personal communication, May 14, 2010)

Toby stated the following when answering the question:

First of all, it’s important as therapists to maintain the human element. People are not the problem. The problem is the problem. That’s the first thing to remember, not to make the client the problem, not to pathologize the client, and to learn to listen for the victories in people’s lives, rather than looking for the pathologies. The pathologies, the hurts, the pains reveal themselves. That’s what people bring. But the real skill is learning how to listen for victories in people’s lives and learning how to become curious and ask the questions that help people see the victories for themselves. (Toby, Personal communication, May 14, 2010)

Patricia stated:

If there’s an African-American woman, they’re an African-American female therapist, I would say don’t make any assumptions. Don’t make any assumptions about who they are, and where they’re from, and what their experiences are. That would probably—that’s the first thing that comes to mind with an African-American therapist or counselor or psychologist. And if it was a Caucasian-
American therapist, I would want to make sure that they don’t go in approaching them in a ‘sister girl’ language, like don’t try to compensate for not being the same race or not being the gender. ‘Well, I know how y’all get. I know that.’ Don’t make any assumptions about knowing this person based on the two or three black women you know. And so, like I’m saying, it’s somewhat similar as far as don’t make any assumptions that this person is like you or what you think they’re like, because that’s going to cut them off. (Patricia, Personal communication, May 21, 2010)

Sarah’s response was:

I’d want them to be really, really clear and have done a lot of thinking about how they feel about black women, including themselves. How do you think about black women? What do you believe about black women? What do you believe are black women’s strengths? What do you believe are black women’s challenges? What are your own unique challenges? I think that that’s the biggest thing. Someone might say the psychodynamically use of self, or whatever, but I think I’m only as clear with—I can only see you as clearly as I can see myself. If I’ve got lots of fog around me I’m dangerous to you. So I think the first thing I’d say, especially if it was an African-American therapist, I’d say you’ve got to be real clear about who you are. Hopefully be operating from a position of loving who you are as a black woman, because if you aren’t, you’re going to be dangerous to other people. Allow that other black women, who might look like you, may have had very different experiences for any number of
reasons, which is why then that position of, ‘You tell me your story. Tell me more.’ (Sarah, Personal communication, June 28, 2010)

The dynamics of being an African American, a woman, and a member of the middle class present various levels of stress, oppression, benefits, and access for middle-class African-American women. The intersection of the three is always present and can fuel the reasons why middle-class African-American women come to treatment. Also, understanding this unique multiple identities, can assist a therapist when choosing interventions and approaching treatment. The participants were clear in stating that being a therapist that is African American, a woman, or both can be beneficial however; much more is required to be serve this population. Additionally you cannot make any assumptions when serving this population.

Table 4

Theory on Strong Black Woman Syndrome

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<tr>
<td>May 21, 2010</td>
<td>So far, almost all of the participants I have interviewed mentioned components of the “Strong Black Woman Syndrome.” Whether directly calling it that or describing the properties of that concept. It appears as though, from the participants’ perspective, that being everything to everyone all the time not only serves as a point of celebration for black women but as a point of destruction.</td>
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Access, Resources, and Privacy

All of the participants commented on the various reasons why middle class African-American women seek mental health treatment in the private sector. Consistently, the concepts of access, resources, and privacy came up as a reason. For example, Jack stated:

Well, I guess it's just an issue of access. They seek care in the private sector because they're consumers with choice and they want the best care, and they look for their options. They're experts on what is in their best interest, and so they can seek—as opposed to a public mental health center, they can—as an informed consumer, they can make a good choice about the care that they would receive in the private sector or in the public sector. (Jack, Personal communication, May 7, 2010)

Patricia also talked about access as it relates to scheduling when she stated:

Most of them are mothers, so maybe single, widowed, or divorced. It just depends, but considering school schedules, their children's schedules and things like that, so there's probably more focus on that maybe than some of my other clients, because they typically have more responsibilities. (Patricia, Personal communication, May 21, 2010)

Paul also talked about access but in the terms of flexibility and availability of the therapist and privacy in the context of stigma when he stated:

The community service board and public agencies are stigmatized because they serve people with no insurance, the lower income people. A lot of the therapists
and psychiatrists and psychologists that work in that area, they’re overworked and understaffed, so they can’t do the things that a private therapist can do; spend the time, be more flexible with time, be more flexible with hours that you can call me on my personal cell phone, and so forth. You can’t do those things in a community setting. (Paul, Personal communication, April 22, 2010)

Ester also talked about access and public services not speaking to the lifestyle of middle-class African-American women:

One is they don’t want to sit in a clinic. It’s not comfortable. It’s not pretty. It’s not clean. It might be clean. I don’t want to say it’s dirty. But it doesn’t speak to their lifestyle . . . it’s a matter of—yeah, I guess—I think probably you’re using ‘access’ the way I was. It’s a matter of, ‘These are the people who covered who are in my plan.’ And then they give them three or four names, they call, and it’s a matter of if my hours are compatible with the time that they want to go in.

(Ester, Personal communication, May 14, 2010)

Carey’s perspectives were in line with other participants. She also talked about resources and privacy when discussing why the middle-class African-American women she serves wouldn’t do anything public, her point is illustrated in the following statement:

I don’t think any people I see ever go to anything public. I mean, they don’t go to a public health thing. They don’t go to a public mental health thing. I never thought of that. There’s sufficient suspicion of mental health services in the black community, no matter what class, to prevent the people who think they can afford
it in the first place, I think, to chance getting whoever they get. (Carey, Personal communication, June 28, 2010)

Diana mentioned access and resources in the context of options when discussing why middle-class African-American women do choose to seek services in the private sector:

> Because usually they have health insurance or money to pay, and I think that’s the first thing that they’re going to do is to go to the EAP person on their job. And the EAP person, sometimes they’ll just refer them out. Sometimes they’ll talk to them a little bit. But I think it’s just having the option, the opportunity, and access to health care. That includes mental health services. (Diana, Personal communication, June 4, 2010)

Toby and Sarah also mentioned the issue of African Americans not wanting to come to therapy and they both had interesting perspectives. Toby’s response also touched on resources, he mentioned the following:

> You know it used to be said that black people do not go to therapists. My whole practice survives primarily on, on black people. I think that what black people look for are safe spaces, affordable spaces. I think the thing that probably affects it is fact that whereas before people might go to a spiritual leader, they might go to a minister or whatever, or wise counselor (a mother, a grandmother, whatever), to kind of work through their problems, the reality is that in the 21st century, all across America families are fractured in terms of, you don’t live in the community that you grew up in, people are moving for jobs, for better opportunities. So it’s
not like the homogenous community that people used to grow up in, where you’ve been there for 30, 40 years and everybody knows each other and is supportive of each other. People are all over and everywhere. So there are different kinds of sources and resources that we have to look to now when we’re in pain, when we’re feeling pain. Particularly, people from the middle class have this sense of. ‘I can talk to—there are people who are trained to do this,’ and there’s much less of the stigma of talking to a therapist. (Toby, Personal communication, May 14, 2010)

Sarah’s response also mentioned the idea of black people not wanting to come to therapy however, she talks about access in a nontraditional way, not as it relates to location, but to safety and trust. Like Toby, she also discussed resources when she stated:

Well, I think they don’t trust the public sector, and they have adequate resources to do it . . . so I find it interesting that the field has not fully caught up with it because we still tell the old story about where black people don’t want to do therapy, black people don’t want to talk about their problems. Black people won’t shut the hell up about their problems. Really, on the bus—you hear it on the bus, you hear it at the family reunions. You’ve got to pay to tell somebody, your therapist. People say they backed away. Well, let me tell me something. The people I’ve been at social gatherings people are telling their medication, so people say that they don’t want, that we don’t talk, and I think that’s an old message . . . people confuse, ‘I don’t want to talk,’ with, ‘I don’t think anyone wants to hear me.’ I think that there’s just a lot more openness among African-
American women to seek therapy, and it’s now finding people who are safe to go to. (Sarah, Personal communication, June 28, 2010)

Additionally, the discussion of labels and diagnoses came up for some of the participants. They talked about this as a privacy construct. For example, Toby stated the following:

The privacy; when someone calls me, for instance, my practice is a fee for service practice, which means that people pay out of their pocket. People will often call and talk to me about their insurance or whatever, and we do not take insurance. What we tell people is the reason we don’t take insurance is, first of all, insurance companies work on the medical model. In order for the insurance companies to pay us, we have to give you a mental illness diagnosis. In other words, we’ve got to make you crazy in order for them to pay us. We don’t believe that people have to be mentally ill to talk to a therapist. And most people don’t want an unnecessary mental illness on their medical record. When people understand that, they make the choice to pay for themselves because of the privacy that they pay for that. The idea of, first of all, working from within a medical model and pathologizing your experience, what it might be, people don’t want. People want that idea of some privacy, someone that they can talk to and they know that their privacy is going to be respected. It’s important. (Toby, Personal communication, May 14, 2010)
Jack and Sarah also talked about the issues of diagnosis when discussing why middle-class African-American women seek services in the private sector. Jack’s statement follows:

I’m very careful with labels, helping consumers recognizing that they’re much more than just the diagnose, they’re much more than just a problem, that their identity is not easily defined by the problems. The problems they present with are part of who they are, but they’re not who they are. (Jack, Personal communication, May 7, 2010)

Sarah also spoke about diagnosis when answering this question. She stated:

I don’t diagnose. That’s one of the reasons why I don’t take insurance. Certainly a lot of that comes out of it never made sense to me — and I have always considered the DSM professional name calling and a way for mostly psychiatrists to pimp the system. They put it together for that reason in 1952 is to sort of create a — we named it, so we get to sell it. If someone says, ‘Well, don’t you find it helpful to—when you were in therapy didn’t you find it helpful that your therapist had a diagnosis?’ I said, ‘No. I actually found it more helpful that my therapist listened to what I described as my challenges and where I wanted to go. A label didn’t help.’ It isn’t that I don’t notice distress, it’s not that I don’t know the status, or depression, or complicated grief, or extreme energy states, whether that’s mania, or bipolar, or something, but I don’t think that people grow—and in fact, I’ve just seen more damage from that as people try to either just to conform to the label and say, ‘I’ve got bipolar. What am I supposed to do?’ Or who have
been mislabeled, straight up mislabeled, and then spent a lifetime both with medication and other stuff, trying to get healed. (Sarah, Personal communication, June 28, 2010)

All of the participants felt like access, resources, and/or privacy play a role in why middle-class African-American women seek services in the private sector. Access was described in terms of flexibility of hours and access to the therapist to name a couple. Resources were discussed in terms of money, insurance, etc., and privacy in terms of safety, trust, and stigma.

**Summary**

The purpose of this qualitative study was to explore the theoretical/philosophical frameworks, treatment, engagement, and diagnostic approaches of private practice therapists who treat middle-class African-American women. This research study seeks to gain an understanding of the following research questions:

RQ1: How does the theoretical/philosophical framework employed by private practitioners influence their approach to treating middle-class African-American women?

RQ2: In their opinion and experience, what influences middle-class African-American women to seek treatment in the private sector?

RQ3: What factors impact the choice of interventions used when treating middle-class African-American women?

This chapter presented the detail findings of eight one-on-one interviews conducted with fully licensed therapist who have been licensed for at least five years and
were or have treated middle-class African-American women within the last five years. As it related to each research question posed, the therapist in this study revealed the following:

- Knowledge of and identification with a theory combined with other contributing factors serve as a guide for approaching treatment.
- Honoring the client as the expert contributes to the approach to treatment and the selection of interventions used.
- The intersection of race, class, and gender, as well as issues of access, privacy, and resources contribute to why middle-class African-American women seek mental health services in the private sector.

This grounded theory inquiry resulted in substantive level theory of the dynamics of treating middle-class African-American women. The theory acknowledges that no one factor guides the process of treatment but various factors interact to create an environment of mental health treatment conducive to treating middle-class African-American women. The combination of knowing and identifying with a theory and other factors like worldview, the race, class, and gender of the therapist, spirituality, and experience create a guide for approaching treatment. With that guide in mind, therapist focus on building a therapeutic relationship that sets the woman being served as an expert on her life, issues, and course of treatment. Interventions are then chosen based on the guidance of theory and other factors, relationship with the woman, and her expertise. A foundation of understanding the unique position of the women and how race, class, and
gender intersect to create a circumstance or experience that is relevant to treatment and the importance of access and privacy all cumulate to create the dynamics of treatment.
CHAPTER V

CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

The purpose of this qualitative study was to explore the theoretical/philosophical frameworks, treatment, engagement, and diagnostic approaches of private practice therapists who treat middle-class African-American women. This research study was designed to gain an understanding of the following research questions:

RQ1: How does the theoretical/philosophical framework employed by private practitioners influence their approach to treating middle-class African-American women?

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RQ3: What factors impact the choice of interventions used when treating middle-class African-American women?

This qualitative study consisted of eight in-depth interviews with private practitioners who were purposefully selected. The interviews took place over the course of three months and were the sole source of data for this study. Each interview was professionally transcribed verbatim. Grounded theory coding revealed a substantive level theory explaining the dynamics of mental health treatment for middle-class African-American women in the private sector. Participants were recruited through advertising to the three national professional organizations and the snowballing technique.
An analysis of the data revealed that the knowledge and identification of a theory combined with other contributing factors serve as framework of influence when serving middle-class African-American women. When the factors that impact the choice of interventions used were explored, one category and a property emerged. Participants indicated a client-centered approach as well as the therapeutic relationship impacted their intervention choice. Additionally, when exploring why middle-class African-American women seek treatment in the private sector, two categories of findings emerged. Participants revealed that from their perspective, the intersection of race, class, and gender as well as access, privacy, and resources impacts middle class African-American women’s choice to seek services in the private sector.

This chapter provides an overview of the substantive level theory generated from the data, the conclusions and discussion, limitations of the study, and implications for theory and practice in the field of social work policy, education, planning, and administration. Recommendations for future research are also discussed. Additionally, all information presented related to a particular participant use the pseudonym chosen by that individual.

**Substantive Level Theory**

This grounded theory study resulted in a substantive level theory of the process in which private practitioners approach and engage in mental health treatment with middle class African-American women. A model emerged which is labeled the dynamics of treatment (see Figure 1, Chapter IV). The data revealed that there are various dynamics involved in treating middle-class African-American women in the private sector. The
diagram illustrates a non directional relationship of various factors that culminate at any given time and serves as influencers of treatment used by the therapist in this study. The treatment of middle-class African-American women serves as the core or central theme of the theoretical model. Each circle represents a factor that the therapist identified as playing a role in how they approach, engage, and conceptualize the treatment of a middle class African-American woman. The therapist identification of a theory coupled with other contributing factors like their worldview, personal and professional values, and experience impacts their approach to treatment. It serves as a guide or compass for the therapist. However, it is the stance of a client centered focus in which the woman is the expert and the strength of a therapeutic bond that impacts the choices made throughout treatment. This factor consistently interacts with the other factors identified.

Additionally, the therapist believe that the intersection of race, class, and gender serves as a reason for the women they serve to seek treatment in the private sector. They believe that this is unique to middle-class African-American women and their understanding of this intersection and issues related to access, privacy, and resources assist them in the course of treatment. The application of this theoretical model is demonstrated in the following example. Sarah is an African-American Licensed Clinical Social Worker engaged in treatment with a middle-class African-American woman (Central Theme). Her knowledge and use of testimony therapy guides her approach to treatment (Knowledge and Identification of a Theory). However, her personal experiences as an African-American woman, her research on African-American’s psychiatric treatment in America, and her experience as a therapist also influences her
approach to treatment (Other Contributing factors). She uses four “healing questions” when serving woman and creates a therapeutic space in which she sees the woman as the expert on her life, issues, needs, and hopes for recovery (Client Centered/Focused). This client centered focus couples with her approach and use of four healing questions to create a dynamic of treatment at any given time through the process. Additionally, as therapy continues, Sarah uses her therapeutic relationship to build a level trust and communicate her acceptance of the woman's place and power as the expert. The woman she serves continues treatment with Sarah until she reaches a place of satisfaction. Sarah attributes this to her ability to provide a safe and private therapeutic space in which she does not label (diagnosis) her clients and provides flexible and customized care. Sarah also believes that her understanding of the unique positioning of middle class African-American women contributes to their use of her services in the private sector. She attributes this unique position to the intersection of race, class, and gender. In Sarah’s example, all of the factors mentioned above interact at various levels and times throughout treatment to impact the central theme, thus creating an environment of treatment specific to middle-class African-American women.

**Conclusions and Discussion**

There were three conclusions based on the findings. The conclusions are:

1. Theory is not the sole influencer when approaching treatment with middle-class African-American women.
2. A client-centered perspective which views the client as the expert as well as the development of a strong therapeutic relationship impacts the course of treatment.

3. The therapists believe that the intersection of race, class, and gender influences middle-class African-American women’s decision to seek services in the private sector.

Theory is not the sole influencer when approaching treatment with middle-class African-American women. Research indicates a clear link between a therapist worldview, personal and professional values, and personality to their identification of and use of a theoretical framework (Poznanski & Mclennan, 2003). The findings of this study corroborate with the research discussed above. Participants indicated that theory alone is not the sole influencer when approaching treatment and serves more as a guide or compass for the therapist. This sentiment was expressed by Toby when he stated, “The treatment mode, for the most part, is the compass for the therapist” (Toby, Personal communication, May 14, 2010). Jack also referenced theory as a guide when he stated, “It guides my mission in the process . . . I think it’s something that has served me well in my understanding of the world” (Jack, Personal communication, May 7, 2010).

Participants had a working knowledge of theory that developed through training and experience however; for them, it was not the key to approaching treatment. Most of the participants clearly indicated other factors that contributed to their choice of theory as well as their approach to treatment. For example, Sarah explained how her research on
African-American psychiatric history and her position as a black woman activist impacted her selection and use of a theory in the following quote:

Probably another influence for me, though, is that I did research on African-American psychiatric history, which then made me immediately question just about everything that’s done in the mental health field because it is based on oppression and trauma. So I had to sort of think about a new way of relating to people that didn’t have that sort of power abuse that’s inherent in mental health in America. So narrative therapy sort of emerged for me at that time as a form of therapy that, one, looked at the person in their environment in a way that my social work training invites me to look at people anyway, and how their environment fits with who they are, and how that impinges upon them. I think it’s one, just being a black woman, being an activist, primarily, so I do sort of identify as an activist therapist with the activist first for a reason. Sort of coming out of the tradition of black women’s health activism, which is also a self-help model, which again, sort of influences how I think about things. (Sarah, Personal communication, June 28, 2010)

Jack also discussed how his personal values and worldview contributed to his identification of a theory. He expressed how his upbringing and spiritual conversion to Christianity contributed to his use of a Christian approach to treatment.

Research also shows that competent therapist and theoretical understanding is an essential component of effective therapy (Hansen, 2006). Although the participants did not link theoretical understanding to effective therapy, they did feel like it was important.
One of the participants in this study confirmed the need for theoretical understanding when he spoke of supervising young therapist. He mentioned the importance of a therapist knowing their work and having a theoretical understanding when approaching treatment. Diana and Carey also mentioned the importance of knowing theory in their head. Even though they did not feel as though they approached treatment with theory in mind, they did value having the knowledge of theory and being able to draw on it if needed.

As the role of theory was discussed with each participant it became clear to this researcher that the therapist worldview, race and gender, training and experience, and personal values impacted the selection of a particular theory or theories. Those factors and the theory selected combine to serve as a guide or compass for the therapist. Theory really has nothing to do with the client for these therapists but everything to do with them. For example, some of the participants discussed how their approach may or may not fit with individual clients. Jack expressed:

I make it very clear that you’re, as a consumer, going to make a choice about what’s in your best interest, and you will make a decision about whether or not this process is going to be useful to you, and I will honor whatever decision you make about your choice of providers. There are many wonderful therapists in the Atlanta area and I encourage you to do research and to be a consumer and to make a good choice about what’s in your best interest. But these are the ABCs of me and you will know what you’re getting when you come to see me. (Jack, Personal communication, May 7, 2010)
Sarah also expressed a similar perspective on fitting with clients when she stated the following:

There are people that are not a good fit for me, so, and what happens, because I’ve had people come in and say, ‘Well, I wanted psychodynamic stuff. I wanted you to sort of play out this thing.’ I said, ‘If your mama’s still alive, go talk to her. If your mama’s dead, I got ways that you could talk to her dead...so for me, there are clients that are not a good fit for me, and I try to be clear with them about how I work because I do believe that people need to be with the therapists that are going to most get them to a place of recovery by their own standard.’

(Sarah, Personal communication, June 28, 2010)

It also appeared as though their theory of choice and their worldview are so tightly integrated that you cannot discuss one without the other. For example, Jack could not separate his choice of theory from his spiritual worldview; actually, his choice is a direct reflection of his spiritual stance. This is demonstrated in his comment below:

I am a person of faith and many of my clients are people of faith. So it’s an integration of Adlerian, solution-focused and an integration of a Christian understanding of behavior modification, what promotes change, what’s curative from a Christian perspective... it’s an affirmation of resilience that comes from a faith informed by the Bible, the inherent word of God and, I don’t like the word dogma, but in this case it applies, that there are beliefs that emerge from a Christian understanding, and that’s the client’s understanding and my understanding, and the negotiation of that. But ultimately, it’s summed up in
Jesus’ words to love God with all your heart, mind, soul and spirit and love your neighbor as yourself. (Jack, Personal communication, May 7, 2010)

This is significant when serving middle-class African-American women because research shows that the worldviews of therapists can serve as a barrier to treatment for African-American women. When a therapist worldview positions an African-American woman in a negative, deductive, discriminatory manner it can result in misdiagnosis, racism in treatment, and ineffective treatment which results in mental health disparities (Report of the Surgeon General Supplement, 2001; Carrasco, 2004; Bitar, Bean, & Bermudez, 2007). Research also indicates that due to racism and cultural bias, some traditional theories may not be suitable for people of color (Minton & Meyers, 2008; Norcross, Karipak, & Lister, 2005; Jackson, 1977).

Fortunately, the therapist in this study viewed middle class African-American women as strong, resilient, and valued. This perspective was reflected in comments made by Jack when he stated: “I can identify a resilience, and you can call it soul, you can call is strength, humor. I guess I would just call it resilience, that there’s a strength that exists. It’s a reserve that I would say is unique.”

The findings of this study support existing literature in regards to the development of a theoretical orientation or framework. A therapist worldview and professional and personal values and experiences impacts their selection and use of a theory, which then serves as a guide for treatment. It is vital when serving middle-class African-American women that a therapist is well aware of how their worldview and theoretical framework positions that woman to ensure effective and appropriate treatment.
A client-centered perspective which views the client as the expert as well as the development of a strong therapeutic relationship impacts the course of treatment. The findings of this study revealed the use of a client-centered perspective which positions the client as the expert and the use of the therapeutic relationship as key factors to treatment decisions. This approach fosters an environment of safety and trust, this is valuable because research shows that trust is a vital component of the therapeutic process and can impact a person's help seeking behavior, continuation of treatment, and medication compliance (Boulware, Cooper, Ratner, Laveist, & Powe, 2003).

Client-centered theory was founded by Dr. Carl Rogers and is based on the idea that the client possesses the capacity and right for self direction and development (Bozarth & Moon, 2008). This approach or position involves what is known as unconditional positive regard in which the therapist conveys to clients that they are valued and worthwhile and empathic process in which the client is free to direct treatment (Harvard Medical School, 2006; Bozarth & Moon, 2008). The ultimate goal of a client centered focus or approach is to facilitate an environment that positions the client as the expert on their lives and acknowledges that the locus of power resides with the client and not the therapist (Bozarth & Moon, 2008). The following assumptions are embedded in this approach (Bozarth & Moon, 2008):

- The client is the expert regarding her life and issues;

- Power within the therapeutic relationship emerges from and resides with the client not the therapist;
• The freedom for the client to determine the direction of treatment is enabled by the attitude of the therapist;

• The focus is on the person not the problem;

• The therapist should in no way Judge the individual (Kensit, 2000)

A client-centered theory, focus, or approach gives attention to the unique experience of the individual and the meanings and feelings they give to their experience. The therapist seeks to understand how the world looks from the client’s point of view (Bozarth & Moon, 2008; Harvard Medical School, 2006).

The findings of this study pose a therapeutic focus or stance that can serve as a method to alleviate some of the mistrust and fear noted in the research as barriers to treatment. Although the participants did not identify client-centered theory as a theoretical orientation and approach to treatment, they did note it as a perspective or position they take when facilitating mental health treatment. The participants in this study expressed many of the components and assumptions embedded in Dr. Rogers’s theory of client-centered therapy. For example, most of the participants viewed the client as the expert therefore giving them power to direct treatment. Toby stated:

What we’re saying is you are an expert in your life. I’m not the expert in your life. I’m not the one who can tell you what you need. How the hell do I know? I can only be an expert in the work that I do, but not in your life . . . As opposed to trying to be an expert in someone’s life and telling them what to do, collaborate. I believe very strongly in client-centered and client-directed work where, as the therapist, I’m not trying to be the expert in somebody’s life and tell them where to
go. I’m making space for that person to tell me where it is they need to go to get
to the place that they want to go; so that they can have the testimony about their
life. (Toby, Personal communication, May 14, 2010)

Carey conferred with this sentiment when she stated: “I want to communicate
that they are the expert on their experience and what’s relevant in their perception”
(Carey, Personal communication, June 28, 2010). Sarah also spent a lot of time
explaining the importance of positioning the client as the expert; her perspective is
reflected in the following comment:

It’s because it sort of positions the person as the expert, it values their telling of
the story and the themes that are important to them, and sort of, for me, checks the
therapist, quite frankly, on who gets to define what the problem is. People may
come to me and say, ‘Well, tell me what’s wrong with me,’ and I tend not to work
very long with those kind of people because if you want me to be the expert for
you, that’s probably not going to work for me because I think that a lot of times
the healing for black women is that it’s being able to define yourself, and that’s
something that a lot of times we’ve been cut off for in other areas of our lives, so I
want to make sure that therapy is a place where there’s a constant invitation to tell
me what you think about that. I can offer you perspectives, I can offer you some
feedback, I can tell you sort of, in the scheme of larger women’s issues, and black
women much like you, sort of what they might be experiencing or some recurrent
themes, but always trying to stay clear with like, ‘What’s your perspective on it?
Does this feel true to you?’ (Sarah, Personal communication, June 28, 2010)
Saleebey (1994) noted that it is imperative when treating African-American women not to listen and engage in dialogue solely to box them into a diagnostic label because this has the potential to be just as damaging as a stereotype or racial slur. However, diagnosis is usually the starting point of therapeutic interventions, for some practitioners this actually drives the direction of treatment or at the very least the selection of treatment modalities especially within the new managed care environment (Hall & Keefe, 2006). The participants in this study expressed their reluctance to diagnosis because their focus is on the person not the problem. This perspective of separating the person from the problem is in line with a client centered focus. Jack and Toby expressed this focus in their comments. Toby noted the following:

First of all, it’s important as therapists to maintain the human element. People are not the problem. The problem is the problem. That’s the first thing to remember, not to make the client the problem, not to pathologize the client, and to learn to listen for the victories in people’s lives, rather than looking for the pathologies. The pathologies, the hurts, the pains reveal themselves. That’s what people bring. But the real skill is learning how to listen for victories in people’s lives and learning how to become curious and ask the questions that help people see the victories for themselves. (Toby, Personal communication, May 14, 2010)

Jack indicated the following:

I’m very careful with labels, helping consumers recognizing that they’re much more than just the diagnose, they’re much more than just a problem, that their identity is not easily defined by the problems. The problems they present with are
part of who they are, but they’re not who they are. (Jack, Personal communication, May 7, 2010)

Sarah also shared Jack and Toby’s client centered perspective on separating the person from the problem which is reflected in her comment below:

I don’t diagnose. That’s one of the reasons why I don’t take insurance . . . I actually found it more helpful that my therapist listened to what I described as my challenges and where I wanted to go. A label didn’t help. It isn’t that I don’t notice distress, it’s not that I don’t know the status, or depression, or complicated grief, or extreme energy states, whether that’s mania, or bipolar, or something, but I don’t think that people grow – and in fact, I’ve just seen more damage from that as people try to either just to conform to the label and say, ‘I’ve got bipolar. What am I supposed to do?’ Or who have been mislabeled, straight up mislabeled, and then spent a lifetime both with medication and other stuff, trying to get healed. (Sarah, Personal communication, June 28, 2010)

A client-centered approach also acknowledges the use of the therapeutic relationship as a way to provide a safe and trusting environment for the client to act as the expert (Laughton, 2010; Bozarth & Moon, 2008). Dr. Carl Rogers indicated the importance of a therapeutic relationship when using a client centered approach. He talked about creating a safe relationship so the client can communicate their experiences (Rogers, 1950). Also, regardless of the theoretical framework or techniques employed, the quality of the therapeutic relationship has been noted as a significant influence on therapeutic outcomes (Laughton-Brown, 2010). The participants in this study also noted
the importance of the therapeutic relationship. Toby discussed this importance when he mentioned the following: "A therapist who knows how to build a strong relationship, a good relationship with their client, is in a much better stead, whatever they’re doing, whatever their theory, than another therapist" (Toby, Personal communication, May 14, 2010)

Similar to Carl Rogers, Ester and Toby discussed the importance of creating a safe and respectable environment that fosters a relationship of trust and promotes disclosure. Ester stated the following:

I do what I can to create an environment that is respectful and where people will feel comfortable. I think coming into a space where you’re going to share your most intimate life story should be in an environment that is inviting. So I start with that. I start with creating an environment that is peaceful, that is respectful. I believe that for every person who comes to tell their story, there’s a level of respect. There’s a level of respect in honoring their story, and that it is an, if you will, sacred experience. And so the pain that a person is sharing, the time that they're taking to come in and ask for me to be with them in their experience, I want them to feel that I’m on the journey with them, and so that, to me, is why the relationship piece is so critical . . . I make a point of being very personal and building the relationship . . . Relationship is a big part of the process. (Ester, Personal communication, May 14, 2010)

Toby used a historical metaphor to describe how important it is to foster a safe therapeutic environment and relationship. He described the following:
I call my therapeutic space—a metaphor that I use for it is brush arbor. Brush arbor, during days of slavery, were safe places that enslaved Africans could go to worship. It’s where Africans went and worshiped in the way that they wanted to worship, because generally, the law was that black people could only have worship experiences if there was a white person present. In other words, there had to be a white person there for them to have church, or whatever. But what black people had was the brush arbor, where they’d go back in the woods and they’d create a cleared space, cut down space and what not, and create basically a covering that they could worship in secret. In that brush arbor, you could say, do and be who you wanted to be. For me, that metaphor is really appropriate for black people in therapy. This is a brush arbor experience where you can say what you need to say... What I work really hard for is to create real transparency within the therapeutic space. (Toby, Personal communication, May 14, 2010)

The findings of this study provide a potential method in which to reduce the level of fear and mistrust African-American women may bring to treatment. By positioning the client as the expert and using the therapeutic relationship to foster a safe and trusting environment, therapists in this study are engaging middle-class African-American women in treatment. The findings also indicate that this focus can be and is applied regardless of the individual theoretical orientation. Although the therapist in this study represented various theoretical frameworks, they all used a client centered focus to view and engage in the therapeutic process. This focus and the use of the therapeutic relationship appeared to be an intervention within itself.
Practitioners feel that the intersection of race, class, and gender influences middle-class African-American women's decision to seek services in the private sector. Research shows that women in general are more susceptible to the effects of mental health disparities than their male counterparts (NAMI, 2008; Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007). However, African-American women face even more barriers related to utilizing mental health services (NIMH, 2008; Jackson, 2006). African-American women experience both the stresses and barriers that come along with their membership in a vulnerable ethnic group and their gender related vulnerabilities. Additionally, the variable of class also provides a level of stress for African-American women. More specifically, middle-class African-American women face a significant degree of stress related to their position of upward mobility. They face a complex reality which includes racism, sexism, and the stress of balancing occupational, family, and community responsibilities. This combination of stressors increase their vulnerability to physical and mental health problems like conflicts in self-esteem, depression, anxiety, addictive behaviors, and other stress related reactions (Smith & Wermeling, 2007).

A book entitled Shifting by Jones and Shorter-Goodeen (2003) discusses how African-American women have mastered the art of shifting back and forth to accommodate differences in class, gender, and ethnicity. Shifting is not new to African Americans; it was used to survive during slavery and the Jim Crow era. During those times African Americans literally had to shift (i.e. looking down, moving off the sidewalk or to the back of the bus). Now, the shifting is subtle and can sometimes go unnoticed. Shifting is what a black woman does when she speaks one way at the office, another at
home, and then another way when she is with her circle of friends. Shifting is working overtime when you are exhausted, ignoring racist comments as not to appear aggressive and threatening, to adjust your personality and behavior to satisfy a black man. It is a result of living in a racist and gender bias society. In addition to the use of shifting, African-American women are also plagued by various myths and stereotypes that infringe on their psychological well being. Those myths/stereotypes include:

- **The Strong Black Woman Syndrome.** This syndrome stems from the enslaved woman’s overwhelming ability to endure and overcome the hardships of slavery. This has translated into African-American women’s continued extension of themselves to their families, communities, churches, and jobs. They often carry heavy loads of responsibility at the expense of their own well being (Heath, 2006; Jones & Shorter-Gooden, 2003).

- **Myths of the Matriarch.** African-American women are viewed as the backbone of the family. They are the one who holds everything together in their communities, churches, and family (Heath, 2006).

- **Mammy.** This stereotype characterizes the African-American woman as faithful and obedient, a domestic servant. She is viewed as a symbol of warm, nurturing, and patient motherhood especially to the white children she takes care of (Roberts, Jackson, & Laney, 2000).

The above stereotypes, syndromes, and myths can have a negative impact on the mental health of African-American women. Women who internalize the strong black woman syndrome will often over extend themselves which adds to their stress, will feel
shame about the mental pain they may be experiencing, and feel like asking for help goes against the nature of who they are as a black woman (Jones & Shorter-Gooden, 2003). Sisterella Complex is what some black women experience as a result of the strong black woman syndrome. A woman experiencing this complex usually overachieves, works tirelessly to appease others, she works so hard to be what other people need and want that she loses herself and control of the shifting process. She begins to experience depression sometimes severe depression and usually suffers quietly. Signs and symptoms of the Sisterella Complex can include overeating, busyness, working hard, sacrificing sleep to accomplish task like child care, job responsibilities. She is constantly on the go, unable to relax, disconnected from her own needs; she experiences headaches, stomach aches, and other physical problems (Jones & Shorter-Gooden, 2003).

Women who internalize the myth of the matriarch may feel like the survival of her family, community, faith, and even race depends on her ability to keep everything together. She will sacrifice her health and happiness to attend the needs of others (Heath, 2006). Society views the matriarch as loud, boisterous, domineering and emasculating to their male counterparts. This image attacks the femininity of African-American women. When internalized, it may impact their self esteem and relationship choices (Roberts, Jackson, & Laney, 2000). African-American women who internalize the mammy image may model the docile, obedient servant behavior that has the potential to perpetuate racial and gender oppression (Roberts, Jackson, & Laney, 2000). Women may experience one or all of these stereotypical myths and images that may influence their mental health, help seeking behaviors, and success in treatment.
Participants in this study also described various components of all of the myths and stereotypes discussed above when discussing their clients. Patricia described components of the strong black woman syndrome and the myth of the matriarch in the following statement:

There’s a different twist probably with women of color, because oftentimes that’s a block or why it might have taken them longer to come in. I mean, some of the issues that they face have been going on for decades or generations. And so we probably spend more time on it, and it’s probably interwoven throughout the therapy process a little differently than maybe with clients who are not African-American. I think, and this is probably also somewhat historically, but we constantly hear or have witnessed about women being the rock or the foundation, and so I think some women celebrate that. At the same time, they want a break too, and that could be either the married woman or the single woman, in whatever way she is single, that they get tired of carrying all of the weight, all the responsibility. And so I think I hear more of an egalitarian relationship, and this might be just what they disclose, from the Caucasian-American clients, for example. But the African-American ones, I think they just feel so overwhelmed. ‘It’s good and I can do better by myself, but sometimes Mama needs a break.’ I hear that pretty consistently, like they’re just overwhelmed, overwhelmed and would love to—just need to share some of the responsibility or get a different perspective on it so it can be more doable. If they’ve been in this position of being so strong and they can do everything and they can handle everything, blah,
blah, blah, and they're often, and this is probably one thing I often do hear, 'I'm the person everybody comes to. Even though I'm the youngest, or I'm the middle, grandmama, auntie, uncle, younger so-and-so, they come to me for money. They come to me for advice. They come to me to babysit their kids, blah, blah, blah. And so being in a place where I'm asking for help is very odd or uncomfortable for me. I've wanted to, but I've had no place to go. So I would have gone to somebody in my immediate circle, but I don't have anybody because they all come to me.' So that's probably, and they're like, 'What is this that I have to come to somebody who I don't even know? But I have all these people around me, but I can't go to them because they need me,' and so that's probably another thing. (Patricia, Personal communication, May 21, 2010)

Diana also mentioned the impact of stress and carrying a heavy load which is also a theme inherent in the strong black woman syndrome when she mentioned the following:

Nowadays it's becoming to be—not only is it historic, but the stresses are even more so, because a lot of African-American women I see are raising kids by themselves, or working two and three jobs, or they're in school and working. So it just—they're trying to take care of parents, or helping brothers and sisters in school. The stresses seem to be getting more in today's climate than ever before. (Diana, Personal communication, June 4, 2010)

Carey mentioned more directly, the components of the strong black woman syndrome when she stated: "It's a result of the models that they're trying to follow. But
we’re trying to follow not only the traditional roles, but we’re trying to follow them like white women that do the superwoman garbage” (Carey, Personal communication, June 28, 2010). Paul also mentioned components of the myths and stereotypes discussed when he said:

A lot of times, they have a lot of pressure on them. They’re the ones that the family had looked up to who were different, who didn’t have the problems, who were supposed to be the 100% person. And when they’re not, they beat themselves up a lot. (Paul, Personal communication, April 22, 2010)

The participants in this study also acknowledged how the impact of identifying with a particular race, class status, and gender contributes to their need for treatment as well as their reason for utilizing services. Many of the participants discussed this intersection of race, class, and gender. For example, Carey mentioned the following: “Well, let me just say what’s unique is that they’re a member of two target groups, and sometimes three. One is African American, the other is gender, and the other is the variable of class” (Carey, Personal communication, June 28, 2010).

Whether discussing, race, gender, or class, components of at least two of the target groups were present in the comments made by the participants. For example, Sarah stated the following when discussing the safety of therapy for African-American women:

White women had to work a long time to make therapy sort of safe for them. It’s not fully safe for white women, so if it’s not fully safe for white women we can be pretty much sure that colorful women still got some work to do. I think it’s still
normed on men. Sort of what’s normal, and what’s considered healthy sort of emotional identity, or mental health is still very much normed on what’s—on men’s behavior. At the same time, being a woman is not a fundamental problem and flawed, and the goal is not to be like a man. (Sarah, Personal communication, June 28, 2010)

Toby talked about race and gender as well, he stated the following:

I’m very much aware of the discourses about gender, and to question them; things about what men are supposed to do, what women are supposed to do, and to raise questions about those. ‘Well, where did you hear that?’ So the question of gender becomes very important . . . what I work really hard for is to create real transparency within the therapeutic space; transparency about issues of gender, sexuality, color, ethnicity, so that it is a safe space to have those conversations in ways that are not stilted. (Toby, Personal communication, May 14, 2010)

When discussing the intersection of race, class, and gender ethnic matching came up for some of the participants. However, Toby and Sarah talked more about safety as opposed to ethnic matching. This sentiment is expressed in Toby’s statement below:

The things that you may not say if you had a white therapist, the things that you might not say, even with a black therapist who does not explicitly make that an open space. Often, sometimes people will go to a black therapist, and if that black therapist is not being transparent about questions of color, questions of race, questions of gender and sexuality—there’s a lot of silencing that goes on. So a lot will not get said; even questions of spirituality or religion. If the black therapist is
presenting from a context of whiteness, the black person is not certain what they can say safely in that space. (Toby, Personal communication, May 14, 2010)

Sarah’s comment was in line with Toby when she stated the following:

Just because I’m black doesn’t mean I understand her experience…that’s why I think it makes so much more sense for me to really stay clear about the power, and knowledge, and expertise of the person sitting next to me. (Sarah, Personal communication, June 28, 2010)

Provider racism and patient awareness of negative historical events such as the experiments on slaves have contributed to the lack of access and trust of the healthcare system for African Americans (King, 2003). Some of the participants in this study also acknowledged the impact and legacy of slavery on the mental health of their clients. For Example, Sarah mentioned the following:

I just think there is still a lot of stuff out there, and more conversation happening around the legacy of slavery. I think there is something about multi-generational transmission of trauma, which is very profound. Black people were not considered to be capable of depression because it was like saying the cow was depressed . . . The black woman over there, she’s got no problems. Yet she’s being raped at work and all this kind of stuff, but they don’t have the capacity. So I think there are . . . sometimes when the story comes out it’s very hostile, or very confused, or crazy. Almost like, ‘Why are you mad like that? I don’t get why you’re mad like that.’ It’s not just because they’re mad about this, it’s about the whole thing. It’s almost like all of this ancestral stuff coming through in many
ways. So that’s a piece of the therapy too, and they might come in for conflicts at work, or depression, or relationship stuff, and if they choose to do the work there may be this other thing they get to say about—you’re dealing with a legacy you didn’t create, but you’ve got to live it out. You want to clear it up so you don’t—so your kids don’t have to do it. (Sarah, Personal communication, June 28, 2010)

As for class, the findings supported the research in regards to work related stress and racism as well as balancing work and other responsibilities. Sarah’s description of what one of her clients was experiencing at work expressed that phenomenon. She described the following:

I was talking to someone the other day who came in, and some of her dilemma was about trying to figure out what was going on in a work environment, Someone had sort of said to her that she was maybe arrogant. I said, ‘Do you think that someone would ever use that language in an evaluation for a white man? That the term arrogant would come up?’ because she was stepping out of place . . . in some ways that arrogant entitled is a smoother way to call her a bitch, quite frankly, black bitch, and who does she think she is? In a corporate setting you can’t put on someone’s evaluation form, ‘This black bitch thinks she’s somebody good.’ Yet, to sort of say, ‘You’ve got to look at that dynamic, and so how does that position you, but how do you stay clear with your core about your right to ask for what you need, your right to be compensated for quality of work, for your ability, and to trust your own ability to assess your own good work.’ (Sarah, Personal communication, June 28, 2010)
The findings of this study clearly touched on the intersection of race, class, and gender and acknowledged how it positions an African-American woman as it relates to treatment. Issues of access, resources and privacy were also discussed as it related to the race, gender and class of the women served. Participants felt like due to the class status of the woman they serve, they had resources and access to services in the private sector and that served as one of the reasons they chose mental health treatment in the private sector. Carey stated that her clients would not do anything public because it did not speak to their lifestyle. Issues of privacy were discussed in terms of safety, undocumented care, and customized care which related to class and race for the woman they served. Toby illustrated the concept of privacy and undocumented care when he stated:

The privacy; when someone calls me, for instance, my practice is a fee for service practice, which means that people pay out of their pocket. People will often call and talk to me about their insurance or whatever, and we do not take insurance. What we tell people is the reason we don’t take insurance is, first of all, insurance companies work on the medical model. In order for the insurance companies to pay us, we have to give you a mental illness diagnosis. In other words, we’ve got to make you crazy in order for them to pay us. We don’t believe that people have to be mentally ill to talk to a therapist. And most people don’t want an unnecessary mental illness on their medical record. When people understand that, they make the choice to pay for themselves because of the privacy that they pay for that. (Toby, Personal communication, May 14, 2010)
Overall, the findings of the study confirm the issues noted in previous research on how race, class, and gender contribute to the need for services. However, the findings emphasized the practitioners’ belief in the importance of understanding this intersection so it does not pose a barrier when treating middle-class African-American women. The therapist in this study used their understanding of the unique position the woman are faced with due to their status as an African American, a woman, and being middle class. They believe that their understanding of how all of those identities carry strengths and stresses and all intersect at various times and levels to serve as a point of celebration and/or destruction contributes to middle-class African-American woman’s use of private sector mental health services. Additionally, the therapists do not require the women they serve to choose between the three.

**Limitations of the Study**

There are limitations that impact this study. The findings of this grounded theory qualitative study was affected by the use of a purposeful selected sample size of eight fully licensed therapists who had at least five years of experience and who served middle-class African-American women within the last five years. Additionally all of the therapists in my study practiced in the state of Georgia. Because of the small sample size and the method of sampling, the findings of this study cannot be generalized to larger populations of therapist who meet the sample criterion. It is important to note that the goal of this study was to gather an in depth understanding of the research questions at hand; however, some may feel that the inability to generalize serves as a limitation.
Another limitation of this study is the exclusion of therapist licensed on the associate level (i.e. licensed master social workers, licensed associate professional counselors). Although they are not fully licensed, many associate level therapist practice in the private sector under the supervision of fully licensed clinicians. It is possible that they hold information regarding the phenomena explored in this study. However, experience and full licensure was a key sample criterion. Some critics may view their exclusion as a limitation.

Finally, another limitation of this study is the inability to determine if the information reported was truthful. Due to the fact that this researcher is an African-American woman, participants may have been reluctant to share negative opinions regarding this population as it relates to treatment. Additionally, participant responses may have been impacted by the desire to sound or be perceived as competent and professional. The use of pseudonyms and an emphasis on confidentiality were employed as a method to minimize theses limitations.

**Implications for Practice in Social Work Policy, Planning, and Administration**

Very little is known about the help seeking behaviors and patterns of middle-class African-American women however, they tend to have an increased risk of mental health issues, increase in the use of counseling, and resources to access services (Smith & Welming, 2007). Research also shows that due to factors like cultural bias, theoretical orientation, worldviews, and skill and competence of the therapist significantly impacts service delivery for African-American women (Report of the Surgeon General Supplement, 2001; Carrasco, 2004; Bitar, Bean, & Bermudez, 2007). However, there is
little to no literature available that evaluates the mental health treatment of African-American women from the practitioners’ standpoint.

Previous research has explored the factors that contribute to the development of a theoretical framework from a qualitative standpoint (Poznanski & McLennan, 2003). However, there is no existing literature that explored the influence of a theoretical framework on the approach and implementation of treatment for middle-class African-American women in the private sector. This gap in the research provided the bases for this study. The ultimate goal of this study was to explore three gaps in the literature from the perspective of the practitioner with a focus on middle-class African-American women:

1. How does theoretical orientation influence the treatment approach when serving middle-class African-American women?

2. What factors influence the choice of interventions used when serving middle-class African-American women?

3. Why do middle-class African-American women seek services in the private sector?

**Practice Implications**

During the interviews with the participants a question was posed that relates to practice implications. The question was what they would want a therapist to know before working with middle-class African-American women. Three central themes were found in the responses and directly relate to practice implications, self awareness, cultural competence, and a client centered focus.
As previous research indicated, worldviews and personalities impact a therapist’s selection of a theory. The findings of this study confirmed that notion and revealed just how tightly woven a theoretical orientation is with a person’s worldview and professional and personal values. This dynamic begs for a level of awareness on the therapist part in order to prevent bias which could be harmful to the women they serve. Whether a social worker, professional counselor, or psychologist, it is extremely important to explore, understand, and acknowledge how you feel about African-American women of all classes and how that can potentially affect the therapeutic process. The notion and importance of self awareness was described by Sarah in the following statement:

I’d want them to be really, really clear and have done a lot of thinking about how they feel about black women, including themselves. How do you think about black women? What do you believe about black women? What do you believe are black women’s strengths? What do you believe are black women’s challenges? What are your own unique challenges? I think that that’s the biggest thing. Someone might say the psychodynamically use of self, or whatever, but I think I’m only as clear with—I can only see you as clearly as I can see myself. If I’ve got lots of fog around me I’m dangerous to you. So I think the first thing I’d say—especially if it was an African-American therapist—I’d say you’ve got to be real clear about who you are. Hopefully be operating from a position of loving who you are as a black woman, because if you aren’t, you’re going to be dangerous to other people. Allow that other black women, who might look like you, may have had very different experiences for any number of
reasons, which is why then that position of, ‘You tell me your story. Tell me more.’ (Sarah, Personal communication, June 28, 2010)

Research also shows that culture and society plays a vital role in mental health services, both the clinician’s culture, the client’s culture, and beliefs about both can pose as a barrier to treatment for African Americans (Surgeon General, 2003; Beancourt, Green, Carrillo, & Ananeh-Firempong, 2003). It is important to understand the culture of the African-American women and the intersection of race, class, and gender which puts them in a very unique position. Stereotyping and assuming can be damaging to the therapeutic process for middle-class African-American women and serve as a deterrent for treatment. Both Paul and Ester’s recommendation was related to the importance of cultural competence without assumptions. Paul mentioned the following:

If it’s a white therapist, first you have to understand the culture and just don’t put that middle class African-American woman in some type of category, because you don’t know. That middle-class African-American woman can be in a category of an upper-class African-American or European woman, and she can carry herself that way and totally disassociate herself with all of the stressors that lower income people have. Or she can be right of the box of a lower income class African-American woman. So what that says is that there is a broad range. You can’t stereotype them. You have to treat them with a blank slate and then you get your information from them, just realizing no matter which area they come from, they still are tied to the African-American race because this culture will not allow anything but that; so just to say you have to use a broad range of therapeutic
approach with them and not restrict yourself to just one or two types of approaches. Definitely don’t go in with a framework in mind of how you’re going to do with this with this woman without leaving because you just don’t know what you’re going to get into. You meet them and do the background information check. (Paul, Personal communication, April 22, 2010)

Ester had the following to say:

I just think that, not just black people, but that our training is primarily based upon assumptions about white middle-class Americans, not even poor white Americans, but white middle-class Americans. And so what I tell my students, and I guess that’s the place I would go to answer that question, is to ask a lot of questions, and be clear about what the person is telling you, and to not have any assumptions without checking them out. Therapists tend to assume. I think therapists in Atlanta probably not as much, because there’s so many well-educated black people in Atlanta that it would be hard to be in practice and not experience meeting people who are well educated. But there’s a tendency in our field to put a low-income frame on a black person sitting in the room, and make some assumptions from that multi-problem, deprived, disadvantaged perspective as a way of thinking about and listening to them. (Ester, Personal communication, May 14, 2010)

One of the major findings of this study was to position the middle-class African-American as the expert in treatment. Regardless of your theoretical orientation, centering your services or focus in treatment on the woman’s experiences and needs as she defines
it is vital for continued and meaningful treatment. Theories like narrative therapy, testimony therapy, feminist therapy to name a few provide a framework which views the client as the expert. However, the therapist in this study clearly illustrated the importance and use of this client centered focus and client as the expert even though they represented a variety of theories. The therapist in this study were clear in stating that the women they serve know more about their needs, life, and feelings than they do, it is the woman’s story, she is the author. When serving middle-class African-American women, practitioners must understand that the client is the expert. For social workers, this perspective is in line with our self determination ethic.

**Implications for Policy and Administration**

Half of the participants in this study only accept self pay clients due to the medical model employed by most insurance companies and the participants that do accept insurance view diagnosis as a “requirement to get paid” as opposed to a significant component of meaningful and successful treatment. Additionally with the impact stigma has on communities of color as it relates to mental health, this requirement can pose a significant barrier. The requirement to diagnosis and label a client can potentially serve as a deterrent for practitioners. When you couple that with the managed care environment embedded in the mental health arena, it can create barriers for therapist and clients alike. It would be beneficial for insurance companies to reevaluate their expectation of diagnosis for their customers because it excludes qualified and effective therapist who understand the harmful effect diagnosis can have on some mental health consumers.
Social work practitioners who serve middle-class African-American women in the private sector should be evaluating the effectiveness of treatment. Most of the participants in the study felt like treatment was successful based on feedback from the women they serve. Administratively, it would be beneficial for therapists to obtain that feedback in an organized manner and use it to inform their development as a therapist. As the trend for “evidence based practice” continues, it could be beneficial to show how an “alternative approach” (i.e. the lack of diagnosis) to treatment is useful for certain populations.

Implications for Social Work Education

The ability to provide competent practice begins with education. The Council on Social Work Education (CSWE) Educational Policies and Accreditation Standards (EPAS) requires schools of social work to teach students how to provide competent therapeutic services to diverse populations (EPAS, 2008). Due to the fact that African Americans in general are directly impacted by mental health disparities and more specifically African-American women, it may be beneficial to dedicate a course or portion of a course to explore this issue.

Recommendations for Future Research

The purpose of this study was to explore the theoretical/philosophical frameworks, treatment, engagement, and diagnostic approaches of private practice therapists who treat middle-class African-American women. This study used a grounded theory qualitative approach was used to facilitate this inquiry. As a result of the research findings, the following recommendations are made for future research:
1. Explore the effectiveness of mental health treatment for African-American women in private practice from the women’s perspective.

2. Replicate this study with therapist in the public sector to see if the perspectives are similar.

3. Replicate this study. However, include associate level licensed therapist who practice in the private sector to see if there is variance in perspectives based on licensure level.

4. Replicate this study with therapists and their particular consumers to compare the perceptions of treatment.

5. Explore the concept of client as the expert and client centered/focused therapy with middle-class African-American women.

6. Replicate this study when serving middle-class African-American men to see if there is a difference related to gender.

7. Explore the impact of diagnosis on middle-class African-American women.

8. Explore the motivation to pay out of pocket for treatment when you have insurance from the middle-class African-American’s woman’s perspective.

9. Replicate this study from the combined perspective of both middle and lower-class African-American women adding the use of focus groups to determine if there is a class difference.

10. Conduct a study with middle-class African-American women exploring the impact of shifting and myths and stereotypes related to being a black woman.

Summary
The purpose of this qualitative study was to explore the theoretical/philosophical frameworks, treatment, engagement, and diagnostic approaches of private practice therapists who treat middle-class African-American women. The research questions directing this study were as follows:

RQ1: How does the theoretical/philosophical framework employed by private practitioners influence their approach to treating middle-class African-American women?

RQ2: In their opinion and experience, what influences middle-class African-American women to seek treatment in the private sector?

RQ3: What factors impact the choice of interventions used when treating middle-class African-American women?

This study adds to the body of knowledge by filling a gap as it relates to middle-class African-American women’s utilization of mental health services in the private sector. It also adds to the body of literature related to theoretical orientations of mental health therapist. Three general findings were revealed from the analysis of eight one-on-one in-depth interviews with fully licensed private practitioners. The findings were:

(a) Theory is not the sole influener when approaching treatment with middle class African-American women; (b) A client-centered perspective which views the client as the expert as well as the development of a strong therapeutic relationship impacts the course of treatment; and (c) Practitioner’s feel that the intersection of race, class, and gender influences middle-class African-American women’s decision to seek services in the private sector. A substantive level theory was also discovered from this grounded theory
study which revealed the dynamics of treating middle-class African-American women. The findings, theory, and implications for social work policy, planning, education, and administration, and recommendations for future research were discussed in this chapter.
APPENDIX A

Email Invitation to participate in the Study

Greetings:

My name is Aisha D. Williams and I am a doctoral candidate at Clark Atlanta University’s Whitney M. Young Jr. School of Social Work. The purpose of this email is to invite you to participate in a research study that explores the theoretical and philosophical framework, treatment, engagement, and diagnostic approaches of private practice therapist who treat middle-class African-American women.

This issue of underutilization of mental health services, mistrust, access, and race related disparities is still active problems in the United States. Public mental health services are changing in regards to the market of services and privatization of services resulting in a potential for more access. However, access is not the only issues facing African-American women. This study is significant because it explores mental health disparities as it relates to middle-class African-American women in the private sector as opposed to low-income African-American women in the public sector. This study also seeks to explore from a qualitative standpoint the philosophical undercurrents of private practitioners who treat middle-class African-American women and how those undercurrents impact treatment and engagement.

To be eligible for this study you must meet the following criteria:

A. Fully licensed private practitioner
B. Have at least five years post licensure experience
C. Serve or have served middle class African American women within the last five years.

Your participation would include completing an 11 item demographic survey and a 60 to 90 minute face-to-face interview with this researcher. Your participation in this research is greatly appreciated. If you would like to participate and meet the eligibility criteria please respond to this email or contact this researcher at 404-583-0667. Thank You.

Aisha D. Williams, LMSW
Doctoral Candidate
APPENDIX B

Consent Form

You are invited to participate in a research study that explores the theoretical and philosophical framework, treatment, engagement, and diagnostic approaches of private practice therapist who treat middle class African American women. You were selected as a possible participant in this study because you met the eligibility criterion which includes being a fully licensed private practitioner, have five years of post licensure experience, and serve or have served middle class African American women.

If you decide to participate, I will administer a 5 minute 11 item survey that is designed to collect basic demographic information and then conduct a 60-90 minute in-depth, semi-structured one time face to face interview at a location convenient to you. Participation in this study is not expected to present any greater risk than you would encounter in everyday conversation with a colleague.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty. The Committee on the Protection of Human Subjects at California State University, Fresno has reviewed and approved the present research.

If you have any questions, please ask. If you have any additional questions later, Ms. Aisha D. Williams will be happy to answer them. Questions regarding the rights of research subjects may be directed to (will add the appropriate information upon completion of IRB).

YOU ARE MAKING A DECISION WHETHER OR NOT TO PARTICIPATE. YOUR SIGNATURE INDICATES THAT YOU HAVE DECIDED TO PARTICIPATE, HAVING READ THE INFORMATION PROVIDED ABOVE.

Date ___________________________  Signature ___________________________
APPENDIX C

In Depth Face-to-Face Interview Guide

Time of Interview: ____________________________

Date: ______________________________________

Place: ______________________________________

Interviewee: __________________________________

Pseudonym: __________________________________

Questions

1. Theoretical/philosophical orientation and training

   a. Tell me about your training on counseling theories

   b. Which theory do you see fitting for your work in mental health? Why?

   c. Which theory do you see fitting when serving middle class African American women?

   d. Describe the factors that contributed to the development of your theoretical orientation.

   e. What value do you place on your theoretical orientation as it relates to your treatment choices and outcomes?
Appendix C (continued)

2. Theoretical/philosophical framework employed when serving middle-class African-American women
   a. Walk me through the treatment of a middle class African American woman you have served.
   b. Did race, gender, or both influence your treatment choices? Why
   c. Describe the connection of your theoretical orientation and treatment choices used with the scenario you described?

3. Explain how your theoretical/philosophical framework influence the following when serving middle class African American women:
   a. treatment approach
   b. treatment decisions
   c. interventions used

4. From your perspective, what factors impact the middle class African women you serve to seek mental health services in the private sector?
   a. From the women you have served, what factors appear to be unique to middle class African American women seeking your services?
   b. Why do you think they chose mental health services in the private sector?
   c. What factors impact their willingness to continue mental health treatment with you?
   d. Is treatment successful? Why or why not?
Appendix C (continued)

e. What would you want a therapist to know who has never worked with middle class African American women?

5. Housekeeping question

a. Are you willing to participate in a member check to ensure the information I collected today adequately represents your perspectives?
APPENDIX D
Demographic Survey

The following questions are designed to collect basic demographic information that will be utilized to describe the sample used in this study. Please circle your answers to question 1-4 and write in your responses to questions 5-11.

1. What is your race/ethnic background?
   a. White
   b. White, Non-Hispanic
   c. African American
   d. Hispanic
   e. Native American
   f. Asian Pacific Islander
   g. Other

2. What is your Gender?
   a. Female
   b. Male

3. What is your highest degree obtained?
   a. Bachelors
   b. Masters
   c. Doctorate

4. What is licensure credential do you practice under?
   a. LCSW
   b. LPC
   c. LMFT

5. What is your age? __________

6. What forms of payment do most of the middle-class African-American women you serve use?

7. How long have you been licensed? ____________________________
Appendix D (continued)

8. How long have you been serving middle-class African-American women in private practice?

9. What is the income range of the middle-class African-American women you serve?

10. Please list the type of insurance your practice accepts.

11. Please list other private practice clinicians serving middle-class African-American women you would like to recommend to be a part of this study (please include contact information):
REFERENCES


