2013

# Disparities in mental health service use among African-American adolescent males released from juvenile detention facilities

BOSTON UNIVERSITY

GRADUATE SCHOOL OF ARTS AND SCIENCES

Dissertation

# DISPARITIES IN MENTAL HEALTH SERVICE USE AMONG AFRICAN AMERICAN ADOLESCENT MALES RELEASED FROM JUVENILE DETENTION FACILITIES

by

**IGNATIUS A. SAMUEL**

B.S., University of Massachusetts–Dartmouth, 1994
M.S.W., Rhode Island College, 1998

Submitted in partial fulfillment of the

requirement for the degree of

Doctor of Philosophy

2013

Approved by

First Reader

Mary Collins, Ph.D.
Professor of Social Welfare Policy

Second Reader

Sigrun Olafsdottir, Ph.D.
Assistant Professor of Sociology

Third Reader

Renee Spencer, Ed.D.
Associate Professor of Human Behavior

# DEDICATION

This piece of work is dedicated to my beloved wife Remmy, and my three little children:

Etebom, Nene, and Kufre Samuel

# ACKNOWLEDGMENTS

Completing this project would not have been possible without the abundant grace of God. In the face of all odds, I remained assured that I can do all things through Christ who strengthens me. Thank you Lord for your grace, strength, and the means that made this project a reality.

I wish also to acknowledge the guidance, encouragement, love, assistance, and contributions of so many individuals without which this dissertation would not have been possible.

I am sincerely grateful to my advisor, Professor Mary Collins for her guidance throughout my doctoral study and dissertation. Thank you for your invaluable advice, encouragement, expertise, and support. You demonstrate the commitment of seeing your students succeed and without such mentoring, I would not have completed this dissertation.

To my wife Remmy, thank you for your love and support not only during this project but throughout my academic as well as my personal endeavors. Thank you for enduring the loneliness during my long hours of studies. You are an inspiration and a positive force that always moves me to action. I count myself truly fortunate to have you in my life. I love you dearly.

To my children Kufre, Nene, and Etebom, thank you all for your love and understanding. I am greatly indebted to all of you for the sacrifices you have made towards the success of this project. Many times you forego your quality family time with

Daddy so that Daddy could do his work. I really appreciate your contributions and I love you all very much.

To my Dissertation Committee Chair, Dr Maryann Amodeo, thank you for your willingness to serve in this committee. I started this journey with you. You guided me through the critical essay, a precursor to this dissertation. Thank you for your encouragement and support.

To Dr. Renee Spencer, thank you for participating as a member of my dissertation committee. Your expertise and insightful questioning provided the much needed direction for this dissertation. The Department of Human Behavior in the School of Social Work is fortunate to have you as their chair.

I am very grateful to my other dissertation committee members, Sigrun Olafsdottir, Professor in the Department of Sociology and Scott Geron, Professor in the School of Social Work for their willingness to serve in my dissertation committee. I am particularly grateful to Dr. Olafsdottir for her valuable advice and guidance in mental health treatment utilization models. Her expertise was very helpful in this dissertation. I also wish to thank Dr. Geron, who introduced me to the sociology of social work profession, a course that made an indelible mark in my knowledge of the profession.

I would also like to extend my gratitude to many in the Family Renewal Center Program of John Hope Settlement House and the Rhode Island Training School, especially the Deputy Superintendent *Administration for their help in collecting data for this dissertation.

**DISPARITIES IN MENTAL HEALTH SERVICE USE AMONG AFRICAN AMERICAN ADOLESCENT MALES RELEASED FROM JUVENILE DETENTION FACILITIES**

(Order No. )

**IGNATIUS A. SAMUEL**

Boston University Graduate School of Arts and Sciences, 2013

Major Professor: Mary E. Collins, Professor of Social Welfare Policy

ABSTRACT

While a number of studies have indicated disparities in mental health services use among African-Americans, specific factors that account for within-group disparities have not been thoroughly addressed. Research shows that African-American adolescent males generally are less likely to utilize mental health services and this is especially true among those involved with the juvenile justice system (Hazen, Hough, Landsverk, & Wood, 2004). Previous research indicates that culture is a viable and necessary factor to consider regarding African-Americans' pattern of mental health help-seeking (Cauce et al., 2002). This study utilized a qualitative research design and the Network-Episode Model (NEM) (Pescosolido & Boyer, 1999) as the theoretical framework to examine the influence of culture on the attitudes of African American adolescent males released from juvenile detention facilities to understand their mental health help-seeking.

Criterion sampling procedures were utilized to recruit for the study, two groups of African-American adolescent males (n = 54) who initially received services at John Hope

Family Renewal Center following their release from juvenile detention. In-depth interviews with participants were conducted and participants' case records were reviewed. Thematic analysis of interview transcripts produced four overarching themes: (1) beliefs about causes of mental health problems, (2) other beliefs about mental health, (3) social barriers - isolation/exclusion, and (4) social network influence on service utilization. Comparisons were made between those youth who used services and those who discontinued service use.

Findings revealed that: 1) participants' beliefs about the root causes of mental health problems prevented some from utilizing mental health services, 2) cultural factors partially influenced participants' attitudes and negatively shaped their behaviors towards use of mental health services. Findings also revealed that mental health stigma, ineffective treatment, fear and shame from peers, negative community reaction, and mistrust of mental health providers were important barriers to service utilization. Implications for social work practice, policy, and future research are discussed.

## Table of Contents

## LIST OF TABLES

## LIST OF FIGURES

# CHAPTER I.

# INTRODUCTION

## 1.1 Background

Despite increasing research interest in utilization of mental health services by minority groups, researchers have not explained why some African-American youth access and use mental health services after they are released from juvenile justice facilities while other do not, even when both groups are equally emotionally disturbed. Research on within-group differences in mental health service utilization among minority groups in general is scant but a careful analysis of available data clearly shows that most African-American male youth are less likely than others to utilize mental health services and this is particularly true for those involved with the juvenile justice system (Hazen, Hough, Landsverk, & Wood, 2004).

Youth in detention facilities endure unbearable living conditions such as overcrowding, locked sleeping rooms, separation from loves one, and risk of communicable diseases. Most of them suffer from impulsiveness, hopelessness, anxiety and depression, with increased risk of suicidal ideation, suicide attempts, and sometimes death. In a recent study, Abram, Choe, Washburn, Teplin, King, & Dulcan (2008) examined juvenile offenders (n=1,829) after intake to a Detention Center in Chicago, Illinois. The researchers administered the Diagnostic Interview Schedule for Children (DISC) to assess for thoughts of death, suicide ideation and plans within the past six months, and found that (i) approximately one in ten juvenile detainees had thoughts about committing suicide in the past six months, (ii) more than one third of juvenile detainees

and nearly half of females had felt hopeless or thought about death in the six months, and (iii) that recent suicide attempts were most prevalent in females and youth with major depression and general anxiety disorders.

Studies show that the majority of youth in juvenile detention have high rates of mental health problems, co-occurring substance abuse issues, and other health-risk behaviors than other youth in the general population. Among youth involved with the juvenile justice system, research indicates that those in need of mental health services make up approximately 65 to 70 percent. Rogers, Pumariega, Atkins, & Cuffe (2006) examined the prevalence and severity of psychiatric symptoms among a total of (n=240) youth ages 13–17 at a juvenile detention facility. The investigators randomly selected those who were referred for mental health services (n=120) and those not referred for mental health services (n=120) and evaluated psychopathology using the Diagnostic Interview Schedule for Children and the Child Behavior Checklist. They found that 96% of referred youth and 69% of non-referred youth had one or more psychiatric diagnoses. They also found that co-morbidity was common in both groups.

The high prevalence of mental health problems among young offenders in juvenile justice facilities, and particularly among ethnic minority youth is not surprising considering the toxic environments in which many of them have been raised. Minority youth who end up in jails, detention centers, or prisons have many things in common, such as greater exposure to delinquent peers (Nebbitt & Lombe, 2008), frequent community/family violence, familial substance abuse problem, physical and/or sexual abuse, and inconsistent parenting (McMackin & Pittel, 2007). This, when combined with

the living conditions in detention, heightens their vulnerability to developing mental health problems when compared to other advantaged groups. It is not clear why so little effort is being made towards providing adequate mental health treatment services for them while in detention, or why no consensus has been reached by researchers on specific factors that hinder service use among this population.

Unfortunately, these youth are released with untreated mental health problems into the community at the end of their term of incarceration. Snyder (2004) estimates that nearly 100,000 juvenile offenders are released annually into the community even though aftercare and reentry programming of most states and local communities remain under-developed (Mears & Travis, 2004). Thus, youth released from detention who need treatment services for their mental health problems usually have no place to turn to for help. For most minority youth, their time in detention often represents their only significant contact with a health care provider outside of an emergency setting (Rawal, Romansky, Jenuwine, & Lyons, 2004), and even for those who were receiving services while in detention, a large number frequently lose those services when they leave the juvenile justice system because few communities have formal programs and policies to link youth to services following their release from detention (Mears & Travis, 2004). Researchers agree that care received (if any) while in detention will likely be of little value if it is not maintained upon the youth's community reentry and afterwards (Altschuler & Brash, 2004). For example if medications prescribed and taken while the youth is in detention are not continued upon release, the condition under treatment will most likely return and may even become worse. Therefore, the important questions

begging for answers are, “what happens to these youth after they are released into the community – how do they cope with their mental health problems, or why do they fail to take advantage of the scanty mental health services provided for them?” A recent study found that youth who do not utilize mental health services post-incarceration are more likely to have impaired thinking, impaired functioning, and are less able to contribute meaningfully to the social and economic life of the society (Abram, Choe, Washburn, Romero, & Teplin, 2009). In fact, a national stigma study found that youth with untreated mental health problems were perceived as somewhat likely or very likely to be dangerous to themselves or others (Pescosolido, Fettes, Martin, Monahan, & McLeod, 2007).

Mental health is the cornerstone of every individual’s relationship with one another and an essential characteristic of a productive citizen. Adolescents who have mental health problems usually demonstrate impaired reasoning and adjustment problems. They struggle with or lack the drive to compete like other youth in the general population. According to the Department of Health and Human Services (2001) mental health is the basis of our thinking and communication skills, learning, resilience, self-esteem, and successful contributions to family, community, and society; yet it is always too easy for our society to dismiss the value of mental health or shy away from the provision of mental health services until problems appear. Even when problems appear, society continues to demonstrate unwillingness to provide adequately for their treatment. For example, although the state is legally obligated to provide mental health services for youth in detention, advocates for juvenile justice-involved youth continue to claim that resources for behavioral health treatment have not kept up with the increasing number of

youth in custody, particularly those needing extensive behavioral care (Thomas, Gourley, & Mele, 2005).

Minority youth released from juvenile detention face other challenges that exacerbate the problem of integration into the community. Mears and Travis (2004) noted that in addition to the burden of their mental health issues, many of these youth have children of their own to care for, yet most have never graduated from high school, held a job, or lived independently. Moreover, many are returning to communities where poverty, unemployment, drug addiction, and crime are endemic. In addition, these youth carry along with them track records of failure, which undoubtedly increases their emotional instability. With no mental health treatment, they are prone to exhibit antisocial behaviors and have an inability to hold jobs, which inevitably increases their desire to return to criminal activities and consequently begin another cycle of arrest, detention, and release. Further, mental health issues when left untreated, have been shown to persist into adulthood with long-term deleterious effect on one's psychological and social well-being. For example, in a long-term follow-up study published in the British Journal of Psychiatry, Fombonne, Wostear, Cooper, Harrington, & Rutter (2001) investigated the link between juvenile and adult depression and found that adult depressive recurrence was high for major depression (62.4%) and any depression (75.2%). They conclude that adolescent depression carries an elevated risk for adult depression. In fact, research on adolescent mental health has found that untreated depression is the most common cause of suicide among youth (Munson, Floersch, & Townsend, 2009; Olfson, Shaffer, Marcus, & Greenberg, 2003). Given the

characteristics of these youth and the negative consequences of untreated mental health problems, it is surprising that to date, very little has been thoroughly investigated regarding the sources of underutilization of mental health treatment services among ethnic minority youth particularly African-Americans released from juvenile detention facilities.

In the general population, mental health services are underutilized by adults and this is also true of children and adolescents. Many detained youth in need of mental health services do not receive the care they need either because of lack of available services or due to internalized psychological problems. A national survey to determine mental health service use among adolescents involved with the juvenile justice system revealed that services such as mental health counseling, anger management, life and communication skills that were provided to about 60 percent of youth across juvenile correctional facilities, the number of youth that attended treatment in all types of facilities on any given day was very low (Young, Dembo, & Henderson, 2007).

In a review of studies on young offenders involved with the juvenile justice system, Desai, Goulet, Robbins, Chapman, et al. (2006) examined and highlighted the tension surrounding the provision of mental health care in juvenile detention. The researchers reviewed data on the prevalence of psychiatric problems and the types of services currently provided. They found reasons to suggest that certain types of services might not be appropriate for juvenile detention settings, and conclude that although there were some promising interventions that may be appropriate, much more research, especially in detention settings was needed to determine their effectiveness. This review

conclusion suggests that underutilization of mental health services among youth involved with the juvenile justice system could also be traced to inappropriate interventions or ineffective treatment services provided.

Underutilization of mental health services among minority groups has been a general concern not only for clinician, but also for policy makers regarding the health and social well-being of ethnic minority groups. Attempts to increase service use among this population have not yielded desired results. For example, despite the expansion and enrollment of poor youth in Medicaid/Children's Health Insurance Program to remove the barrier of lack of insurance coverage and increase service use (Kenny, Cook, & Dubay, 2009; Ryan, 2009), research results continue to show lower rates of service use among this population.

The challenge in research involving ethnic minorities and utilization of mental health services is the lack of attention to within group differences in service use. Health care researchers have not paid adequate attention to the differential effect of culture on the attitude of minority groups towards mental health and use of treatment services. Neighbors, Caldwell, Williams, Nesse, Taylor et al. (2007) lament the inadequacy of research on minority culture and disparities in mental health service use among American blacks, and noted, "Unfortunately, no studies have addressed black ethnic variation in help-seeking for mental disorders within the United States" (p.2), and stressed that studying blacks of different ethnic origins is important for public policy and mental health professionals because of questions about the contribution of culture to differences in group behaviors. In another study that examined the help-seeking behaviors among

Filipino-Americans, the authors noted the paucity of research on the effects of culture on help-seeking behavior and stated: "although some important and specific cultural factors have been hypothesized to affect the help-seeking behavior of ethnic minorities, very few empirical studies have been conducted to specifically test these hypotheses" (Gong, Gage, & Tacata, 2003). There is no doubt that research has identified culture as an important influence on mental health services use behavior of ethnic minority groups, yet the differential effect of culture on attitude which leads to disparities in mental health service use is still understudied. The present study examines cultural influence on mental health help-seeking behaviors of African American male adolescents released from juvenile detention facilities in relation to within-group disparities in mental health service use to understand whether such influences account for the observed disparities in service utilization among this population.

This chapter introduced the problem of underutilization of mental health services by African American adolescent males released from juvenile detention facilities and discussed potential consequences of living with unresolved/untreated emotional disturbances. The section also laid the groundwork for understanding the problem of within-group disparities in service utilization and its relationship with the influence of culture on the attitudes of these youths toward mental health services. The rest of the chapter explains the purpose and significance of the study, states the research questions, and provides definitions for terms used in the study.

### 1.2 Purpose of the Study

The purpose of the study was to understand the relationship between cultural influences

on the attitude of African-American male adolescents towards help-seeking and within-group disparities in mental health service use after release from juvenile detention. Experience reveals that some African-American youth access and utilize mental health services after they are released from detention but others do not even when they face serious emotional disturbances. This study focused on the within-group differences in mental health services use and aimed at clarifying the relationship among variables that connect with African-American youths' attitude towards mental health and its system of care delivery, particularly how their cultural beliefs and values influence their perception of mental health problems, and how such perception differentially shapes their attitude towards use or non-use of services during and after they are released from juvenile detention.

### 1.3 Research Questions

The study answers the following questions:

1. What prevents some African-American youth from utilizing mental health services provided for them after they are released from juvenile justice facilities?
2. How does culture shape the attitudes of African-American adolescents selectively in their decision to use or not to use mental health services post-release?

### 1.4 Significance of the Study

This study is significant for the following reasons: (i) It did not focus on the general

adolescent population like other research studies on utilization of mental health services. Instead, it focused exclusively on African-American male youth released from juvenile detention and their help-seeking behaviors. (ii) Most research studies on adolescent use of mental health services utilize a quantitative approach to examine factors that determine health service use. This study utilizes a qualitative approach which allows the participants, who actually experience the phenomenon under study, to provide information directly to the researcher from their own perspective. (iii) Because of the attention given to the impact of culture, findings from this study will contribute to the knowledge base of current cultural competence movement in the social work profession, particularly concerning culturally sensitive practice interventions with African-American youth population. Further, findings can provide guidance for health policy-makers in designing effective consumer health campaigns, policies, and promotion programs to encourage service utilization among ethnic minority groups and thereby reduce disparities in mental health services utilization.

## 1.5 Definition of Terms

This section presents the definitions of the following key words and terms as used in this study:

### 1.5.1 Juvenile Justice System

The Juvenile Justice System is a network of agencies that deal with juveniles whose conducts come in conflict with the law. These agencies include police, prosecutor, family court, probation, and the Department of Juvenile Corrections (Public Law 93-415, US Code 5031-5042).

### 1.5.2 Juvenile/Youth

The Office of Juvenile Justice and Delinquency Prevention defines a juvenile as "a youth at or below the upper age of juvenile court jurisdiction in a particular state". In all states, the upper age of jurisdiction is defined by statute. But in most states, individuals are considered adults when they reach their 18th birthday. Thus, for those states, juveniles are children who are 10 through 17 years of age living within the geographical area served by the juvenile court (Office of Juvenile Justice and Delinquency Prevention, 2004). In this research study, the words: juvenile, youth, and adolescent are used interchangeably.

### 1.5.3 Juvenile Justice Facilities

Juvenile justice facilities are public and private facilities maintained by the Juvenile Justice System to house delinquent youth removed from home and placed in the custody and supervision of the State, County, or Office of Juvenile Justice and Delinquency Prevention pending the determination of their cases. These facilities include: the training schools, group homes, foster care, youth centers, and/or diversionary programs. Any youth who resides in any of the aforementioned institutions can be referred to as juvenile offender, juvenile in detention, or detainee - these words are also used interchangeably.

### 1.5.4 Mental Health Problem

"Mental health problem" is a term used to describe disturbances in individual's thought processes, feelings, and behaviors when it interferes with the individual's normal level of functioning. It represents the individual's temporary loss of capacity to cope with stressful situations, ability to think logically and rationally, or successfully deal with personal losses/disappointments that may cause emotional distress. The term is also used

to describe other short-term or long term psychological conditions such as depression, adjustment disorder, anxiety, or conduct disturbances.

### 1.5.5 Mental Health Services

These are health services provided by licensed professionals such as psychiatrists, primary care physicians, psychologists, clinical social workers, and mental health counselors in hospitals, community mental health clinics, and private settings to help individuals deal with problems of impaired psychological or cognitive processes. It includes services also provided to help individuals cope with disabling conditions such as anxiety or depression as well as external stressors such as death in family, divorce, or serious economic difficulties.

### 1.5.6 Attitudes Toward Mental Health Services

Fishbein & Ajzen (1980) conceptualized "attitude" as a trigger and predictor of human behavior. Thus attitude is a mental disposition of how individuals express their likes and dislikes towards a particular people, thing, or an event. Attitude towards mental health services could be defined as those individuals' feelings, perceptions, and assessments that cause them to react positively or negatively towards mental health services.

### 1.5.7 Culture

Culture is defined as the way of life of a distinct group of people or particular society. It typically refers to the beliefs, values, symbolic meanings, and shared patterns of behavioral practices of a specific human group. It includes all organized ideas, language, habits that distinguish one group of people from another which are learned and

transmitted from one generation to another through the process of socialization (Schaefer, 2000).

### 1.5.8 Help-seeking Behavior

Help-seeking behavior is a term used to describe an individual's willingness to seek help when dealing with challenging personal problems or confronting difficult times in their lives. It describes the process that individuals undergo when they are looking for assistance in meeting their needs. Thus, help-seeking behavior can best be explained as individual's attempts to cope with stressful conditions. Snowden & Yamada (2005) define help-seeking as "a process wherein distressed persons sometimes consult several potential sources of assistance concurrently as well as sequentially in socially influenced steps with feedback loops".

In this chapter, the background to the problem was presented. The chapter also called attention to likely consequences of continued inaction by policy makers in developing policies that encourage youth to utilize mental health services and remove barriers to service use especially among minority youth as a precursor to successful reintegration into the community post-incarceration.

The chapters that follow accomplish the following: chapter two presents a review of the literature relevant to the rationale of the study. The first section traces African-American's historical experiences with mental health services and assesses the impact of such experiences on their perception and attitude towards mental health problems, the care providers, and the care delivery system. Section two examines the influence of culture and related factors as impediments to mental health service utilization, and the

third section discusses the relationship between underutilization of mental health services and the problem of establishing need for services. Chapter three presents key conceptual issues related to culture, need for mental health services, and bias in mental health diagnosis. The chapter also describes the study's theoretical framework comparing and contrasting relevant models of help-seeking and describing variables theorized to significantly influence the help-seeking behaviors of African-American youth released from juvenile justice facilities. Chapter four discusses methods and procedures used in conducting this research study. Chapter five presents the study findings, and chapter six discusses the findings in the context of the literature and draws conclusions and implications for service delivery and further research.

# CHAPTER II

## REVIEW OF THE LITERATURE

This chapter presents a review of the literature on utilization of mental health services by African-Americans as an ethnic group with particular reference to youth involved with the juvenile justice system. The first two sub-sections trace the negative historical and contemporary experiences of African Americans with the mental health care delivery system in terms of access to and use of mental health services and discuss the racial and ethnic disparities in mental health service use. Section three makes a comparative analysis of service utilization between African Americans with other ethnic groups in the United States to establish some evidence of disparities in mental health service utilization. The last two sections review studies specific to African American youth especially those with links to the juvenile justice system and examines their attitudes towards mental health service utilization.

For many years, research literature has documented underutilization of mental health services in the general population and particularly among racial and ethnic minority groups (Ward, Clark, & Heidrech, 2009; Barksdale & Molock, 2008), Gonzales, Alegria, & Prihoda, 2005; Alegria, Perez, & William, 2003). In the United States, access to mental health care – defined as "the timely use of personal health services to achieve the best possible health outcome" (Institute of Medicine, 1993) – is often a challenge to realize. For ethnic minority groups, this challenge has become a lifelong struggle. Studies comparing mental health service utilization across groups and subgroups (McGuire & Miranda, 2008; Jang et al., 2009; Agency of Healthcare Research and Quality (AHRQ,

2008), have found evidence of disparities in access and use of mental health services. Although researchers agree that access alone does not insure better mental health because the following problems still exist: (i) services received does not guarantee high quality (Snowden & Yamada, 2005), (ii) access to treatment gained is often marred by early dropout - frequently after just the first session, and (iii) high rates of missed appointments, usually due to non-engagement (Atdjian & Vega, 2005), it seems obvious however, that lack of access results in underutilization of mental health services. McGuire & Miranda (2008) noted that disparities in mental health care can be rooted in inequalities in access to good care providers.

**2.1 African Americans and use of mental health services: Historical perspective**

The importance of historical context has become a routine concern in medical as well as mental health practice. Health practitioners usually obtain past, present, and family history of illness from their patients to help them understand why and how a particular illness episode/career should be managed. Mental health providers like to explore also the feelings associated with meanings and interpretations that their clients assign to their illness histories in order to correctly assess their willingness to engage in treatment. In order to understand the contemporary African Americans relationship with mental health services and the system of care delivery, it is important to also understand their historical experiences and be familiar with how African Americans perceive mental health, and what mental health treatment means to them.

The history of African Americans and how they deal with their mental health problems is inextricably linked to their troubling history of racism, questionable clinical

diagnosis, and pseudo science entrenched in medical research (Sue, 1999; Williams & Williams-Morris, 2000; Corbie-Smith, Thomas, & St. George, 2002). Although a full-scale genealogy of the racist mental health legacy is beyond the scope of this dissertation, describing just one of such practices can shed some light on how the negative stereotypes were incorporated into societal policies and institutions, and how such practices shape the perception of African Americans and their involvement with mental health services and the service delivery system.

During the 19th century, a period associated with slavery, the causes and treatments of mental health problems for African Americans and Whites were viewed differently. While environmental stress was widely believed to cause mental health problems for the general population (Lowe, 2006), a different etiological premise was invented for African Americans. For example, in 1851, Dr. Samuel Cartwright coined the diagnosis of "Dyseathesia aethiopica", or disease of the mind, and "Drapetomania", a mental illness that caused slaves to run away from their masters, or develop intentional work habit that results in poor attention to their work and/or destruction of equipment (e.g., plow, hoe). Dr. Cartwright also prescribed preventive measures and cure for these ailments determining that slaves exhibiting these behaviors should be whipped – strictly as a therapeutic early intervention (Jackson, 2002). These diagnostic labels were used exclusively to officially diagnose African American slaves who were non-compliant or disruptive (Cartwight, 1851, as cited in Jackson, 2002).

What is important from this example is the historical fact that while other white physicians criticized Cartwright's ideas and theories (Savitt, 2002), the bulk of his work

designed to degrade African Americans were not isolated creations. In fact they were accepted for publication in southern medical journals, newspapers, and magazines (Washington, 2006). According to Lowe (2006), "both diagnoses were culturally and contextually bound to the institution of slavery and reflected the intrusion of social, political, and economic views into psychiatry", ( p.2).

Most African Americans at the time were enslaved or disenfranchised and thus had no political power to resist how they were treated. As a result, the caliber of mental health care provided to them was a function of undeserved restrictive policies relative to their position in the society. For example, they did not have equal access to the state-funded asylums where mental health services provided were thought to be at par with what was considered the best treatment approach of the time. Due to the segregated admission practices, African Americans were not allowed in the State Lunatic Asylum, and where some were admitted, they were kept in separated quarters from whites (Grob,1994). As such, those who needed mental health services had to take alternate pathways to services in almshouses and in jails (Babcock, 1896, as cited in Lowe, 2006). As time went by some northern states succumbed to the pressure of the enlightenment movement and abandoned, or at least began to phase out state sanctioned slavery but with few changes in the service delivery system (Lowe, 2006). These experiences and others like the Tuskegee Experiments (Rusert, 2009) have created a culture of mistrust hypothesized as contributing to negative attitudes among African Americans towards mental health and the system of care delivery.

However, African Americans have made tremendous gains in their struggle to

remove structural barriers that impact their access to mental healthcare. For example, through their persistent struggle for political equality and social justice, African Americans now have other options of receiving mental health care from professionals rather than from almshouses and in jails. Unfortunately, traces of the inherited legacy can still be detected in the American mental healthcare system, which had been deeply shaped by the Anglo-American culture and its downbeats of racial and social injustices (Neal & Turner, 1991). Nonetheless, African Americans seem to have overcome their darkest period where prevailing views of their mental health problems and provision of care were predicated on the assumptions of white supremacy and black inferiority even though existing barriers to mental health care utilization are likely rooted in this same reality.

### 2.2 Contemporary view of African Americans and mental health service utilization

Contemporary mental health practice and the service delivery system have taken a different turn for African Americans. Following major Civil Rights victories of the 1960s that created programs of the Great Society – job training, food stamps, Medicare and Medicaid, mental health, and social services (Gilbert & Terrell, 2005), those laws advanced the U.S. welfare state and powerfully supported increased access to health and mental health care through the expansion of public insurance. Although this expansion of opportunities had some positive effects on the help-seeking behaviors of individuals in need of mental health services, disparities in access to and use of mental health services continue to persist. Research continues to report underutilization of mental health care services particularly among African Americans compared with other ethnic groups. For

example, a large sample of African Americans and Caucasian patients (n = 685) who had a diagnosis of schizophrenia and receiving treatment were interviewed as part of the Schizophrenia Patient Outcome Research Team study. Dixon, Green-Paden, Delahanty, Lucksted, Postrado, & Hall (2001) utilized multivariate analysis to assess the associations of race with past and current diagnoses and with current treatment for depression, mania, and anxiety disorders. The researchers found that African Americans were significantly less likely than Caucasians to report having a past or current diagnosis of depression, manic-depression, or anxiety disorder and to be receiving current treatment for these disorders. They conclude that the study suggests the possibility of racial and other disparities in the diagnosis and treatment of patients with schizophrenia and comorbid affective and anxiety disorders.

In 2001, the Surgeon General's report on mental health identified racial/ethnic disparities in mental health service use as a major public health problem. Data presented at the Surgeon General's Conference on Mental Health (Satcher, 2001) indicated that racial/ethnic minorities have less access to mental health services; minorities are less likely to receive needed mental health services; and minorities in treatment often receive a poorer quality of mental health care (U.S. DHHS, 2001). The President's New Freedom Commission on Mental Health (2003) also issued a companion report that reiterated the Surgeon General's (2001) report regarding racial, cultural, and ethnic problems with access to mental health services. It maintains that barriers still remain in access, quality, and outcome for minorities. The Commission concluded that minorities suffer a higher burden due to access limitations.

Since the unreserved acknowledgement of disparities in mental health service use, both by the Surgeon General and the Presidential Commission in 2001 and 2003 respectively, underutilization of mental health services among racial and ethnic groups remains large. For example, in a nationally representative sample of African Americans, Asian Americans, Latinos, and Whites (n = 8,762) taken from the National Institute of Mental Health Collaborative Epidemiology Survey (CPES), Alegria, Chatterji, Wells, Cao, Chen, Takeuchi et al. (2008), a team of researchers assessed disparities in both, having access to and receiving adequate care for depression among racial and ethnic minority populations. The researchers found that among individuals with any depressive disorder within the past 12 months, 63.7% of Latinos, 68.7% of Asians, and 58.8% of African Americans did not access any mental health treatment, compared with 40.2% of non-Latino whites. This study is significant because of its large sample size and racial/ethnic representativeness, which included a large number of non-English-speaking minority respondents, and a rich array of diagnostic and quality indicators (see National Institute of Mental Health (NIMH) Collaborative Psychiatric Epidemiology Survey (CPES) program data set for more details).

Numerous studies have identified economic barriers, (e.g. lack of insurance coverage) as a causal element in poor mental health service use among African Americans. Economic barriers exist among all populations but the effect is not always proportional (DeNavas-Walt, Proctor, & Lee, 2005). Thus, prevailing economic conditions may disproportionately impact African Americans and Hispanics, as they are less wealthy on average than whites. In order to determine variations in mental health

service use independent of insurance coverage and health status, Dobalian & Rivers (2008) examined variations in use of Mental Health Professionals (MHP) among Whites, African Americans, Hispanic, and Other, using data derived from the 1998-1999 National Household Survey Restricted Use file of the Community Tracking Study (CTS). The researchers found that on the whole, African Americans and Hispanics were less likely to visit a mental health professional (MHP) in the prior year than were whites. They also found that, independent of health insurance and health status, low- to middle-income African Americans may be at particular risk for inadequate use of a mental health professionals compared to higher-income African Americans; suggesting that health insurance may not be the cause of low service utilization among this sub-group. However, it is important to note that even among people with health insurance, disparity could still exist due to changes that occur in their health coverage (e.g., increased copayments and higher deductible), which may discourage service use.

In another study using data from the National Epidemiologic Survey on Alcohol and Related Conditions (2001-2002) conducted and funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), Hatzenbuehler, Keyes, Narrow, Grant, & Hassin (2008) sought to determine whether black/white disparities in service utilization for mental health and substance use disorders persist or are diminished among individuals with psychiatric comorbidity. The investigators identified individuals with lifetime co-occurring substance use disorders and mood/anxiety disorders (whites, n = 3597; blacks, n = 653). Lifetime service utilization for problems with mood, anxiety, alcohol, and drugs was assessed. Despite the fact that comorbidity generally increases the likelihood of

service utilization (Braden, Zhang, Yu Fan, Unutzer, Edlund, & Sullivan, 2008), the researchers found that blacks with co-occurring mood or anxiety and substance use disorders were significantly less likely to receive services for mood or anxiety disorders, but more likely to receive some type of services for drug use disorders, suggesting that African American subjects in the study still hold on to the belief that mental health problems would improve on their own (Anglin et al., 2008).

Underutilization of mental health service was measured by Cook, McGuire, & Miranda (2007) through tracking trends in disparities to determine increase or decrease in mental health service utilization over time. Data for this study was taken from a nationally representative survey – Medical Expenditure Panel survey (MEPS, 2000-2004). The sample included Hispanics, non-Hispanic African-Americans, and non-Hispanic Whites over 18 years of age. The purpose of this study was to determine whether gains in eliminating mental health care disparities have occurred since the Surgeon General's report. It is important to recall that the principal aim of the Surgeon General's national spotlight on mental health was to positively change the help-seeking behavior of minorities to eliminate racial disparities in utilization of mental health services. Thus, the researchers estimated trends in mental health service use in two measures: (i) having any mental health visits, and (ii) total mental health care expenditures in the past year. Disparities between African Americans, Hispanic, and white Americans were examined based on the definition of "disparities" approved by the Institute of Medicine (IOM), and defined as: "the difference in health care quality not due to differences in health care needs or preferences of the patient" (McGuire & Miranda,

2008, p.393). The researchers found that disparities worsened from 2000-2001 and 2003-2004. Thus, they concluded that the mental health care system continued to provide less care to persons in African-American and Hispanic minority groups than to whites. It is important to use caution when interpreting the result of this study because based on IOM definition, there are certain variables such as discrimination, socio-economic or geographic variables that are excluded from or allowed in the calculation of disparities. Discussions on disparities calculation are beyond the scope of this dissertation - for details on disparities calculation see Smedley, Stith, & Nelson (2003).

Researchers in another study tracked disparities in mental health service utilization by measuring the duration of visits to office-based psychiatrists by Whites and African-American patients. In this study, Olfson, Cherry, & Lewis-Fernandez (2009) analyzed a nationally representative sample of visits to office-based psychiatrists between 2001 and 2006. Visits were grouped by patients' race as non-Hispanic African-American (n = 504) or non-Hispanic White (n = 7,094). The researchers measured duration of face-to-face contacts between patient and psychiatrist. They found that unadjusted mean duration of psychiatric outpatient visit by African-Americans (mean duration, 28.3 minutes) were 4.4 minutes shorter than visits by Whites (32.7 minutes). Using the same data, the researchers conducted a stratified regression analysis that combined time periods and controlled for several relevant characteristics, and found significant racial differences in visit durations in the following characteristics: adjustment disorder diagnosis (10.0 minutes), female patient sex (5.4 minutes), depressive disorder diagnosis (5.2 minutes), psychotherapy provision (5.1 minutes), practice with high patient volume (5.0 minutes), and absence of

psychiatric comorbodity (3.3 minutes). The researchers concluded that against the backdrop of persisting racial disparities in other areas of mental health care, ongoing attention to reducing disparities should continue to be encouraged.

Other studies tracking mental health utilization trends nationally also report that African Americans and Latinos have fewer mental health treatment visits to both generalist and specialty mental health care providers than whites do, and that blacks suffering from mood and anxiety disorders are less likely than whites to receive care (LeCook, McGuire, Lock, & Zaslavsky, 2010; Agency of Healthcare Research and Quality (AHRQ annual reports: 2008a, 2008c, 2009).

Mental health help-seeking among racial/ethnic minorities has been linked to Limited English Proficiency (LEP), and studies recommending the use of interpreters to remedy the problem of language barrier and increase service use is gaining traction in research literature. In a study to determine whether LEP contributes to underutilization of mental health services among minority groups, Sentell, Shumway, & Snowden (2007) analyzed the 2001 California Health Interview Survey where adults aged 18 to 64 who provided language data (n = 41,984) participated in the study. Subjects were categorized into three groups using self-reported English proficiency and language spoken at home: (i) English-speaking only, (2) Bilingual, and (3) Non-English speaking. Mental health treatment was measured by self-reported use of mental health services by those reporting a mental health need. The researchers found that non-English-speaking individuals had lower odds of receiving needed services than those who only spoke English, when other factors were controlled. Thus, they concluded that LEP is associated with lower use of

mental health care, and since LEP is concentrated among Asia/Pls, Latinos, and among most African immigrants, it appears to contribute to racial/ethnic disparities in mental health care.

However, not all studies find disparities in mental health service utilization among racial/ethnic groups. Chen and Rizzo (2010) investigated racial and ethnic disparities in the use of psychotherapy utilizing a nationally representative sample of 7,376 patients with depressive or anxiety disorders drawn from the National Survey of Medical Expenditure Panel (1996-2006). The researchers performed bivariate and multivariable analyses to estimate disparities in the probability of receiving any psychotherapy, total psychotherapy expenditures, and out-of-pocket payments. They found that Caucasians were more likely to use psychotherapy than Latinos (57% versus 52%), but there was no significant difference between Caucasians and African Americans in the probability of receiving any psychotherapy. Thus, they concluded there was little evidence of racial and ethnic disparities in access to psychotherapy services. Similarly, in the Garland et al., (2005) study earlier cited, the researchers aimed to test for racial/ethnic disparities in use of a variety of outpatient, inpatient, and informal mental health services among high-risk youth with the effects of other predictive factors controlled. They utilized established measures of mental health services use, psychiatric diagnoses, and functional impairment to interview 1,256 youths ages 6 – 18 years who received services in a large, publicly funded system of care (including the child welfare, juvenile justice, special education, alcohol and drug abuse, and mental health service sectors). They found significant racial/ethnic group differences in likelihood of receiving any mental health service and,

specifically, formal outpatient services were found after the effects of potentially confounding variables were controlled. However, race/ethnicity did not exert a significant effect on the use of informal or 24-hour-care services.

In sum, the evidence presented above traced the historical experiences of African Americans regarding access and use of mental health services from the early years of slavery to the contemporary Civil Rights periods of comparative positive changes, and described how such experiences created an almost indelible negative image for mental health, the service delivery system, and the care providers in the minds of African Americans as an ethnic group. The evidence also show a clear picture of how and why disparities existed, and continue to exist in mental health service use between African Americans and other ethnic groups although some studies have suggested the contrary. The next section specifically examines present day mental health service use by African American adults and the youth, especially adolescent males involved with the juvenile justice system.

### 2.3 Utilization of mental health services by African American Adults

There are few studies specifically designed to measure mental health service use by African American adults. Most studies compare African Americans with other ethnic groups in determining the level of disparities in mental health service use, as described above. This section reviews studies that are closely aligned with the service use behaviors of both male and female African American adults.

In a recent qualitative study exploring attitudes and beliefs about mental health and service utilization among African American older adults, Conner, Lee, Mayers,

Robinson, Reynolds, Albert et al. (2010) utilized a focus group methodology to explore the attitudes and beliefs about mental health and service utilization among 42 African American adult patients (55 years or older) recruited from a Community-based Primary Care Center who had recently suffered a major depressive episode. Data for the study were provided directly by participants within four focus groups. The researchers found that the overarching themes that emerged supported negative attitudes and beliefs about mental health and service use. In addition, the investigators found that only 33 percent of the focus group participants reported having ever sought mental health treatment, and an even smaller percentage (22%) reported seeking mental health treatment within the prior six months.

A large study of older African Americans examined mental health services utilization with data from the National Surveys of American Life. A subsample of African American (n = 837) aged 55 years or older participated in the study. In the study, Neighbor, Woodward, Bullard, Ford, Taylor & Jackson (2008) assessed and identified thirteen mental disorders, including mood, anxiety, and substance disorders using the Diagnostic and Statistical Manual of Mental Disorders (DSM–IV) and World Mental Health Composite International Diagnostic Interview. Seventy-four respondents (9.6%) met criteria for a disorder. Self reported service use included psychiatric and non-psychiatric mental health services, general medical care, and non-health care (e.g., human services complementary-alternative medicine). The researchers found that overall, 46.5% (n = 30) of older African Americans with any one 12-month disorder used some form of services in the last year; 47.2% (n = 12) with two or more disorders used any services.

Those reporting any mood disorder had higher service use in every sector compared with those with any anxiety or any substance disorder. These findings have some practice implications: (i) if study participants with one mental health disorder reported significantly lower rate of service utilization (46.5%) while participants with two or more disorders reported slightly higher rate of service use (47.2%), this suggests some degree of correlation between comorbidity and service utilization, and (ii) findings of higher rate of service use among those with mood disorders compared to those with anxiety or substance disorders also suggests that service use among African American adults could be related to the types of disorder under consideration.

Neighbor and other colleagues (Caldwell, Williams, Nesse, Taylor, Bullard et al. 2007) also assessed mental health help-seeking behavior in an ethnically diverse sample of black Americans. The researchers utilized data from the National Surveys of American Life (NSAL) conducted between 2001- 2003 to examine 12-month mental health service use by African Americans and Caribbean blacks (blacks from Caribbean area countries now living in the United States). Participants included 3,570 African Americans and 1621 Caribbean blacks 18 years and older (n = 5191). Most interviews (88%) were conducted face to face and 12 percent by telephone, using a computer assisted instruments and lasting about 2 hours. The overall response rate was 72.3%: 70.7% for African Americans and 77.7% for Caribbean blacks. The researchers found that overall, 10.1% of respondents used some form of mental health care services in the past year. They also found service use to be much higher among those who met criteria for a 12 month DSM-IV diagnosis (31.9%) than among those who did not (5.4%). They

concluded that underutilization of mental health services among black Americans remains a serious concern. It should be noted here that an estimated Caribbean-descendants and immigrant groups constitute 10% to 15% of the United States' black population (Neighbor et al., 2007).

Using a qualitative research design, Ward, Clark, & Heidrich (2009) employed the Common Sense Model (CSM) to interview 15 African American women from three age groups (young adult, 25 to 45, n = 5; middle-aged, 46 to 55, n = 5; and older 66 to 85, n = 5) to examine their beliefs about mental illness, coping behaviors, and barriers to treatment seeking. The researchers found that participants endorsed the use of prayers and counseling as coping strategies, but were ambivalent about the use of medications. Participants also identified poor access to care, stigma, and lack of awareness of the illness as barriers to service utilization. Overall, the investigators reported that differences were found in beliefs, coping behaviors, and barriers.

Tidwell (2004) investigated the "no show" phenomenon and the issue of resistance among African American female patients at a low-income urban health care center. Using data from 90 African American female medical and mental health patients, the researcher collected information about their appointment keeping behaviors and examined the reasons patients missed scheduled appointments and found that of the 90 African American female no-show respondents, 53 had missed medical appointments and 37 had missed mental health appointments. Of the 37 mental health no-shows, only one claimed to have forgotten the appointment, 27 offered excuses, and 9 had no explanations. The researcher concluded that the "no show" phenomenon is a complex matter, noting that a

relatively high rate of dropouts or no-shows could mean a number of things including scheduling conflicts, lack of transportation, resistance, inability to develop ongoing relationship with health care provider, or mistrust of formal health care system.

### 2.4 Mental health service use among African American youth

Adolescents in general underutilize mental health services despite the documented high prevalence of mental health problems among adolescent population. For example, data from the National Survey of Child and Adolescent Well-Being (n = 616) were analyzed for patterns of outpatient mental health service use among youth aged 12 to 15 years from adolescence to early adulthood. The researchers found that almost half of the youth in this sample had one or more indicators of mental health problems. They also found that there was a significant decrease in use of specialty mental health services from adolescence to young adulthood, declining from 47.6% at baseline, to 14.3% at the five- to six- year follow-up (Ringeisen, Casanueva, Urato, & Stambaugh, 2009).

For African American youth in particular, there is evidence that they significantly underutilize mental health services. For example, the (2001-2003) Collaborative Psychiatric Epidemiology Surveys (CPES) estimated that about 13% of 18 to 24 year-old African American youths had depression and among that number only 25% used any services (e.g., medical doctor, psychiatrist, other mental health professionals, spiritual leader, or healer) for sadness lasting more than two weeks with the percentage dropping to 19% among those that were unemployed (Alegria, Jackson, Kessler, & Takeuchi, 2008, as cited in Maulik, Mendelson, & Tandon, 2010).

In another study designed to help mental health counselors provide effective

services to impoverished African American male youth who exhibit symptoms of Attention Deficit Hyperactivity Disorder (ADHD), Tucker & Dixon (2009) assessed African-American adolescent males with ADHD, their need for mental health services, and the barriers to services that they face. In addition, the researchers reviewed issues of diagnosis, policy and structural barriers to care and found that African-American males living in poverty are among the least likely adolescents to receive mental health services in the United States, even though they are the most likely to be referred to mental health agencies for services.

Underutilization of mental health services has been a serious concern particularly among African American boys and many scholars have given several reasons to explain the phenomenon. Gonzalez, Alegria, & Prihoda (2005) reported that attitudes toward seeking mental health treatment in young males in general are the most negative of all groups, but among African American boys in particular, Lindsey, Joe, & Nebbitt (2010) noted that underutilization of mental health services is due to the concomitant risks associated with living in high-risk environments and experiencing low social network support. One study suggested that African American boys are reluctant to seek and utilize mental health services because of the gender-based notions of help seeking or masculine norms, that is, socialization reinforced by "macho messages" (Scott, Munson, MacMillen, & Snowden, 2007).

As stated earlier, due to scarcity of studies designed specifically to study African American youth mental health service use patterns, the remainder of this sub-section reviews research studies that measure satisfaction and previous experience with services

to understand mental health service utilization patterns among this population.

In a recent study to assess mental health services use by African American youth, Thompson, Dancy, Wiley, Perry, & Najdowski (2011) examined mental health service use experience and satisfaction among 40 dyads of African American youth (aged 13 to 19 years) and their mothers. The investigators utilized a cross-sectional qualitative research design with semi-structured interviews that elicited information about their past experiences and satisfaction with mental health services received. They found that both the youth and their mothers reported dissatisfaction centered on medication and lack of professionalism, confidentiality, and concern by providers. Thus, they concluded that the failure of mental health services providers to meet basic standards of quality and professionalism may explain the low rate of service use by African American youths. In the Lindsey et al. study mentioned above, which also hypothesized that stigma was a major reason for underutilization of mental health services by African American boys, the researchers measured stigma tolerance (i.e., the extent to which participants might be concerned about what others might think if they (participants) visited a mental health professional for treatment) among African American boys who sought treatment for depressive symptoms. They found that (i) stigma associated with depressive symptoms is a powerful influence on service use and is based on both actual and perceived experiences, (ii) that family and peers differentially influence help-seeking behaviors related to depression, and (iii) that family members provided support to utilize treatment for depressive symptoms, whereas peers incited both negative feelings about symptoms and a reluctance to ask for or seek help, (p.6).

In a systematic review of the scientific literature, Elster, Jarosik, VanGeest, & Fleming (2003) examined a total of 60 studies to determine whether minority adolescents received fewer, greater, or the same mental health care services as white youth after taking into account socioeconomic status. Of the 60 studies reviewed, 11 met the criteria for inclusion in their analysis. Ten studies reported on mental health care service utilization among white and black adolescents. In six of these studies black adolescents received fewer mental health care services than did white adolescents (Larson, Sharma, & Miller, 2002; Kodjo & Auinger, 2003), whereas no racial group differences were noted in three of the studies (Pumariega, Glover, Holzer, & Nguyen, 1998). And in one study, black youths actually received more services than did white youth (Bui & Takeuchi, 1992). For Hispanic adolescents, only four of the11 studies reported data on Hispanic youth and only one study (Larson et al., 2002) indicated that Hispanic adolescents received fewer mental health care services than did white adolescents; the other three studies found no differences in service use among the different racial/ethnic groups (Burns, Costello, Angold, et al., 1995). This split in research findings regarding use of mental health services by African American youth strongly suggest that the real causes of disparities have not yet been found. According to Alegria et al., (2010), disparities remain in mental health status and care for racial and ethnic minority youth, despite national attention to disparity reduction.

## 2.5 Utilization of mental health services among African American youth involved with the juvenile justice system.

Providing mental health services to African American males involved with the

juvenile justice system is not the same as providing mental health services to other segments of the population. Although research evidence supports the underuse of mental health services as a general trend among adolescents, those involved with the juvenile justice system provide reasons for added concerns over their service utilization behavior. It is not clear whether or not the conditions within the juvenile justice system negatively affect how the juveniles perceive mental health services even after they have been released into the community. For example, in a large metropolitan study, Hazen, Hough, Landsverk, & Wood (2004) compared mental health service use behaviors of youth ages 6 -17 years (n = 1,706) who were involved with at least one of the following service sectors: Child Welfare, Juvenile Justice, Alcohol and Drug Services, and Special Education. They found that 87% of the sample used at least one outpatient service, 45% used at least one inpatient service, and 71% reported use of a school-based service. Youths involved with the special education sector had the highest rates of service use. However, youths drawn from the juvenile justice system tended to have the lowest rates of service use.

For African American youth involved with the juvenile justice system, their mental health service use records have not been encouraging. As pointed out by Scott & Davis (2006), being an adolescent black male in American society today means a myriad of things including being a member of a group that perhaps is least likely to voluntarily seek and use mental health services despite confronting myriad stressors and problems that might make service use a necessity. Most African American youth especially those involved with the juvenile justice system internalize these stereotypical perceptions, and

in many instances act-out what society expects of them including avoidance of mental health service utilization. In Maulik and colleagues' (2010) study cited above, the researchers examined factors associated with different types of mental health services among African-American adolescents and young adults (n =500) aged 16 – 24 years old in an employment training program in Baltimore City, MD. Participants were involved with the juvenile justice system, disconnected from the labor force and school, and were transitioning to community living. The investigators developed and utilized an audio computer-assisted self-interview (ACASI) to assess mental health needs and service use by enrolled program participants. To capture the variety of ways in which this population sought support for mental health concerns, the researchers evaluated use of a range of mental health services across diverse contexts (formal mental health services, social services, correctional facility services, school-based services, and other human services). They found that depression and anxiety symptoms were present in 36% of study participants, and about 9% had problems with alcohol. Out of that number, only thirty-four percent had received treatment services from one or more of the five types of mental health services in the last year. A breakdown of services utilized indicated that the most commonly used service type was correctional facilities (18.8%) and formal mental health services (17.8%). Forty-five percent of individuals with depression and/or anxiety used at least one of the five different types of mental health services within the last year. They concluded that participants were more likely to have received mental health services in correctional facilities than in community- or school-based contexts.

In another study to determine the use of mental health services by African

American adolescent males released from juvenile detention, Paskar, Abram, & Teplin (2009), utilized data from the Northwestern Juvenile Project to examine the prevalence and characteristics of service use among 779 former juvenile detainees with substance use disorders three years following detention. The authors reported that over 50% did not receive any mental health service three years after they were released.

Underutilization of mental health services among African American male youth has also been documented in other jurisdictions of both the family courts and child protection agency. For example, the Scott & Davis (2006) study cited earlier examined the relationship of negative social contextual experiences of seventy-four adolescent black males transitioning from foster care into independent living with two factors relevant to the delivery of mental health services to them, namely: cultural mistrust of mental health professionals, and attitudes towards seeking professional help. The investigators found that young black males who reported a high frequency of negative social contextual experiences reported significantly greater cultural mistrust of mental health professionals and significantly less positive attitude towards seeking professional help for mental health problems than young black males who reported a low frequency of negative social contextual experiences. This study is very important because it is directly related to African American male youth involved with the systems of child protection: how they perceive the society, their mental health professionals, and the mental health system. For example, a detailed analysis of the Scott & Davis study reveals that over 40% of participants in the study checked “always” or “almost always” concerning the frequency to which police (47.3%), White people (45.9%), and people they do not know

(40.5%) thought they were doing something wrong. Also over 60% of participants checked “sometimes” to “almost always” concerning the frequency to which White people tended to lock their car doors when they passed (60.8%) and sales associates tended to follow them when entering a store (66.2%). These experiences significantly discourage black youth from trusting or sharing any information about their personal issues in counseling and greatly impede the development of any therapeutic relationship with their counselors and consequently lead to underutilization of mental health services.

In another study of the foster care system, Kerker & Dore, (2006) reviewed current research to determine service use among youth with emotional and behavioral issues involved with the foster care system. The reviewers report that a national study of youth in foster care found that just 23% of youth in foster care received at least one mental health service in the past 12 months (National Survey of Child and Adolescent Well-Being [NSCAW], 2003). They noted that utilization of mental health services in the foster care system vary by both race and reason for placement, and concluded that although African American youth are the largest racial group in the foster care system, their rate of mental health service use has been lower than that of comparable white counterparts (deReis, Zito, Safer, & Soeken, 2001). Other studies in the review report that most placement establishments seldom formally assess the youth for mental health problems (Halfon, Zepeda, & Inkelas, 2002), and even for those who are assessed and referred for mental health services, they often do not receive adequate care (American Academy of Child and Adolescent Psychiatry, [AACAP], and Child Welfare League of America [CWLA], 2002). Further, the review found that Child and Family Services

Reviews conducted by the Administration on Children and Families (ACF) in 32 states during 2001-2002 found that only one of these states was in compliance with federal mandates regarding provision of services to meet the mental health needs of children in foster care (Administration on Children and Families, 2002). These two studies reviewed above indicate that underutilization of mental health services by African American male youths in the foster care system seems to parallel mental health service use in the juvenile justice system among the same population suggesting that the problem of service utilization among this sub-group could either be a systems problem or problems inherent in the youths themselves. This information does not only support the rationale for this study, it also provides information regarding possible intervention point for policy makers and juvenile justice facilities administrators.

The review of empirical findings regarding present day use of mental health services by African Americans as discussed above in three sections continues to indicate underutilization of services particularly among male youth involved with the juvenile justice system when compared with other youth groups. Previous studies have addressed disparities in mental health service use between African American adolescent males and females involved with juvenile justice system (Veysey, 2003), others have advanced several reasons to account for underutilization of mental health services among African Americans in general (Satcher, 2001) but little is known about within-group differences in service use among African American male youth released from juvenile justice facilities. No study has been conducted to clarify why some African American youth access and utilize mental health services after they are released from juvenile justice

facilities while some do not even when both groups are equally emotionally distressed. The present study is designed to fill this gap. Information about the differential influence of culture on their help-seeking behavior will greatly help clinicians to understand the sensitivities of these youth and be able to provide service that will meet their mental health needs.

# CHAPTER III

# THEORETICAL FRAMEWORK

This chapter presents key conceptual issues that inform the study's framework namely: culture and mental health help-seeking behavior, need for mental health services, and race/ethnic biases in mental health diagnosis. The chapter then discusses relevant theoretical frameworks with particular reference to Network-Episode Model, the theoretical framework that guides this study.

## 3.1 Culture and mental health help-seeking behavior

Cultural values and beliefs of youth and their families affect their experience of mental health problems, perception and definition of the problem, beliefs about the desirability of mental health symptoms, the manifestation of symptoms, and methods of coping – including whether or not to obtain help and from whom (Rogler & Cortes, 1993). Help-seeking behavior is thought to occur only if symptoms are seen as highly culturally and socially undesirable, thereby making such help-seeking more desirable. As Olafsdottir & Pescosolido (2009) point out, culture categorizes knowledge and shapes attitudes. What groups of people come to know and believe to be the causes of mental health problems which incidentally are a reflection of their cultural conventions, are likely to impact their choice of mental health treatment option. In some cultures, for example, there is the belief that the best way to deal with psychological problems is to avoid thinking about them (Cauce et al., 2002). Some Asian American groups in particular believe it is best not to dwell on upsetting thoughts or events (Cheng, Leong, & Geist, 1993). Similarly, African American adolescents are often encouraged to simply use

willpower to overcome undesirable psychological problems, and to "tough out" difficult situations (Broman, 1996).

Understanding the help-seeking behaviors of post-incarcerated African-American youth therefore requires understanding the subjective norms, values, and beliefs that have become a part of or developed in their interaction with multiple social networks (family, peers, school, etc.). While cultural and social context are not the only determinants of help-seeking behaviors, they do shape the attitudes of ethnic minorities and alter the types of mental health services they utilize. Research evaluating adolescent attitudes about behaviors suggests that adolescents' beliefs are important if one really wants to understand their intentions to seek mental health care (Cauce et al., 2002).

**3.2 The meaning of culture**

Defining culture has been a topic of debate among sociologists and anthropologists for many years. The traditional approach to defining culture, from a social context in which people share social norms, values, beliefs, language, and institutions given by Guerra & Jager (1998), to the totality of learned, socially transmitted behavior including values, customs, ideas, and artifacts by Schaefer (2000), or that credited to the Department of Health and Human Services (2001), as a common heritage or set of beliefs, norms, and values, has been challenged for placing too much emphasis on values in explaining the effect of culture on action (Swindler, 1998). This "value paradigm", as it is called, is viewed by some scholars as misleading because it assumes that culture shapes action by supplying ultimate ends or values towards which action is directed, thus making values the central causal element of culture (Swindler, 1986). An alternative

definition by Keesing (1974) views culture as the publicly available symbolic forms through which people experience and express meaning. Building on the symbolic meaning concept, Swindler (1986) argues for the replacement of the value paradigm, noting that although culture does influence action, it does not do so by providing value as the ultimate towards which action is directed, but rather culture shapes a repertoire, or the "tool kit" of habits, skills, and styles from which people construct strategies of action. Thus, she concluded that culture should be seen as consisting of such symbolic vehicles of meaning, including beliefs, rituals practices, art forms, and ceremonies, as well as informal practices such as language, gossips, stories, and rituals of daily life (p.273). Despite differences in how culture is viewed here, both, the "value paradigm" and the "tool kit" approach do accept the fact that "values" remain the major link between culture and action. The argument is concerned with the focus on values which seems misleading since other cultural models, such as ideologies, or the French revolutionary political culture (Hunt, 1984) also play a powerful role in organizing social life.

Similarly, most studies use race and ethnicity as the marker for culture while others seek to isolate context from culture. The argument becomes more complex when we realize that some contextual features, such as socioeconomic status (SES), gender roles, or regional differences, which are contextual variables, are not necessarily tied to culture (see Cauce, Coronado, & Watson, 1998, for detailed discussion on this issue). Although this dissertation will not dwell on a universally acceptable definition of culture, it is appropriate to remind readers that, to a large extent, culture develops as a result of specific contextual demands, and that context can be thought of as a collection of cultural

dimensions (Cauce et al., 2002). As we have known, human development occurs within a cultural context and individuals learn to make sense of the world around them within a cultural framework (Cauce et. al., 2002), as such, an attempt to separate culture from context will present more problems than solutions because one is so often used in defining the other. For purposes of this dissertation, culture is viewed from the relativistic point of view as a social context in which people share social norms, beliefs, values, language and institutions including all informal practices of daily life transmitted through generations by the process of socialization. These cultural elements facilitate or constrain patterns of action or behavior and greatly affect individual attitudes towards mental health service utilization decisions.

Increasingly, culture has become an important consideration in mental health services utilization discourse, and clinicians as well as researchers have learned not to ignore its influence when dealing with ethnic minority groups. In a study of parental cultural influence on youth mental health services utilization, Ho, Yeh, McCabe, & Hough (2007) examined parental cultural affiliation on youth mental health services use. The researchers found that parental acculturation levels as measured by affinity to an alternate culture, as opposed to the mainstream American culture, was a partial mediator in the relationship between race/ethnicity and mental health service use for Asian/Pacific Islander and Latino youth.

Culture seems to be the yardstick for measuring what is described as mental illness within ethnic groups. It also dictates acceptable remedial responses to mental health problems. Green (1995) noted that “any culture provides a repertoire of explanations for

mental health problems, explanations related to etiology, symptoms recognition, and the course of illness episodes. A culture also provides a sick role for those who suffer expectations concerning treatment and a definition of desirable outcomes" (p.58).

Cultural influence on action has also been shown to be important in the choice of where or who individuals go to for services when they experience mental health problems. Olafsdottir & Pescosolido (2009) developed the concept of "cultural mapping" to explain if and how individuals discriminate among different available sources of formal treatment for mental illness. Cultural mapping here refers to the choices individuals have at their disposal regarding health care providers (p.229). The researchers argue that mapping the cultural climate that individuals are faced with when they encounter mental health problems provides insight for understanding service use and general social processes of making decisions. They found among other things that the public discriminates between providers based on cultural attitudes, their evaluations of the situation, and occasionally on their social locations.

**3.3 Need for mental health services**

Need for mental health services is defined as having a diagnosable disorder or a condition that could profit from receiving service or treatment for that condition (Landerman, Burns, Swartz, Wagner, & George, 1994). Utilization of mental health services is driven principally by need for services expressed in terms of the presence of illness, the perception of illness, or symptoms. Although mental health disorders have been shown to be highly prevalent in juvenile detention facilities, and among youth released from

detention into the community, prevalence is not synonymous with need for treatment (Mechanic, 2003).

Establishing need for mental health services has been very controversial even among scholars. Currently, the need for mental health services is typically self-defined or defined by DSM-IV diagnosis whose criteria include some environmental factors that have been argued to be non-scientific. These two paths to establishing need for services have become a major concern for clinicians as well as others in the mental health field. The dilemma is that on one hand, the social context (stigma) of mental health problem makes it difficult to establish need for services with individuals who think they have no mental health problem, and on the other hand, nearly all managed care organization require that mental health treatment be based on DSM-IV diagnosis in order to receive reimbursement. It is the diagnostic label that carries the stigma because individuals do not like to be labeled especially when it has a negative connotation.

Most youth as well as some adults like to deny any association with the term "mental health problem", even when the diagnosis is determined by a psychiatrist. In a study published in the British Medical Journal titled: "Time to Abandon the Term Mental Illness", Baker & Menken (2001) present an interesting argument about how the term "mental illness", itself has become a barrier to mental health service use. It makes it difficult therefore to establish need for services with individuals who think they have no mental health problems. In addition, most youth are unaware of their altered perceptions or affects and thus cannot assess the effects and magnitude of the psychological changes that occur in them. Therefore, they do not know and cannot decide whether they have a

problem or not.

The other pathway to determining need for services through the DSM-IV diagnostic criteria is plagued with controversy over the relationship between DSM-IV definitions of mental disorders and a credible concept of service need. At the center of the controversy is the argument that perceived or self-defined need for services might not be an indication of objective functional impairment, and thus may not constitute need (Mechanic, 2003). This has led to the DSM-IV being accused of over-inclusiveness of diseases that are clearly normal "problems in living" (Szasz, 1960). These and other considerations have made some people skeptical about expressed need for mental health services.

However, beyond diagnosis and impairment, clinicians and mental health professionals weigh other factors in the process of considering the establishment of need for professional care. According to Regier (2003), need for care should not be based solely on diagnosis both in mental health and the rest of medical care. Mojtabai and colleagues (2002) found that the magnitude, severity of distress, and disability are the most important determinants of perceiving a need for care.

Although there is agreement that people with high levels of need should receive care, considerable skepticism still exists that the presence of disorder itself is a reliable indicator of need. As Mechanic (2003) noted, without a reliable standard of measuring need, "it is an illusion to believe we can avoid muddling through to some extent" (p.1). This lack of an acceptable standard of measuring need might affect assessment and determination of genuine need for services thereby forcing clinicians to unnecessarily

increase or reduce the number of referrals for treatment with serious consequences on service utilization.

### 3.4 Race/ethnic biases in mental health diagnosis

The Surgeon General's report on mental health care identified among other things, limited provision of optimum treatment and questionable diagnostic practices as viable explanations for disparities in mental health service use among ethnic minorities (Satcher, 2001). Other studies also report that disparities in mental health service use among African Americans are related to racial bias in psychiatric diagnosis. Bias in mental health diagnosis occurs when practitioners and mental health program administrators make unwarranted judgments about people on the basis of race or ethnicity (Snowden, 2003). For example, the stereotype that Black men are prone to violence operates at the unconscious level in the mental health clinician's diagnostic judgment about Black men and has been found to contribute to overdiagnosis of paranoid schizophrenia in Black male psychiatric patients (Whaley, 2001). Research reveals that African Americans are more often diagnosed with specific mental disorders (e.g., psychotic disorders) compared with European Americans. Schwartz & Feisthamel (2009) investigated disproportionate diagnosis of mental disorders (psychotic, mood, and childhood disorders) among African American versus European Americans in a sample of (n = 1,648) clients selected from a 10-county community mental health agency in a southeastern state. They found that African Americans presented for treatment were significantly more likely than were European Americans to receive psychotic and childhood disorder diagnoses. Thus, they concluded, "counselors disproportionately diagnosed African Americans with psychotic

disorders to a statistically greater degree than what would be expected if race/ethnicity did not affect diagnostic decisions" (p.298). In a similar study, Thomas, Stone, Osborn, Thomas, & Fisher, (1993) compared rates of inpatient admissions at first admission and readmission among African Americans versus other racial/ethnic groups. They found that rates of both first admissions and readmissions were significantly higher for African Americans compared with other ethnic groups. Whaley (2004) also reported that African American clients are significantly more likely to be hospitalized in psychiatric facilities and are more likely to be involuntarily committed than are European American clients. This trend results in more days off work among African Americans compared with other racial/ethnic groups (DHHH, 1999) and in a loss of social freedom. These and other examples heighten African Americans' skepticism towards mental health care and the desire to avoid service utilization.

However, it should be noted that racial bias in mental health diagnosis is not always an intentional activity. Snowden (2003) noted that bias should be isolated from other barriers to high- quality mental health care and should be understood at its various levels (practitioner, practice network or program, and community). Although it has been documented that many white Americans harbor negative stereotypes about American blacks (Davis & Smith, 1990), most misdiagnosis or overdiagnosis of mental health disorders by white providers occur because they are unaware and unable to distinguish between cultural and pathological aspects of Black men's coping responses. According to Whaley (2001) for example, Black men developed what has been referred to in the past as "healthy cultural paranoia" or more contemporary term of "cultural mistrust" as a

defense against threats of racism and discrimination. He argues that since paranoia can be viewed either as a symptom of psychopathology or as a type of cultural coping response in Black men, failure to recognize the milder form of paranoia, such as distrust, as non-pathological may contribute to high rate of psychiatric diagnosis, and most African Americans who are aware of such possible mix-up tend to avoid contact with formal mental health providers.

### 3.5 Theoretical framework

The Institute of Medicine (1993) defines health care access as "the timely use of personal health services to achieve the best health outcome" (p.4). This timely use of mental health services can be achieved by individual voluntary efforts to obtain care (e.g., going to the medical expert to seek help) or by having other people impose the need to seek help on the individual (e.g., allowing one's self to be arrested by law enforcement for bizarre behavior and taken to the hospital for psychiatric evaluation). Regardless of the way an individual prefers to seek help, three basic factors must exist: (i) identified or perceived illness or symptoms, (ii) personal/individual resources, and (iii) external/environmental resources.

Several theories and models have been utilized to explain how individuals access and use physical/mental health care. Among the most frequently used are the Socio-Behavioral Model (Andersen & Newman, 1973, Andersen, 1995), the Theory of Reasoned Action (Ajzen & Fishbein, 1967), and the Network-Episode Model (Pescosolido, 1992). A brief summary of these theories or models is necessary to

establish the rationale for selecting the Network Episode Model as the framework guiding this study.

### 3.5.1 The Socio-Behavioral Model (SBM)

The Socio-Behavioral Model (SBM) is one of the earliest models of help-seeking developed by Andersen and Newman (1973) and later revised in 1995. The model, designed to be an explanatory and predictive model for utilization of health services, consists of three basic components: (i) predisposing factors (demographics, social status, level of education, ethnicity, health beliefs), (ii) enabling factors – resources (personal/family and community), and (iii) need factors (perceived and evaluated). Essentially this model suggests that individual's health care service use is a function of their predisposition to use services, factors that enable or impede use, and their need for care (Andersen, 1995). The revised version (Andersen, 1995), which included several key components related to access, made the model fully recursive where all of the other components (i.e., predisposing factors, need, and enabling resources) are influenced by the outcome of the health care received.

Andersen's model of health care utilization is fundamental in explaining health services use behaviors because it introduced and incorporated the construct of "need" for services, an essential concept in understanding health care service utilization. As Pescosolido and Boyer (1999) acknowledged, "some need for care must be defined or individuals are not likely to consider whether or not to use services, what services to use, and when to go" (p.400). In 1964, this model was found reliable in providing guidance for the analyses of a national survey of families' health care utilization and expenditure

(Andersen, 1968). Frequently, this model has been used in other health care research including the Health and Retirement study (1992-2004) to examine racial/ethnic differences in relationship between functional disability and the use of health care services in a nationally representative sample of older adults (Bowen & Gonzalez, 2008), to identify the factors important in explaining the use of health services in a random sample (n = 1,317) of older adults and to examine the interrelationships of the variables (Evashwick, Rowe, Diehr, & Branch (2005), and in long-term care services use focusing on nursing homes and home care services among minority elders (Bradley, McGraw, Curry, Buckser, King, Kasl, et al., 2002).

However, the SBM does not, on its own, explain adequately the influences on the help-seeking behavior of youth or how they get into mental health treatment. As will be seen in other theories to be discussed, adolescents do not often make health care decisions on their own volition. Usually, they get into mental health treatment system through different entrances, which are not accounted for by the SBM. Even in the presence of need for services and a profile of predisposing and enabling characteristics, youth still often lack the capacity to act on a desire to receive care – an essential assumption of the SBM. Thus, this model has essentially been criticized for paying little or no attention to social networks and interactions (Portes, Kyles, & Eaton, 1992).

Most importantly, for the purpose of this dissertation, the role of culture or cultural context is ignored. Although Andersen (1995) argues that cultural factors can fit in the predisposing factor category, the model does not adequately explain or predict how the cultures of ethnic minority groups influence the help-seeking behaviors of their people.

For example, Portes, Kyles and Eaton (1992) utilized Anderson's model to study mental health help-seeking behaviors of Cuban and Haitian immigrants to the U.S. The researchers did not find any of the enabling factors in Andersen's model to be a predictor of their mental health help-seeking. Rather, they found that cultural factors, such as, nationality, context of exit, manner of reception on arrival (i.e., the facilitating role of the receiving ethnic community), and cultural competence of mental health providers, which Andersen's model seemed to have ignored, were the most powerful determinants of mental health service use even after all individual-level variables were controlled. This limitation makes this model inappropriate for explaining the cultural factors that shape the attitudes of ethnic minority youth in their decision to use or not to use mental health services, particularly post-incarceration.

### 3.5.2 Theory of Reasoned Action (TRA)

Martin Fishbein developed his Theory of Reasoned Action (TRA) (1967) to explain the link between attitudes, norms, intentions, and the behavior of individuals. This theory posits that individual behavior is driven by intentions to perform the behavior, and the intentions themselves are determined by the individual's attitude towards the behavior, and the subjective norms. According to this theory, attitudes are the perceived positive and negative feelings anticipated by the individual as he/she evaluates the consequences of performing a behavior. Subjective norms on the other hand represent the normative beliefs (approvals or sanctions) that other people who are important to the individual have about performing the behavior in question (Ajzen & Fishbein, 1975). Thus, the theory has three basic components: behavioral intentions (BI), attitude (A), and

subjective norm (SN). TRA looks at behavioral intentions rather than attitude as the main predictor of behavior, and suggests that a person's behavior intentions depend on the person's attitude about the behavior and subjective norms (BI = A + SN). If a person intends to carry out a behavior then it is likely that the person will follow through.

This theory has been used extensively to study behavioral intentions, including intentions to utilize mental health services. For example, Werner & Mendelsson (2001) utilized this theory to examine the intentions of nursing staff members to use physical restraints with older people, and found attitudes, subjective norms, and moral considerations to be significantly associated with intentions to use physical restraints with older people. Sable, Schwartz, Kelly, Lisbon, & Hall (2006) utilized this theory in a cross-sectional survey of 96 faculty physicians from one Southern and three Midwestern universities to assess factors associated with the physician's intentions to prescribe emergency contraception, and found that high intention to prescribe emergency contraception was associated with positive attitude towards doing so and with the perception that specific colleagues or professional groups support prescribing it. The investigators also reported that only 42% of participating physicians strongly intended to prescribe emergency contraception for teenagers but 65 – 77% intended to do so for all other specified groups (i.e., women who ask for the method, who have had a method problem, who have experienced rape or incest, and who have had unprotected sex). Most recently, Mullan & Westwood (2010) applied this theory to study school nurses' intentions to assist with sexual health education in schools designed to reduce the high rates of teenage conceptions and sexually transmitted infections. The researchers

distributed questionnaires to 46 school nurses (all females) in a large geographical area in the United Kingdom. They found that the theory accounted for 43% of the variance in intention and 46% of the variance in behavior. Thus, they concluded that the theory has good predictive utility and has provided some important information regarding school nurses' intentions to practice in sexual health.

It is very important to discuss this theory in this study because it illuminates and clarifies the concept and function of subjective norms as a major influence on the individual's behavioral intentions. Thus, this theory orients the reader to the proper understanding of the role played by subjective norms, a key component of culture, an important variable in this study.

However, this theory seems inadequate in explaining the mental health utilization behavior of black adolescent males because the TRA works most successfully when applied to behaviors that are under a person's volitional control (Morisky, 1980). Similarly, the theory has been faulted on grounds that its explanatory scope excludes behaviors that are spontaneous, impulsive, or habitual (Hale, Householder, & Greene, 2003). Sheppard, Hartwick, & Warshaw (1988) also criticized the theory for not making exceptions for choice among alternatives; arguing that the presence of choice among alternative behaviors may dramatically change the nature of an individual's intention formation and the role of intentions in the performance of behavior. Considering these limitations, this theory does not seem an appropriate guide for explaining the help-seeking behaviors of post-incarcerated male African American youth because their health care utilization decision-making is usually not made by a single individual, rather it is

mostly the result of consultations with parents, family members, or close associates in the community.

### 3.5.3 The Network-Episode Model (NEM)

Consistent with TRA's recognition of subjective norms, the Network-Episode Model (NEM) further recognizes the central role of social interaction in mental health treatment decision-making and grounds the individual decision-making process within a multilevel social network (Pescosolido, 1992, 2000; Pescosolido & Boyer, 1999). The NEM which focuses on mental health and chronic health problems posits that, "interaction in social networks forms the principal mechanism through which individuals recognize health problems, contact health facilities, and comply with medical advice" (Pescosolido, Wright, Alegria, & Vera, 1998, p.2). Its basic idea is that dealing with any health problem or physical disability is a social process that is managed through the contacts (social networks) that individuals have in the community, the treatment system, and social service agencies, including support groups, churches, and jails (Pescosolido & Boyer, 1999). It stresses the important role played by gateway providers (initial contact person) embedded in the community, who first recognizes mental health problems and provide referrals to treatment (Stiffman, Pescosolido, & Cabassa, 2004).

In the NEM, the influence of the community seems to be paramount in determining how, when, where, or if individuals obtain health care. Hwang, Abe-Kim, & Takeuchi (2002) investigated predictors of help-seeking in the Chinese American community across formal and informal sources of care, and found that family conflict predicted both mental health and medical service use. Among the poor in Puerto Rico, however, large

and supportive networks substituted for informal care and harbored negative beliefs about the efficacy of the mental health system, thereby lowering the probability of using formal providers (Pescosolido et al., 1998). These findings are in line with the NEM's assertion that members of the community (including family and friends) can work in concert or in opposition to produce the "push" toward or away from service use.

The Network-Episode Model provides the theoretical guide for this study because, as stated earlier, since help-seeking is not an isolated, rational action, but instead, a process involving influence from individuals in one's social network (Pescosolido & Boyer, 1999), the social support and the illness career concepts of this model are well suited for examining how African American young males' social network might contribute to negotiated service utilization. As depicted in figure 1, it consists of four basic components: the illness career, the social support system, the treatment system, and the social content.

Although the embedded influence of culture is evident in almost all components of the NEM, this study focuses only on the social support and the illness career components in explaining how the influence of culture which is embedded in the community differentially shapes the decision-making of African American youth towards mental health and its service delivery system. The other components of the model: the treatment system and social content, though important in understanding the model, are not the focus of this investigation.

The NEM conceptualizes its social support element as the encounters people have in their day-to-day lives in the community (Pescosolido & Boyer, 1999). This social

support component consists of the structure (e.g. size), content (e.g. beliefs about and experiences with the medical system), and functions (e.g. support or coercion) and are culturally embedded. Youth who experience mental health problems are likely to consult with members of their community that include parents, family members, clergy, teachers, etc. The advice these youth receive from the combination of advisors in the community during the course of an illness episode are influenced by the community's cultural beliefs and values. For example, if the advisors contacted during an illness episode view the problem as an issue of faith or an issue of domestic squabble they would encourage the youth to consult their pastor, the family head, or other people. On the other hand, if the advisors see the problem as "criminal in nature", they may encourage them to inform the police or lawyer which may eventually result in coercing the youth into remedial programs. Numerous studies have found that when the social network ties of the individuals who need help indicate positive attitudes toward mental health problems, especially among friends and relatives, who may also have been in treatment themselves, the individuals seeking help are more likely to utilize services (Turner & Liew, 2010; Weinstein, 1993).

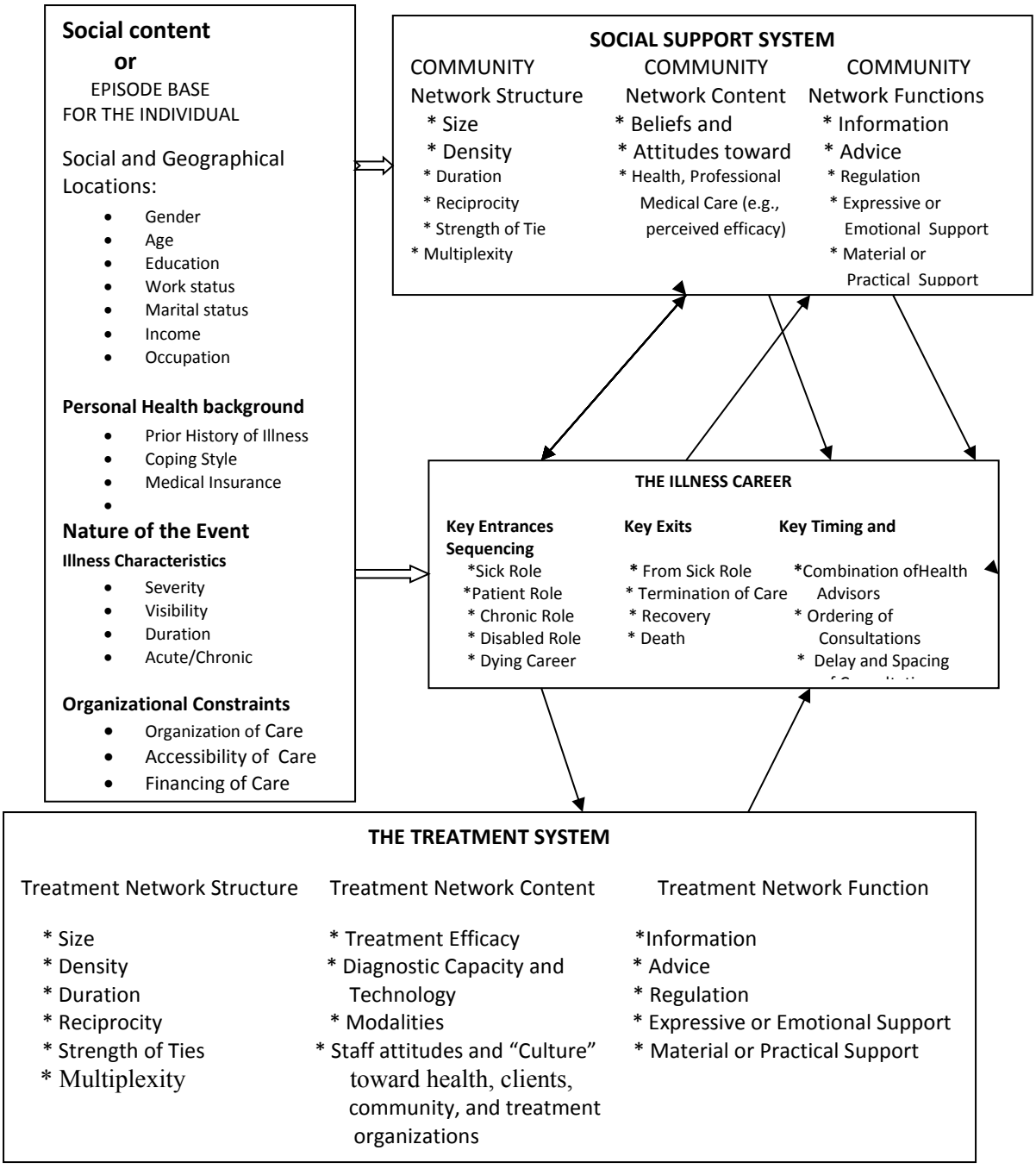



Figure 1. *Revised network-episode model: Pescosolido (1991, 1992).*

Source: How do people come to use mental health services? Current knowledge and changing perspectives. In Horwitz & Scheid (Eds. A handbook for the study of mental health: Social contexts, theories, and systems (pp.392-411).

In sum, the NEM asserts that an event (sickness) initiates a coping process that is embedded within a structured system of social relations therefore service utilization is negotiated at the micro level and is constrained by the social structure (Pescosolido, 1991, 1992, Pescosolido et al., 1998). This model has been adapted to explore the help-seeking behaviors and mental health attitudes of depressed African-American adolescent boys recruited from community-based mental health centers and after-school programs for youth (Lindsey, Korr, Broitman, Bone, Green, & Leaf, 2006), to examine mental health service utilization among impoverished people accessing resources for the homeless in Canada's universal health care setting (Bonin, Fournier, & Blais, 2007), and to examine the nature and correlates of utilization among Puerto Ricans reporting mental health problems (Pescosolido et al., 1988).

Much of the research on attitudes and care seeking focus on the decisions individuals make about entry into treatment, but from a process-focused perspective there are actually multiple decision points associated with care seeking and service utilization (Pescosocido & Boyer, 1999; Pescosolido, Gardner, & Lubell,1998) that occur in the context of the influence of social networks (e.g. family, peers, community). The NEM clearly demonstrates that social network members are used as a resource for identifying pathways to care, though this sometimes may result in coercing the affected individual into care (Pescosolido et al., 1999). Social network members are the advisors and consultants embedded in the community who determine whether or not the affected individual actually needs care. Social network members decide where to go to obtain services if they decide there is need for one, and social network members also monitor

the care received (Lindsey et al., 2006), by providing care maintenance (e.g., transportation). This social process of decision-making, recognizing that adolescents do not often make treatment decisions on their own volition makes the NEM a better model for this study. Thus, this perspective will guide this dissertation in examining how these cultural factors -their ways of doing things - influence the attitudes of African-American youth and selectively shape their decision to use or not to use mental health services after they are released from juvenile justice facilities.

The present study hypothesizes that cultural factors embedded in the community create differential attitudes among African-American youth that act as barriers to accessing and utilizing mental health services. Further, the study discusses other components of ethnic minority youths' cultural experiences that positively or negatively shape their attitudes and encourage or prevent them from seeking mental health treatment such as: stigma; belief systems anchored in religion and spirituality; the tradition of utilizing more informal means to help rather than psychological services, and the perceived importance of cultural identification.

### 3.6 Conceptual framework for the study

Research has established a strong relationship between attitude (positive/negative) and use/non-use of mental health services. In one of such studies, Have, Graaf, Ormel, Vilagut, Kovess, & Alonso (2010) investigated prevailing attitudes towards mental health help-seeking in Europe to confirm whether favorable attitudes towards mental health disorders were associated with actual use of services for mental health problems. Using data derived from the European Study of Epidemiology of Mental Disorders, a

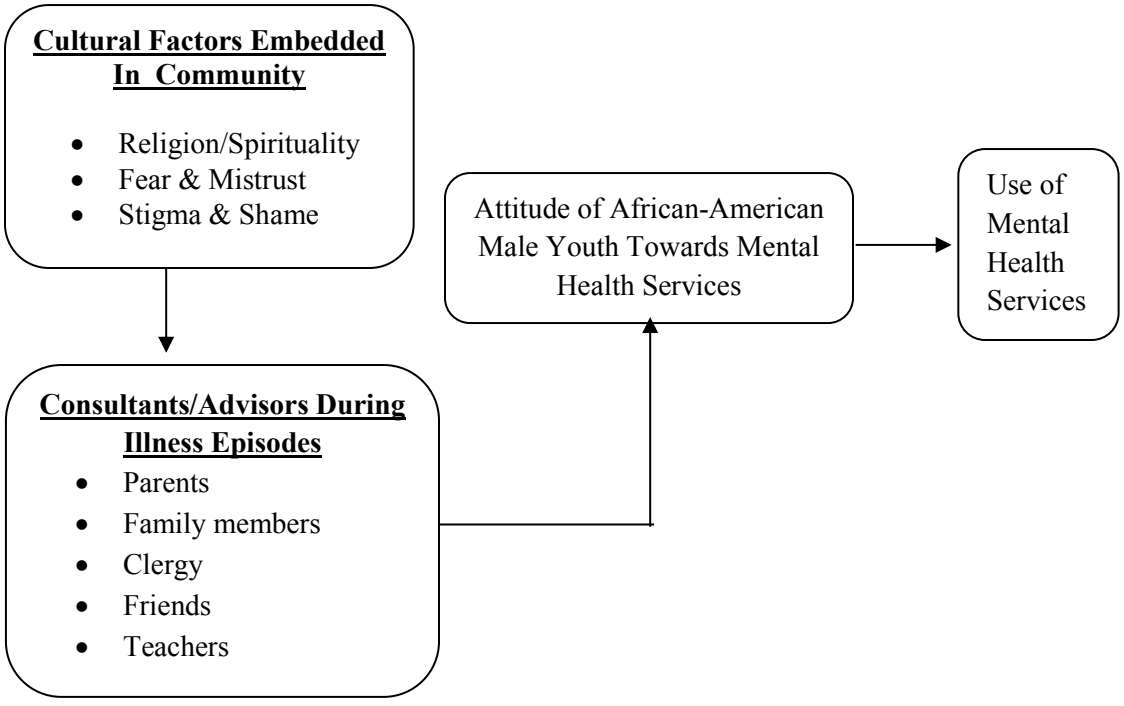
representative survey of the adult population in six countries: Belgium, France, Germany, Italy, the Netherlands, and Spain (n = 8,796), they found that positive attitudes towards mental health disorders were significantly associated with mental health service use while negative attitudes towards mental health disorders was the reverse. This means that people would be unlikely to seek services for mental health problems if their attitudes and beliefs (which are colored by culture) about those services are negative or unfavorable. As stated earlier, youth do not typically seek mental health treatment on their own volition. They consult with and depend upon advisors (the initial contact persons) (Stiffman et al., 2004) who decide whether or not treatment is needed. The advice given to the youth during an illness episode grows out of the cultural beliefs and values of the advisors and consequently creates or shapes the attitudes of the youth towards help-seeking. Thus, attitudes towards seeking professional mental health services and the cultural barriers/factors embedded in the community which shape those attitudes are pivotal and the focus of this study.

As shown in figure 2, cultural factors embedded in the community constitute the values and belief system of the consultants/advisors (the initial contact persons) that the youth go to for advice during an illness episode. Any advice given to the youth is influenced by these cultural beliefs and this greatly shapes the attitude of the youth (positive/negative) towards mental health treatment. A positive attitude towards mental health, the health system, or the health services provided leads to the decision to utilize services. On the other hand, a negative attitude towards mental health, the system, or its services leads to the decision not to utilize mental health services. Using samples of

African-American youth released from the juvenile justice facilities, the key issue for this study is to understand how the same culture could exert differing influences on attitudes that encourage some youth to access and utilize treatment while pushing others away from taking advantage of available treatment services.

The role of the consultants and advisors shown in figure 2 during any mental health episode is to recognize whether or not any mental health problems exist, determine whether or not there is need for treatment, and decide who or where to go for services. This means that use of mental health services follows the determination of "need" for services. Thus, prior to discussing culture and its influence on use of mental health services, it is necessary to understand what constitutes "need" as it relates to mental health service use.

**Figure 2. Conceptual Framework for the study:**



### 3.6.1 Cultural factors embedded in community

This section explains the following cultural factors in the study framework and the role they play in the complex decision making process of youth who experience mental health problems: religion/spirituality, fear & mistrust as well as stigma & shame. Other variables in the framework that require brief explanation include the consultants/advisors, attitudes of African American youth, and use of mental health services.

### 3.6.2 Religion/Spirituality

For a long time in human history, religion and spirituality have played and will continue to play a significant role in human life. Like culture itself, religion consists of systematic patterns of beliefs, values, and behavior acquired by individuals as members of their society. According to Koenig (2009) religion involves organized sacred beliefs, practices and rituals related to the mystical supernatural, God, or the ultimate reality. Spirituality on the other hand seems a little more difficult to define since it tends to be more of personal application of the religious teachings but largely free of organized rules, regulations, and responsibilities. Sociological literature lists religion/ spirituality among factors described as cultural universal (Schaefer, 2000). This means that religion and spirituality are aspects of individuals' cultural heritage adapted to meet essential human needs. Since religion and culture appear to be inextricably interwoven, the influence of one over the other cannot easily be understood. Carter (2002) warns that certain African American religious/spiritual practices, rituals, and beliefs such as speaking in tongues, the presence of hallucination, or states of demonic possessions mimic the manifestations of most mental health problems, which can easily be mistaken for psychopathology. Thus,

what clinicians may see as mental health problems, may be interpreted differently within this ethnic group.

Most African-American communities are very religious, thus these religious factors, which are embedded in the community, are likely to exert a strong influence on their health services utilization decisions (both physical and mental). For example, the majority of African Americans are evangelical Christians with fervent beliefs that their religion bestows upon them the spiritual control over the overwhelming forces of nature including the will-power to conquer mental illness. Thus, they view mental health problems as one of life conditions that could be overcome through prayers and faith (Wittink, Joo, Lewis, & Barg, 2009). In addition, African Americans belief that religion/spirituality provide them with a powerful coping behavior (the strength of hope) and this enables them to make sense of physical or emotional sufferings (Koenig, 2009), as evidenced by their delay in service utilization in the hope that mental health problems will go away on their own. In the present study, I will either refer to religion or use both terms religion and spirituality interchangeably.

### 3.6.3 Fear & Mistrust

Fear and cultural mistrust are among the myriad of barriers that prevent African American youth from utilizing mental health services. The negative attitudes of African Americans towards the health care system in general and mental health in particular could be traced to the long history of slavery they were subjected to, and the demeaning practices of pathologizing their cultural and racial differences (Suite, Bril, Primm, & Harrison-Ross, 2007). Research indicates that most African Americans in need of mental

health services delay or avoid service use for fear of exposing concealed personal information (Vogel & Webster, 2003) or for the mistrust of their white counselors (Townes, Chavez-Korell, & Cunningham, 2009). For example, Sue & Sue (2003) noted that African American clients in counseling may view White counselors in particular as racially biased agents of the establishment who push, through the counseling process, for solutions that reject their cultural values. Thus, in most cases, they perceive the counseling process itself as an instrument of oppression. Other studies cite fear of hospitalization or institutionalization (Sussman, Robins, & Earls, 1987) as a barrier to service utilization.

The construct, cultural mistrust was created by Terrell & Terrell (1981) to describe the theoretical level of distrust and suspiciousness that most black people harbor and sometimes exhibit in the therapeutic relationship with white counselors. Such distrust and suspicion according to Townes et al., (2009) is not limited to therapeutic relationships, but extends to relationships in other domains including business transactions, political activities, education, and other interpersonal and social contexts.

Cultural mistrust of mental health providers by African Americans arises, in the broader sense, from historical persecutions (Suite et al., 2007), and from present-day struggles with racism and discrimination (Barksdale & Molock, 2008). In a study titled: "Cultural mistrust of White mental health clinicians among African Americans with severe mental illness", Whaley (2001) examined the association between cultural mistrust and beliefs about white mental health clinicians among African American patients recently admitted to a psychiatric hospital. The researcher found that self reports and

clinician rated measures of cultural mistrust predicted patients' beliefs about white mental health clinicians.

In a similar study to determine the relationship between African American students' attitudes towards counseling/counselor preference and cultural mistrust, self-consciousness, and socioeconomic status (SES), Duncan and Johnson (2007) found that cultural mistrust and SES were statistically significant predictors of attitudes towards counseling, and that black college students from lower SES background with high cultural mistrust attitudes preferred a black counselor to a white counselor.

**3.6.4 Stigma & Shame**

The report of the President's New Freedom Commission on Mental Health (2003) identified stigma as a major barrier to Americans who suffer from mental health concerns from getting quality mental health care. Mental health stigma according to Pescosolido et. al. (2007) can be described as "the prejudice and discrimination linked to individuals with mental illness", (p. 611). Stigma has the effect of reducing the strength of individual's intentions (Ajzen, 1980) to use professional mental health services. Corrigan & Watson (2002) distinguished between public stigma, the negative public reactions towards the consumer of mental health services, and self-stigma, which involves the application of negative societal stereotypes associated with mental health problems to oneself. In most individuals, self-stigma, also known as internalized stigma (Moses, 2009) produces negative psychological feelings about one's sense of self. On the other hand, public stigma manifests in social rejection, prejudice, or discrimination.

In general, research has shown that African Americans hold more stigmatizing

beliefs about mental illness and register more concerns about stigma related to mental health service use compared to Caucasians (Anglin, et al., 2006; Barksdale & Molock, 2008). For example, in a study of stigma related to mental illness, Roeloffs & colleagues (2003) examined a diverse sample of insured African-American, Caucasian, and Latino adult patients taken from one of the 46 primary care clinics for treatment of depression. The researchers found that primarily African Americans were more concerned about the impact of stigma when a history of depression was disclosed than were persons of other ethnic groups.

Among African Americans, mental health stigma has been an important obstacle to mental health service utilization due to shame associated with the notion of being a recipient of mental health services. Turner & Liew (2010) found that parents with minor children exhibiting early signs of internalizing or externalizing problems may be less likely to seek mental health services for the children for fear or shame of being perceived as having poor parenting practices. Indeed, cultural norms among African-American families, such as keeping the family business within the family, usually conflict with the basic principle of disclosure in professional treatment. As such, African Americans tend to deny mental health problems and strive to overcome such problems through the exercise of willpower and prayers (Barksdale & Molock, 2008).

African Americans also abhor the practice of labeling (diagnosis) by professional mental health service providers. The effect of labeling is one of the reasons adolescents and parents may abstain from using mental health services and this has contributed to the high rate of dropouts from service use. Hinshaw (2005) noted that labeling has a negative

impact on children and parents including peer-isolation, rejection, parent's guilt, and above all, it strains parent-child interactions. Considering the impact of mental health stigma on service use, a good knowledge of the effects of stigma on individuals' intentions to use mental health services may be key to understanding underutilization of mental health services among African Americans especially adolescents.

### 3.6.5 Consultants/Advisor

Health services utilization research reveals that adolescents do not make health care decisions on their own volition (Pescodosido & Boyer, 1999), rather they confide in or consult with adults to determine the right action to take when faced with health care problems. Stiffman et al., (2004) refer to these initial contact persons who advise the youth on how and what to do when dealing with mental health problems as the "gateway providers", and they include: parents, family members, teachers, the clergy, and other close confidants. In fact, the gateway provider could be anyone who may pick up the youth for disorderly bizarre conduct and takes him in for evaluation and he finally ends up in treatment at the hospital for mental health problems.

These gateway providers or initial contact persons are members of the same community who share the same cultural beliefs with similar view of mental health problems. Thus, the advice they provide to the youth as to the cause or cure for mental health problem are strongly culturally biased. These individuals play an important role in service utilization in many ways including: identifying the problem, providing referrals, providing transportation, insurance coverage, and encouraging youth to utilize services or dissuading them from service use.

Gateway providers do not only identify mental health problems and provide referrals, they also must be knowledgeable, connected, and familiar with the larger community service network (Bunger, Stiffman, Foster, & Shi, 2009) to be able to plug-in the youth in a timely manner when services are needed. This special attribute of the gateway providers set them apart and has been given special recognition by this model. For example, Bunger et al., (2009) tested this model by examining 27 child welfare workers' connectivity to resources and youths' receipt of services. They found that youth received help from a greater variety of service sectors when their workers were not only able to identify behavioral health needs, but also were familiar with and able to connect to other providers in the community.

Thus, the conceptual framework figure 2 draws from and utilizes the variables and functions of the social support and the illness career components of the NEM (figure 1) to explain the timing, sequencing, and relationship of the initial contact persons (advisors/consultants) with the individual youth in need of mental health services during the social process of attempting to deal with mental health problems. In sum, all the variables in the conceptual framework (the cultural factors embedded in the community, the consultants/advisors, and their influence on the attitude of youth towards mental health) work in combination to explain how the youth gets into using or refuses to get into using mental health services. The conceptual framework charts the pathways and describes the individual's attempts as he bounces back and forth between advisors, consultants, and other community resources to decide how and what to do regarding his mental health problem.

# CHAPTER IV

# METHODOLOGY

This chapter describes the methods and procedures used in conducting this study. The chapter discusses briefly the major philosophical doctrines (qualitative and quantitative) in social science research and argues for the choice of qualitative methodology justifying its appropriateness in this study. This is followed by a description of the study setting and the population served by the organization. Data collection instruments and analysis techniques are discussed in detail including methods of sample selection, procedures, and techniques for establishing trustworthiness.

## 4.1 Methodology

Gough (2000) describes methodology as the principles that inform the organization of research activity, the assumptions that guide research, and the reasons for using such techniques in relation to the kind of knowledge or understanding the researcher is seeking. As Neuman (2003) points out, research methodology is what makes social science scientific, thus the selection of an appropriate research methodology was an important part of this research project.

There are primarily two distinct methodological approaches to research: the quantitative approach and qualitative approach, both approaches are governed by specific paradigms, an idea made famous by Kuhn in the (1970s) and defined as “a basic orientation to theory and research”. Patton (2002) explains paradigm as “a worldview – a way of thinking about and making sense of the complexities of the real world” (p. 69). According to Neuman (2003) paradigm is “a whole system of thinking which includes

basic assumptions, the important questions to be answered or puzzles to be solved, the research techniques to be used, and examples of what good scientific research looks like" (p. 70). Over the decades quantitative and qualitative researchers have engaged in a debate over which paradigm best portrays what is real, valid, and scientific in the production of knowledge. A qualitative design was utilized in this study primarily because this investigator was interested in achieving insight into the influence of culture on the youths' attitudes and perception of mental health services and the service delivery system in relation to their decisions to access and utilize services for their mental health problems. Rich description was sought to explain youths' experiences. Also, the study's focus on race, and the youths' explanations of their experiences with mental health help-seeking support a qualitative approach.

### 4.2 Qualitative approach

The qualitative approach is grounded in the interpretive social science paradigm (Secker et al., 1995) and constructivism (Guba and Lincoln, 1994). Proponents of this approach hold that social life is based on social interactions and socially constructed meaning systems, thus this paradigm adopts the inductive approach to the research process with the goal to develop understanding of social life and discover how people construct meaning in natural settings (Neuman, 2003).

The qualitative paradigm was selected for this study because the strength of its inductive approach, its focus on specific situations or people, and its emphasis on words rather than numbers (Maxwell, 2005). Understanding the youths' explanation of their experiences with mental health help-seeking requires story-telling and this is only

possible with a qualitative research design; it allowed these African American youth released from juvenile detention to describe their experiences in their own words and provide the unique perspectives of their lived experiences (Neuman, 2003).

A qualitative research design offered a more flexible approach that permits deeper probing into subjective meanings of race, context, mental health problems, and culture. The probes usually seek to generate new insights rather than attempt to test hypotheses. It enables the researcher to take into account the participants' reasons, beliefs, and the social context of action to better understand and interpret how African American adolescent males create and maintain their individual social world. Understanding "meaning" from the participants' perspectives facilitated awareness of how meaning influenced their behaviors. Indeed, this paradigm suits this study because it recognizes that human life cannot be thought of as numbers or experiments since that would take away not only the social interaction (Patton, 2002) but also the emotional and mental processes involved in the experiences and behaviors of the youths - the essential factors to be considered in this study.

Admittedly, qualitative approach is subjective, since it relies on the participant's reports of lived experiences, and usually involves small number of participant in the research process. But this is balanced by the aim to collect rich and detailed data to describe an in-depth perspective.

### 4.3 Study Setting

Participants in this study were recruited from the Family Renewal Center Program of John Hope Settlement House. The Family Renewal Center Program is one of the step-

down programs created and sponsored by the Rhode Island State Department for Children, Youth, and Families and administered by the Juvenile Corrections Department to facilitate community reentry for youth released from juvenile detention facilities. The program provides mental health care delivery for youth with severe emotional disturbance or adjustment problems to ease their transition to community living. This agency was chosen for recruitment purposes because it is one of the oldest social service agencies in Providence County serving predominantly ethnic minority population. In addition, the youth program in this agency had been experiencing high rate of drop-outs which indicated availability of study participants.

John Hope Settlement House was founded as a non-profit organization to benefit the African-American community and has provided more than 70 years of social services for its main constituency, as well as the broader Providence community. While African-Americans of all ages are served by John Hope programs, the major focus has been on youth, defined as those from 13-17 years of age. The majority of these adolescents have had some form of contact with the juvenile justice system and most have been residents of the juvenile correctional facilities. The goal of the John Hope programs for these youth is to provide mental health services and prepare them for transition to community living as productive citizens. Annually, the John Hope youth programs report that more than 250 adolescents (male & female) are processed through their intake department and some have successfully received services including mental health services. However, some youths in these programs have prematurely terminated services and the system has not yet determined how to provide for this population.

As a licensed clinician, I had the opportunity of working with youth in this agency for more than four years and during that period observed that a large number of the youth, particularly African-Americans released from juvenile detention facilities and referred to this agency in transition to community living terminate services prematurely although a good number of them also continued receiving services untill they were officially discharged. This experience informed my research questions and helped to secure access to youth to conduct the study.

### 4.4 Sample Selection

To answer the research questions, two groups of young people were selected from the setting. Criterion sampling procedures were utilized to recruit participants into the study. Criterion sampling is a strategy in which particular persons, settings, or activities are selected deliberately in order to provide information that cannot be gotten as well from other choices (LeCompte & Preissle, 1993, p. 169, as cited in Maxwell, 2005). This sampling technique allows the researcher to review and study all cases that meet some predetermined criterion of importance (Patton, 2002) before being selected. Youth who fit the following inclusion criteria were selected for the study:

1. the adolescent must be African American male between 15 and 17 years of age who were or are still receiving mental health services following their release from juvenile justice facilities in transition to community living;
2. the adolescent must be male and a former resident of the juvenile justice facility;
3. must describe himself as an African-American;

4. must (a) have completed the formal intake process at the Family Renewal Center program, and started receiving ongoing services (b) completed treatment and was officially discharged or (c) stopped keeping regular service appointments for more than two consecutive months; and
5. Those who stopped keeping appointments and gave no indication of returning to participate in the program in the future.

The key point in criterion sampling is to be sure to understand individuals or cases that are likely to be information rich which is necessary to answering the research questions. A total of sixty (60) African-American adolescent males (n=60) were recruited for the study. They constituted two groups of participants (30 who were no longer service users and 30 ongoing users/officially discharged).

**4.5 Procedures**

Following a series of e-mails and telephone discussions on the need for this study, the Principal Investigator (PI) met with the Deputy Superintendent (Administration) of the Rhode Island State Training School to discuss and obtain approval to interview the youth released from juvenile detention facilities and were receiving mental health services in one of the state's transitional programs, the Family Renewal Center Program in John Hope Settlement House (see Appendix A for Approval letter). The PI also met with the program staff at the Family Renewal Center Program to discuss the purpose and nature of the study (see Appendix B – Dissertation Research Information Sheet). After securing agreement, arrangements were made for a designated staff member to generate a list of all youth served by the agency within the past twelve months who fit the eligibility

criteria enumerated above. The designated staff member was instructed to maintain the listing until 30 of each type of subject were identified.

From the list of eligible participants generated, the staff member made the initial telephone contact with the youth and their parents asking if they would be interested in being contacted for this study. Sixty male youth (30 dropouts and 30 ongoing users/discharged) agreed to participate in the study by signing the consent to contact forms (Appendix D). The list together with the participant's contact information was then handed over to the PI to follow-up and schedule interview appointments.

After receipt of the list, the PI made telephone contact with all participants and their parents to review the purpose of the study and encourage participation. After securing their individual agreement to participate, a convenient time for the interview was arranged. Participants were allowed to choose their interview location to enhance their comfort level and all participants opted to have the interview in their homes.

The study was approved by the Boston University Institutional Review Board (IRB Protocol: #2663E) (Appendix C). Written assent and informed consent (Appendix E) and (Appendix F) were obtained in person from parents and the youth respectively. Both the assent and informed consent forms contained information about the purpose and nature of the study, risks involved if any, benefits, extent of confidentiality, principal investigator's contact information, and IRB representative contact information. Copies are in the Appendix.

### 4.6 Instrument Development

The PI developed two data collection instruments**:** a qualitative interview guide and a case record extraction form.

#### 4.6.1 Interview Guide

The Interview Guide (Appendix G) was designed to collect information needed to address the research questions. Interview questions were designed to elicit participants' responses to understand whether their experiences during an attempt to deal with their mental health problem follows the process-oriented approach as illustrated in the conceptual framework. The guide utilized questions related to their cultural and religious beliefs, contacts with parents, advisor/consultants embedded in the community at the time of any mental health problem, as well as other social factors that could influence mental health service use. Two early steps for developing the interview guide were: 1) review of questions and data from the pilot study; and review of standardized instruments (e.g., Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS) (Fischer & Turner, 1970) & Cultural Mistrust Inventory (CMI) (Terrell & Terrell, 1981) for conceptual ideas. This resulted in a draft of 17 open-ended questions. On two occasions the PI discussed the draft questions with two clinicians who are familiar with adolescents in educational setting as well as in therapeutic environments to evaluate the cultural content of the instrument and provide feedback regarding the instrument's format, length, and its appropriateness for the population in question. As a result, several questions were slightly modified where necessary to accommodate youth in both groups (continuers and dropouts). For example, a question such as "why did you dropout from the program?"

for youths in group 'A' (dropouts) was modified to read, "why did you continue with the program even when some of your friends dropped out?" for youths in group 'B'(continuers), while others were eliminated, reducing the questions to only 11 including the relevant probes. Throughout the process, the conceptual framework was continually utilized to keep the interview questions focused. For example, interview questions such as "who would you go to if you experience mental health problem?", was included to aid understanding of participants' willingness to consult with the advisors/consultants embedded in the community in the event that they experience any mental health problem.

### 4.6.2 Case Record Extraction Form

The Case Record Extraction Form (Appendix H) was designed for use in extracting data from participants' administrative case records. These data included the youth pattern of service use, nature of emotional disturbance, substance abuse issues, treatment planning, and type of discharge. Such information was needed to supplement or complement data gathered from the interviews. The PI then met with the Clinical Director of the Family Renewal Center Program to discuss and obtain approval for the release of participant's files for examination. Following the approval, the PI was allowed to review and extract needed information from the case files of study participants only on site with strict instruction not to make copies. This exercise was completed within the five business days allocated.

## 4.7 Data Collection

Fifty-four youth participated in the qualitative interviews and each interview lasted

about an hour. Interviews were conducted in the participant's homes and all were audio recorded with participant's permission

The PI conducted the interview himself to ensure adherence to the study protocol and reduce bias attributable to interviewer variability (Ward & Heidrich, 2009). Open-ended questions were utilized based on the conceptual variables and focusing on the influences of culture on: the factors embedded in the community, advisors and consultants during illness episodes, attitudes of African American youth towards mental health problems, and use of mental health services. Probes were used to encourage participants provide detailed account of how the factors embedded in their communities influence their help-seeking behaviors. Participants were also asked how they perceive mental health problems and their thoughts on coping strategies. At the end of each interview the participant received a $10 gift card for his time.

Although 60 interviews were originally planned, six participants did not show up for the interview, leaving 26 participants in group A (dropouts) and 28 in group B (continued users) resulting in a final sample of 54. Two of the six contacted complained of schedule conflicts but four gave no explanation for their inability to keep the interview appointment. Two attempts were made to each of them, one by phone and the other by an unscheduled appointment to arrange for the interview but none of them was willing to make any commitment towards following through with the interview.

### 4.8 Data Analysis

Data collected during the interview process as well as during the case record review were analyzed as follows:

### 4.8.1 Interview analysis

All audio recorded interviews were transcribed verbatim. The PI decided to transcribe his own data to increase familiarity with the data and ensure accuracy (Fade & Swift, 2010).

Thematic analysis was utilized to identify, analyze, and report patterns within data. Thematic analysis involves searching across a data set to find repeated patterns of meaning related to the research questions (Brauns & Clarke, 2006). A thematic style of analysis was appropriate for this study because the researcher intended to identify and describe behavioral patterns of service use by this group of youth therefore it was necessary to remain faithful to the participants' own account of their experiences.

Data analysis was completed in four phases: Phase one involved familiarization with data set. This began with the transcription process and also involved reading and re-reading the data (Braun & Clarke, 2006) after transcription and noting down initial ideas.

In phase two, thematic content of interest within the two strata defined as "dropouts" and "continued users" were determined by a careful examination of the youths' description of barriers to or triggers for mental health service use and how each participant framed the reason(s) for or against the use of mental health services. For example, a youth who expresses fear of isolation regarding self-disclosure in therapy as a barrier to service utilization might say, "it's like everybody knows everything about you", or another youth stressing why he continued with service use might say, " I listened to my mom cos I needed some relief with the hurt I was feeling inside". Phase three focused on searching for themes within the coded data. Themes are summaries of the essence of a

number of related codes (Morse, 2008; as cited in Fade & Swift, 2010). A word processing program was utilized to cluster the codes and generate categories which were later conceptualized into broader themes that relate to the variables to be addressed in this study. For example, the Microsoft word color feature was activated to color-code and highlight participant's phrases, sentences or paragraphs that were of interest to the investigator for further analysis. Specifically, the data was examined for interview responses to questions related to the youths' perception of mental health problems, influence of social support on service use, effects of racial consciousness, and peer pressures.

The final phase four was a review of the selected themes, combining them to create overarching themes. A matrix was developed (Table 2) for the overarching themes and sub-themes identified. The definitions of each theme and sub-theme are also presented and their meanings in relation to the conceptual variables clarified. Quotes that illustrate each theme or sub-theme capture the differences between the two groups of participants in service use behaviors.

### 4.8.2 Case file analysis

The case files of participants were analyzed and contents that were relevant to answering the research questions extracted. These included: demographic and health characteristics of participants, history of emotional disturbances, service utilization patterns, service plan, and type of discharge. This information was used to compare and confirm among other participant's characteristics, the study inclusion criteria (age, sex, ethnic origin, involvement with juvenile justice system, etc.), patterns of service

utilization (regularity with counseling attendance), and types of discharge. Information obtained from case files complemented those collected during face-to-face interviews.

### 4.9 Establishing trustworthiness

Trustworthiness in qualitative research refers to the strength of the reader's confidence that the study findings truly reflect the meaning of what the participants said. Lincoln & Guba (1986) suggested that the following criteria: credibility, transferability, dependability, and confirmability are viewed in combination as addressing "trustworthiness (itself a parallel to the term rigor)" (pp. 76-77, as cited in Patton, 2002, p. 546).

Several steps were taken to enhance the trustworthiness of the data. First, an expert audit review process was utilized (Patton, 2002) to receive feedback from a disinterested expert. The disinterested expert, a visiting Professor at Rhode Island College School of Social Work independently reviewed the coded transcripts and the themes/sub-themes that emerged and provided feedback regarding inherent ambiguity of word meanings, definition of themes and sub-themes, and coherence and consistency of coding practices. For example, although he was not a formal coder in the sense of the word, he provided an avenue for me to assess inter-coder reliability based on our simple agreement on codes and/or categories that constituted a theme or sub-themes. According to Lincoln and Guba (1986, as cited in Patton, 2002) this part of expert audit that examines the process of the research results in a dependability judgment (p. 562).

Second, use of reflexive journal was another technique utilized to minimize threats to trustworthiness. Reflexivity is the acknowledgement by the researcher that his/her own

identity, beliefs, or actions could undoubtedly impact upon the meaning or interpretation of the experiences under investigation. This process of reflection reminded me to ponder the ways in which who I am or my social location could interfere with the research process and shape the research outcome. For example, I made a reflexive journal entry on November, 2011 about power differentials and how my personal biases (e.g. values, beliefs, closeness to study participants being a black researcher, or my expectations) could affect data collection, analysis, or the interpretation of research findings. As I noted in my research proposal, I drew on my reflexive journals and made my background (black male clinician), values, assumptions, beliefs, and expectations explicit (Patton, 2002, p. 553), and open for discussion, not only to reduce the power differentials between myself, the researcher and the study participants, but also to make it visible to the readers. For example, in the second paragraph of chapter 4.4 (methodology) of this study, I made clear the extent of my involvement with youth who have had contacts with the Juvenile Justice System and with the agency that rehabilitates them.

In addition, I utilized other strategies to manage the threats to trustworthiness. While considering how our differences (power differentials) might shape the process, I also reflected on the effect of potential commonalities between myself and the participants. When I was planning the interviews, I knew that most African-Americans have a strong commitment to faith that may come up during the interviews and I made a note of that. As a practicing Christian, I thought about my personal spiritual identity. Specifically, I wondered if I as a Christian could really carry out a non-judgmental and unbiased evaluation of the experiences of another person of faith. This acknowledgement

was an important reflexive strategy because it led to further self questioning that led to more reflections. However, it should be noted that these questions do not eliminate threats to trustworthiness instead they alert the researcher to these threats and compel him/her to be more diligent in the data analysis process.

As another example, I made some entry in my research journal about the usefulness of triangulation in qualitative research as a way of reducing systems' biases and for cross-checking data to validate research findings (Patton, 1990). However, as I read more about data analysis in qualitative research in preparation for writing the methodology chapter of this dissertation, I reflected upon those journal entries and found myself changing from what I initially thought about the usefulness of triangulation as I discovered competing views on validity (trustworthiness). My readings indicated that there would be some problems with the use of triangulation in this study to demonstrate trustworthiness.

A third technique utilized to enhance trustworthiness was the interview process. In-depth interviews with open-ended questions used for data collection solicited participants own account of the decisions they made as to whether or not to utilize services for their mental health problems. The themes and sub-themes that emerged from the interview greatly established credibility because they were in the participant's own words just as they appeared in the interview transcripts.

### 4.10 Summary

This chapter described the choice of methodology used to conduct this dissertation study. The methods, style and approaches described fall within the paradigm of qualitative research approach. I also made a justifiable argument for method selection

with detailed description of the techniques utilized to minimize threats to trustworthiness. The chapter that follows presents the study findings.

# CHAPTER V

# RESULTS

The chapter is organized into two main sections. First, the emergent themes and sub-themes are presented. Second the stated research questions are specifically addressed. The organization of the chapter reflects the themes and sub-themes identified from the data together with interview extracts of participant's cultural beliefs or evidence of cultural influences on their attitudes or behaviors towards mental health service utilization. All participants were African-American males between 15 and 17 years of age. The majority (39%) were 15 years old, 37% were 16 years old, and the rest (24%) were 17 years old. The mean age was 16 and the median level of educational attainment was the $10^{th}$ grade. Two out of the thirteen 17-year-olds reported having children of their own aged 11 and 8 months respectively. Study sample characteristics are summarized in Table 1.

## 5.1 Emergent themes

Thematic analysis of 54 interview transcripts with study participants yielded responses that fit within these four overarching themes: (i) beliefs about causes of mental health problems, (ii) other beliefs about mental health, (iii) social barriers (isolation/exclusion), and (iv) social network influence on service utilization. These themes are presented and discussed in detail in the following section to aid understanding of how the influence of cultural factors and the role of the initial contact persons embedded in the community affect the attitude of study participants and thus shape their

help-seeking decision-making regarding use of mental health services. Table 2 presents the identified themes and sub-themes together with the definitions. To enhance systematic analysis and proper understanding of the results, a diagram of the study themes is presented (See Figure 3).

**Table 1. Study Sample Characteristics**

| Total (N = 54) | N (%) |
|---|---|
| **Group A** (Drop-outs) | 26(48%) |
| **Group B** (Continued users) | 28(52%) |
| **Gender** (All male) Black adolescents | 54(100%) |
| **Age** (15 – 17 year olds) | |
| 15 year olds | 21(39%) |
| 16 " " | 20(37%) |
| 17 " " | 13(24%) |
| **Education** | |
| Grade levels | |
| 9th grade | 11(20%) |
| 10th grade | 26(48%) |
| 11th grade | 13(24%) |
| 12th grade | 4(8%) |
| **Parenthood** | |
| Youth fathering a child | 2(4%) |

**Table 2. Identified themes and sub-themes**

| Theme | Sub-Themes | Definition |
|---|---|---|
| **1). Beliefs about causes of mental health problems** | ⇒ | Participant beliefs about the root causes of mental health problems among African American communities. |
| | Racism & Discrimination | Participant belief that racism and discrimination are the major causes of mental health problems among minorities. |
| | Dysfunctional family situation | Participant belief that problems in the family cause mental health problems among African Americans. |
| | Stress of living in poor Neighborhoods | Participant belief that environmental problems *(crime, unemployment, violence, etc.)* are stressors that cause mental health problems. |
| | Genetic | Participant belief that mental health problems could be inherited *(transferred from parents to off-springs)*. |
| **2) Other beliefs about mental health** | ⇒ | Participant beliefs about mental health based on other factors |
| | Culture specific beliefs about mental health problems | Beliefs that in the African American culture mental health problems should be handled according to their cultural norms. |
| | Denials | Participants denying the existence of mental health problems to others and even to themselves |
| | Religious and Spiritual factors | Participants beliefs that faith in God and prayers can protect or cure their mental health problems through divine intervention |
| | General beliefs about mental health problems | Participants beliefs about mental health problems that are based on other factors |
| | Efficacy of mental health treatment | Participants lack of confidence in the effectiveness of mental health treatment |
| **3) Social barriers (isolation & exclusion)** | ⇒ | Participants' perceptions of the consequences of societal reaction against individuals with mental health problems |
| | Stigma and Shame | Participants' perceptions or experiences of stereotypes, prejudices, or isolation based upon mental health status and |

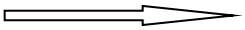
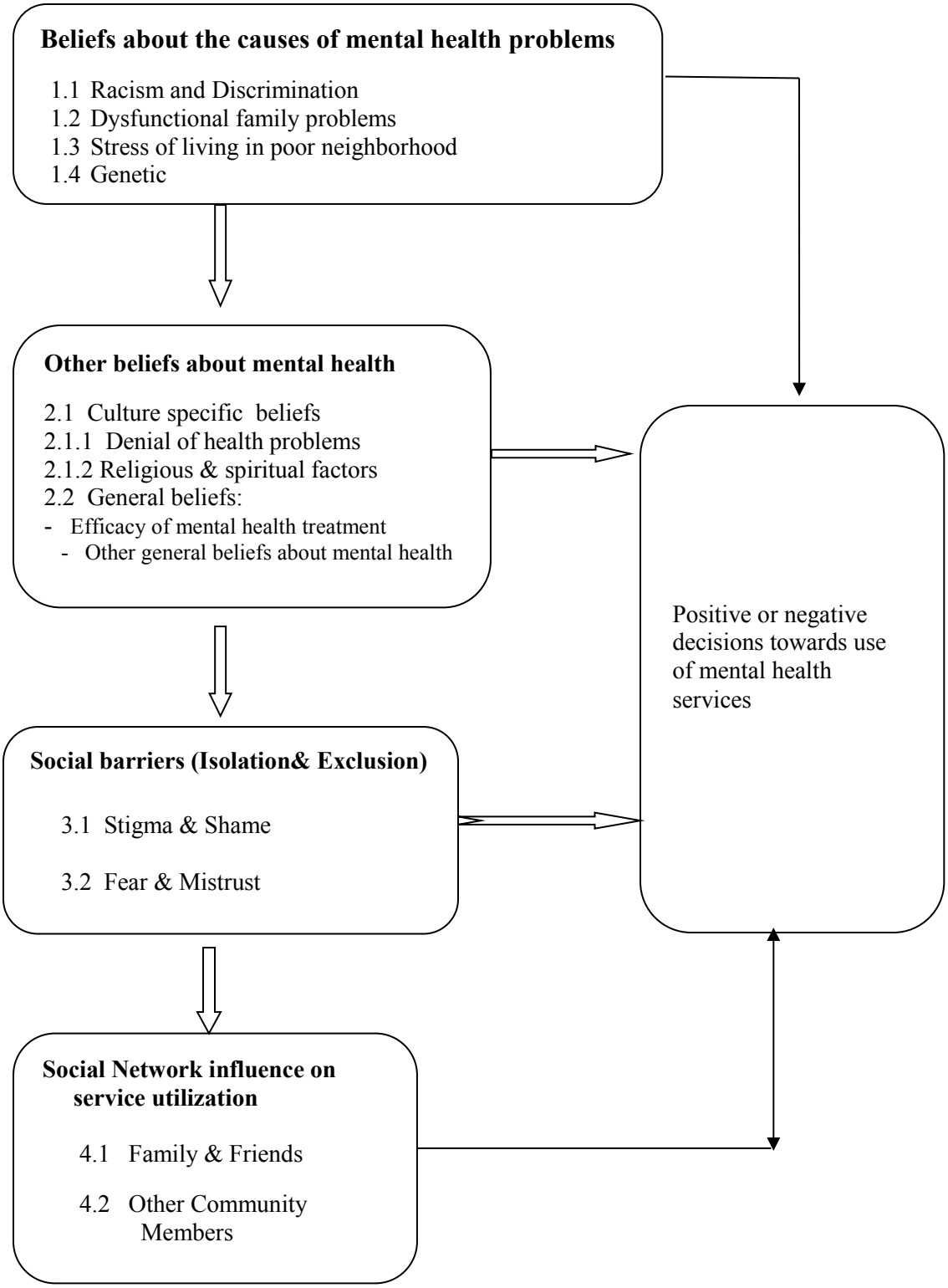
| | | |
|---|---|---|
| | | Participants feelings of shame for disclosing mental health status and of possible ridicule by peers when mental health status becomes public knowledge |
| | Fear and Mistrust | Participants' fear of exclusion or repercussion for being identified as having mental health problems in the African American community and for seeking or utilizing mental health services and<br><br>Participants' lack of trust in the mental health system and the mental health service providers |
| **4) Social Network influence on mental health service utilization** |  | Participants' connections in the community (peers, church, advisors, probation officers, social workers etc.)<br>Who also play some role when mental health treatment decisions are made. |
| | Family and Friends | Participant's parents, family members, and other close relatives. Friends include peers and other swell-wishers |
| | Other community members | Individuals who the participant may go to for help during episodes of mental health problem. These include: teachers, clergy, school nurse, social workers, peers, and probation officers etc. |

**Figure 3. Diagram of study results**



**Theme 1: Beliefs about causes of mental health problems**

The first theme examined participants' beliefs about causes of mental health problems to understand whether such beliefs or knowledge might impact their mental health service utilization decisions. Causes of mental health problems here refer to factors that can cause or are associated with the onset of mental health problems. The specific question asked during the qualitative interview to obtain this information was: "what do you think are the causes of mental health problems?"

Participants' beliefs about what causes mental health problems were one of the most powerful themes that emerged from the qualitative interview transcript. Many participants believed that the causes of mental health problems stem from outside of the individual rather than from inside the individual. During the interview, participants talked about what they believed to be the causes of mental health problems, identifying the following as the most common: racism and discrimination, dysfunctional family situation, and the stress from living in poor neighborhoods. Fewer participants believed that mental health problems are biological or genetic conditions usually transferred from parents to their offspring.

**1.1 Racism and discrimination**

Research has mainly conceptualized racism as a stressor and health professionals have acknowledged for many years that people who are subjected to particular types of physical, psychological, or emotional distress may experience a stress reaction.

During the interview, 38 participants (70%) reported beliefs that racism and discrimination are key factors that create stressful and hostile social and economic

environments that cause mental health problems. They talked about experiences of overt and covert practices, actions, behaviors, and attitudes that amount to racism or discrimination including everyday race-related realities intended to demean and "put you in your group." When asked, "what do you think are the causes of mental health problems?" Participants expressed themselves in different ways:

> " I think mental health problems is caused by when you get tired of keeping quiet….you know, it hurts from the inside when you know what someone is thinking about you and you always keep quiet. Like someone feel you don't deserve something just because your color is different" (Lyles).

Other participants expressing similar feelings made the following remarks:

> "No black man in America has good mental health because of the stress of dealing with racism even in some place that you may think it was good place. Sometimes when they look at you, the rules begin to change" (Lawal).

> "..you know, racism forces black men to live in this country as second class citizens because you take in every abuse without fighting back. If you fight back, then you are the trouble maker. That's the real cause of mental health problem right there, right?" (Rashon).

Responding to the same question some other participant seem to suggest that black men have internalized racism and discrimination and as a result, mental health problems brought about by those feelings of powerlessness and hopelessness have unfortunately become a normal way of life.

> "Most black people have learned to ignore the everyday racial attitude around them and move on with their life cos nobody believes this will ever stop. Like when you try to get help some of them still give you that attitude, so you leave and move on" (Jordan).

> "Racism and discrimination have caused many of us (African Americans) to believe we don't count and our needs are not important" (Andy).

Jamie spoke specifically about the effect of employment-related discrimination and its relationship with mental health problems. He explained how his aunt lost her job due to racial discrimination and how it impacted her normal level of functioning.

> "My aunt lost her job because of racial discrimination at work. She tried but could not get another job. Since then she had a lot of financial problems, she could not take care of her little girl, could not pay her bills including her rent. Her landlord evicted her. She looked very sad all the time, cried most night and refused to be comforted. My mom allowed her to move in with us. When her food stamp application was denied, she was so angry and almost lost her mind. My mom told her to go talk to our minister because she was like breaking down".

Many of the participants felt that most minority unemployment is the outcome of racial and discriminatory acts and behaviors at the work place which occurs regularly "chronic and unrelenting" (Michael) and usually intended only to perpetuate the low social status of minorities, e.g. "remind them of their blackness" (Jamari). In response to

the question, "what do you think are the causes of mental health problems?" Another participant stated:

> "I think mental health problems happen when people won't let you even rent an apartment because of the color of your skin. Before we moved into the project, my mom had a hard time renting. Most white people would not rent their houses to black people. That is racism. It makes you feel bad about who you are. … like you can't live among people. Think about… if you have to live in the streets with your kids….." (Jason).

> "….like when I work at Burger King when something is missing, my mind will be thinking about what they are thinking about me. All the time they give you attitude and make you feel guilty for what you don't do. How would you feel if everyone around you is afraid of you and thinking you always plan to do something illegal?" (Raymond).

Many other participants talked about racism and discrimination in terms of their personal experiences or individual involvement with the child protective services (CPS), the juvenile justice system (JJS), and the special education programs (SEP) all of which the participants perceived to be systems fraught with discriminatory and racist rules and regulations. They talked about their feelings of sadness, loss of hope, and a sense of low-self esteem - which trigger mental health problems in most black adolescents and their families. These experiences are described in the following section.

### *1.1.1. Child Protective Services*

Participants cited the practice of removing children from their homes, separating families from loved ones, and forcing them to live with strangers (in group homes) as the chief causes of mental health problems. Clinicians have long argued that separating children from their parents could cause the child to develop separation anxiety disorder or reactive attachment disorder. Although an abusive family would undoubtedly be harmful to children, removing them from their family home can be just as traumatic. Many study participants felt that this practice is discriminatory and racially motivated because it is mostly prevalent among minority youths and the victims are mainly black children from poor neighborhoods.

> "…the worker who took us away told my mom that neglect was reason they took us. But my mom told us the real reason was who we are (black people) and that is true cos they don't do so in white neighborhoods" (ID# 1004).

> "When they took me there (group home) it was just what I thought. All seven guys living there were black and I was #8" (ID# 1017).

Some participants said they were victims of the practice and talked about the trauma and emotional impact it had on them including the regimented lifestyle they had to endure once they were removed from their homes. The following quotes are among what they reported:

> "The first time I was taken away, I cried for many days because I thought I will not see my mom and my friends again. My social

> worker told me to stop but I did not listen anyway. I did not know where she was taking me….I was so scared" (Jones).

> "…. like for me, I did not want to follow them… for like three days I did not sleep because I was not used to the new place. I felt very sad and afraid thinking something bad can happen to me. mmm… it was…it was not a good feeling" (Johnson).

> "In the group home, all you do is think of running away or something, thinking how to end that kind of life. They make everyone go to bed the same time and too early. You can't make any phone call and none of your friends can visit you…..oh! it was awful. They don't allow you to enjoy your music and the TV is cut out before bed time " (Cooper).

Many other participants noted that the CPS practice of removing children from home inflicts emotional pain and destroys family bonds in the process. These participants shared their experiences in the form of personal stories. The examples below are the detailed stories of some of the victims revealing that these children removed from their homes are actually living with and exhibiting serious mental health symptoms.

**Case Example 1**

A 17 year old participant (Carter) spoke about the feelings of anger, sadness, and loss that he endured when they (participant & sister) were removed from home by CPS and sent to different placements. The participant was emotional while talking about how he and his sister were taken away and deprived of the comfort and security of growing up with their

parents and other relations in the environment they had become accustomed to. He said that the day they were removed from home created a lasting memory in his life because it was the first and only day he saw his parents cry.

> "…Me and my sister were taken away from home when I was in the 9th grade and sent to different placements. They (CPS) said my mom did not treat us well. Since then they moved me from one placement to another. Foster parents are not the best people in the world. Some of them treat you as a bad person…Group home is the worse. People don't care about how you feel. They told me I cannot visit home…cos my mom was still doing drugs. Sometimes I feel like am going crazy. They keep saying that I had behavior problems. Me and my sister have not seen each other for many years. I thought about running away but my social worker said I will be in a bigger trouble. She said she will take me to see my sister but that did not happen. I don't even know why I was there. All I was told was wait, wait, and wait for nothing and ….."

**Case Example 2**

Another 16 year old participant (Mark) recounted his experiences with out-of-home placement stating that his experience was not what the representatives of CPS told him at the time he was removed from their home.

> "When the two social workers came to our home, they told my mom that they were taking me away. They also told me that things would be great after I was removed from home. To me I did not believe a word. They took me to a group home in Providence, far away from the small town of Tiverton where we lived at the time. Providence is like a big city and I have not been there ever in my life. I was overwhelmed by everything around. The boys in the group home were like too tough for me to

> deal with. Sometimes they were like controlling what I should do, teasing me as the 'new comer to the block', which made me so angry. I had no appetite for the food they had. The worst thing was that we had to share the same rooms. For the first 3 nights, I was not able to sleep. I was like scared thinking these guys could start something at night. My thoughts keep racing and I was not comfortable at all. I could not call home again because I finished my call for the week. The next day they took me to a new school district to register and start attending school. Then I began to think that might stay here for a long time. This made me very unhappy and angry at every one. For the first month in the new school, I had no friend and I could not contact my old friends even though I did not want them to know where I was at. I was so frustrated. I made myself sick three times just to stay out of school. This did not work out either because it was too boring staying home alone. As they told me, things were not great at all and…."

Shonnell reported that he was first removed from home at the age of 16 and that he had lived in placement for about 9 months before the interview. He shared his experiences as follows and was not happy that this happened to him.

> "I was never told the truth why I was removed from my mother. They say my mother had a "nervous breakdown". I wish I was told the truth. My mom has been there for me since I was born. I also wish that grownups were not as quick to label me or think I was kind of "damaged goods" just because they think my mother was crazy. It's hard, you know, to deal with the pain… I think it is better for me to stay with my mom…..(long pause)."

However, a few participants painted a more positive image of their out-of-home placement. Some participants talked about the positive experiences they enjoyed in placement which their biological parents were unable to provide them and said those things made their lives as children worth living. For example, one participant stated:

> "The group home was not that bad. For me, I think I got more …it was good for me. We went to school every day unless you are sick and the manager will take you to the doctor. We used to go places when we come back from school. I had my own room with nice electronic toys. One time they took us to Six Flags and we played games. There was enough food like in Thanksgiving or Halloween and more things…" (Terry).

One other participant said that being in placement saved his life.

> "…. am happy I was removed from home because I would be dead by now. If I was still staying at home I would be with my friends the day they were shot and I would die with them that day. You know, when I think about them it was like God took me away. So, to me I don't see it as something bad" (Kelvin).

All these participants who share their experiences of involvement with the CPS had one thing in common. They all claimed to be victims of racial prejudice arguing that their being removed from home had nothing to do with abuse or neglect by their parents as suggested by CPS agents but everything to do with what they (CPS) think about black people and their inability to raise children according to the dictates of the dominant culture.

### *1.1.2 Juvenile Justice System*

Many participants believed that involvement with the juvenile justice system is another major cause of mental health problems for young people particularly African American youths living in black neighborhoods. Participants expressed concerns about how police activities in their neighborhood disguised as law enforcement disrupt their means of survival and trigger fear, anxiety, hopelessness, and emotional instability among youth. The most commonly cited police activities were: racial profiling, arrests, and detentions of those they (the participants) called "innocent guys". Participants described the police activities as oppressive, discriminatory, and mostly racially motivated. They felt such activities evoked emotional symptoms among youth including: excessive anxiety, chronic mood disturbances, trauma, and extreme reaction to minor events.

#### *1.1.2(a) Racial profiling*

Many participants talked about police racial profiling as the main cause of emotional problems for youths in their neighborhood. They discussed their experience with police racial profiling, that is, the police practice usually associated with law enforcement whereby police officers judge an individual's likelihood of criminal activity based on race or skin color. The use of racial profiling by police as a crime fighting tool has long been criticized because it presupposes that crime locates within some ethnic population. However, the practice persists in the United States and police officers disproportionately use it against African Americans particularly among youth.

Psychologists have long suggested that the "victim effect" of racial profiling could include: post traumatic stress disorder (PTSD) or other forms of stress-related disorders. Participants felt that it is a form of intimidation because it causes fear, anxiety, and feelings of helplessness. In addition, they said it sends a negative message to the people being profiled that they are less worthy of respect as human beings - an essential measure of individual's self worth.

Many participants view the practice of racial profiling as demeaning, judgmental, and used solely to "bring back the feelings" of blacks being seen as second-class citizens. The following examples below explain why young African Americans males believe that racial profiling causes mental health problems.

**Case Example 1**

Young, a 17 years old African American adolescent recounted his experience of police racial profiling when he was an occupant of a luxurious BMW sedan car driven by his uncle, another black person. This participant said he and his uncle went to North Attleboro in Massachusetts to pick-up his brother and another cousin. On their way back, they were four black men driving on Interstate 95 South towards Providence in Rhode Island at midday. One of the cousins joked and said, "you guys have committed a traffic offense known as 'Driving while Black' and you could be pulled over by police", and they all laughed. A few minutes after, they sighted the police cruiser at the corner. As they drove past they noticed that the police cruiser was following them blasting the siren and flashing his blue, yellow, and red lights and signaling them to pull over which they did. The participant said: "I was frozen with fear inside the car thinking we (occupants in

the car) must have done something wrong." Participant reported that two policemen approached them pointing guns at them and ordering them not to make any move. Participant stated, "I thought they (they police) were going to shoot and kill us". After a thorough search of their vehicle and their pockets, participant said the police found nothing incriminating, so they told them they could continue their journey. Participant said that the terrifying incident remained with him and gives him nightmares. He said he was so frightened that up till today, any time he sees a police car, "it sends chills down my spine". This participant really believed that although the police did not tell them why they were stopped or searched, he was sure that the police probably concluded they were transporting illegal drugs – a common allegation or charges the police usually make against poor black men.

**Case Example 2**

Another participant shared his experience of police racial profiling with two white policemen who he said unjustly pulled him over and spoke to him in an aggressive and bullying fashion. Participant described how he was surrounded by the two police cars with multiple color flashing lights: "I was in shock when they ordered me out of my car in the middle of the street and asked with commanding voice whether I had any drug or weapons in the car". He said, while one officer checked his identification, the other searched his vehicle. "Every spectator on the scene knew me because I live there. I felt violated and very humiliated. Although nothing was found on me, the scene they created followed me home. The news of my ordeal travelled faster than me and before I got home, it was my mother who was telling me the story instead of me telling her." He

emphasized, “Even now the incident is fresh in my mind, I am still afraid of the police. Till today, anytime I see the police car, I am like…sometimes I wake up in the middle of the night from nightmares as I relive that experience in my mind” (Jefferies).

**Case Example 3**

Another case of police racial profiling was shared by a 17 year old participant (Davell). This participant relayed a story about a time when he was returning home from visiting his girlfriend. He stated that she lived quite a distance away and so was driving on the highway to return home. He made a point to emphasize that there was nothing in his car, by which he meant no alcohol or drugs. However, he noticed that a police officer was following him and after about two or three miles the officer switched on his flashing lights and pulled him over and he stopped. The officer, participant said, parked behind him but stayed inside the car for more than ten minutes without saying anything to him. Participant said he waited in his car not knowing what the police was doing or thinking about him. When another police officer arrived, participant said, it occurred to him that the first officer had called for reinforcement and was waiting for back-up before they could approach him. After the lengthy story, participant stated that numerous scenes like this tell more stories about the police “mind set” about black people and what they (the police) are prepared to do to keep this group of people in check and have them under control.

Many participants talked about what they termed “police abuse” as the main cause of mental health problems in their neighborhood. They reported that the police can stop and search people randomly in African American neighborhoods particularly African

American youth without any reason. Many participants were concerned that "the police already believed that all black youth are criminals" … and that the only police duty is to find evidence for prosecution. One participant questioned: "How can someone live like that? …all the time you feel like you are being watched?, that's not fair, and I don't think it's right" (Oris).

Several participants described how they were arrested by police and taken to the station for questioning without the knowledge of their parent for many hours. They talked about the intense fear and anxiety during the lonely hours in police custody. The most common expressions they used to describe their state of mind included: "I felt like my whole energy was taken out of me" (Holder), "I didn't know what to do" (Joshua), "I thought they would lock me up" (Harris), "thought about how I will stay in jail" (Walker), "I thought about what my mom will do" (Marquel), and "it was an awful, awful couple of hours before my mom showed up" (Antshawn).

Another participant (Gare) talked about similar experiences of police arrest and detention in his neighborhood and described the frequency with which these activities were happening as "unbelievable and emotionally draining." Some participants believed that police intimidation of youth in the black neighborhood go hand-in-hand with the rate of mental health problems there.

> "In our neighborhood the police arrest you for nothing and lock you up for nothing…. when you are trying to survive - nobody would be happy about that… then the judge believes whatever they say against you and order you to go to counseling. Who really cause that problem? Not the police? They don't do that in white neighborhoods, do they? …. I think it's all about

control" (Javier).

Many other participants believed that it is difficult to change how any black person is perceived by most white people including the police. They argue that an average white person is always suspicious of the black person and the police are trained to use this as crime fighting tool.

> "….whites always think we (African Americans) have criminal mind, even if they met ' in the church' ….Even when we do everything right and play by all of the rules, we still don't get the respect we deserve, and that is a very stressful feeling to carry along the rest of your life" (Flynn).

> "…where we live it's hard to hang out with your friends for fear that the police may come and arrest you. If you meet your friends in the street and stand there for few minutes talking, the police can come and arrest all of you. It does not matter what you were talking about. Living in the project is just like living in jail. Everything you do is monitored. The police station is right there and they can see when you come in and go out. What is more hard is that your parents are not able to move away" (Rashon).

Other participants expressed similar sentiment about police activities in their neighborhood and the overall effects those activities have had on their mental health particularly among youth. When asked, "what do you think are the causes of mental health problems?" The response below represents the general belief and feelings among participants regarding police activities in their neighborhoods.

"…mm I think when they say black people have mental health problems,

> I feel it may be true because like all black people living here (hand gestures around the housing project) they always look sad….nobody is happy….. Look outside there (pointing to the sub-police post) the police station is right here to keep us straight. It's not like this in all neighborhoods. People living here are always afraid…emm stressed out. You don't know what the police is thinking about you. All the stress of living in this kind of neighborhood is enough to make the people not think right and to have mental health problems" (Cory).

### *1.1.3 Special Education Programs*

The cause of mental health problems among African American male youth was also linked to participation in Special Education Programs. Six participants reported negative feelings when they received the letter recommending them for participation in their school's Special Education Program. They believe that sending any child to special education marked the onset of emotional distress.

One participant (Lester) said that he could not believe he was sent to where he will be interacting with the types of children who were socially and academically dysfunctional. These children, he said, "are trouble makers and are like retarded."

Another participant (Mcgrath) who also said that he was recommended to special education acknowledged that once a student was recommended to special education, it signaled the end of meaningful learning for such student, "you can't learn a damn thing there and you know that you won't graduate."

Another participant described how his teacher who did not like him pushed him into a Special Education Program where he was introduced to the mental health system.

> "I was placed in special education because I was labeled 'emotionally disturbed'. This label had nothing to do with who I am. I know my teacher always said I was too talkative in the class, not allowing other students to learn. Always saying negative things about me. I knew she didn't like me cos for little things, she sent me to the Vice Principal's office four times in one quarter. She made me feel guilty for things I did not do. She always put me down and I started doubting whether I should be here, or whether I would graduate from here. I knew she just wanted me to leave and I did" (Walter).

These participants felt that race, in their case, was the only deciding factor for their being profiled to qualify for special education program. They argued that racism not only causes mental health problems but also seeks to make the individual so discriminated against a permanent consumer of mental health services.

Literature supports the argument that black male youth are often profiled for behaviors that are culturally different and usually irritating to the teachers as evidence of emotional disturbance (Artilles & Trent, 2000; Salzman, 2005). Some teachers in the public school system profile children particularly black males who exhibit behavioral problems that are outside the norm and refer/recommend them for special education programs. It seems obvious that when the child perceives that education, the hope and future success of any child is so threatened by school authorities, the child may develop hostility towards the system, defiance to rules and regulations, anger, and a range of other anti-social behaviors.

Although a **la**rge number of the participants thought that racism and discrimination caused mental health problems, others did not share the same view. Some of them thought of mental health problems in terms of negative family interactions.

### 1.2 Dysfunctional family relationships

Sixteen participants (29%) believed that dysfunctional family relationships lead to mental health problems. They cited divorce, alcoholism, drug use, and absent fathers as the principal causes of conflicts resulting in mental health problems.

#### *1.2.1 Divorce*

Participants believed that divorce separates families, causes emotional pain, and increases the feelings of insecurity for both the couple and their children. Many of the study participants have lived through a divorce, so they talked about the effects on household members particularly the children.

> "When our parents broke-up, we were all like confused. I knew Things were changing because my parents were not following the usual routine in the household. My younger sister and brother were acting-out more frequently. It felt like something very bad was waiting to happen. I was very uncomfortable, and then my dad told me about it. It was a very sad news to me" (Terrance).

> "Some days my dad would come to see us and other days he would just call to say hi. It was very hard to understand that kind of relationship with your own dad. My mom was also showing some kind of new behavior - like yelling at us for every little thing, sometimes cursing at my dad when he was not even there" (Derek).

Other participants shared their feelings about the stress from divorce and how it can manifest itself in different ways including bouts of anger, sleep disturbances, hopelessness, or the feelings of depression which sometimes affect the children more than the adults.

> "...my younger brother brought up the issue one day about what was going on in our home. I was worried also because I knew my mom was having a hard time and spending more time at my grandma's place with our little sister leaving two of us at home all the time. I was always angry because they (parents) were not around with us" (Taylor).

> "Our house was like argument all the time about who did this or who did that. It was like no one wants to see each other. One day my mom asked me 'your dad told you he wants to move out?' I could not say anything to her. All I was thinking was how I would tell my friends… (Shawn).

Another participant (Hamel) talked about how the effect of divorce does not stop with the bitterness and the broken hearts; he shared how the trauma of the split can leave long-lasting damage on the children's mental health.

> "Divorce, it's like starting a fight. The mood in the household change and everyone can feel the anger and hate. As the parents become too busy planning to undo one another, the children are forgotten and they are the ones to suffer the consequences. Like when my parents began their divorce, they were not talking to each other. Our house was no fun anymore. My dad told me things will be ok but it was not. My mom was like …., I don't know. Some days, my dad would even forget when to pick me up from school because he was too angry to call and ask my mom.

> It was shameful because my friends knew that my family was falling apart. I ran away to stay with my grandmother… but, like few days I knew I did not like it there. I was always angry and sad because I did not feel like staying in our house anymore. Really, I felt like.. …like a homeless person."

However, five participants (9%) felt that divorce could also be the best solution for some families because only divorce can help the children avoid witnessing domestic violence and save them from the emotional and psychological trauma especially when the violence becomes too physical resulting in broken bones and spilling of blood.

> " I thought our neighbor needed a divorce in order to save the children but they did not. Every time they fight each other the two little children run outside crying so loud that other neighbors in the building would know it has happened again. Some days the wife would be bruised-up with black and blue marks on the face. Till we moved out, the children continued to watch them fight which I think is bad for them" (Derek).

> "…..like people say divorce is not good, some divorce is good because the two people (husband & wife) can learn from their mistakes that caused the divorce and may start a new life with some other people" (Cook).

### *1.2.2 Alcohol & Drugs*

Several participants framed their opinion regarding the cause of mental health problems in terms of the negative consequences of alcohol and drugs use in the family. Participants reported negative psychological effects of alcohol and drug use while living in their family homes. They noted that alcohol and drug use drained their family finances

and brought fear of insecurity, hunger, and reduced standard of living to their homes. They talked about the psychological effects they suffered in their homes and their inability to function normally in those high-conflict environments.

> "…and staying in our house is not cool either. You are mad all the time but don't know who you are mad at. My dad comes home drunk every day. The fight about almost everything and that's not fun to watch. One time my mom called the police because she was really hurt but that did not even stop them….." (Isaiah).

> "My mom was caught-up in a bad habit (drugs). She spent all her time struggling to stay clean but was not really successful. My grandmother actually took care of me" (Eric)

> "There was so much drug activities in the building that we lived. When the police arrive, usually they arrest anyone around and sometimes innocent people who hang around. We lived in fear, watching over your shoulders always, and feeling anxious because you don't know when the police will come again" (Louis).

Another participant stated that children of alcoholic or drug addicted parents sometimes get entangled with the lifestyle of their parents and become drug users themselves.

> "My friend used to help his parents package drugs just to make some money. At the time he was not using it at all. But along line things change. He started using drugs but was denying it until his head could not handle it, and he was taken to the hospital for detox" (Claudius).

There is evidence in the literature which supports the fact that children reared in alcohol and drug addicted homes are vulnerable to developing mental health problems (National Institute on Alcohol Abuse and Alcoholism, 1990).

### *1.2.3 Absent father*

Many other participants stressed the emotional maltreatment, anger, and the frustration of living with and taking instructions from their step-fathers as important family relationships that contribute to serious mental health problems. A common remark by these participants regarding their relationships with their step-fathers was captured in this quote:

> " …. I can't stand my step-dad. My mom makes him the king of the whole house. He pushes me around as if he was my real dad and sometimes I feel like telling him so…" (Jones).

Another participant (Mendee) was emotional when he acknowledged the absence of his father in his life and wondered whether things could have been different if he were with him.

> "My father left when I was small and since then I have not seen him. My mom don't know where he is. Although it would be nice to have him around, he's not here and I don't care. My mom does everything for me. She tried (pause)"

Others talked about their powerlessness in maintaining control of the household in the absence of their fathers. When asked "what do you think are the causes of mental health problems?" The quote below captured the frustration of a participant who could not control his emotions due to irresponsible family behaviors.

"Well, I don't know for sure what cause mental health problems. Sometimes people think if you do wrong things what happen to you is mental health problem. Like they told me I need help for my anger management my mom took me here for my counselor to help me ….But sometimes in the house you get mad cos things ain't right. There is some things like my father is in jail it's hard not to get mad, you know, cos thing don't work out…., I,… I can't do anything (pause)……My mom and my sister say I have anger problem. I don't think I do but when I think like when people bring a fight, I can't run away, you know….My sister (15years old) bring too many boys to the house and there is always trouble, and that's not right. Um… sometimes I want to start a fight and make them stop coming, you know what I mean? My mom won't say nothing you know?" (Justin).

### 1.3 Stress from living in poor neighborhood

Almost all study participants (90%) in one way or the other said that the stress of living in poor neighborhood causes mental health problems. Participants talked about unsafe conditions (e.g. crime and street violence), lack of resources (e.g. employment possibilities), poor quality housing, and other taken-for-granted amenities (e.g. good quality water supply) in poor neighborhoods as conditions that intensify the harmful effect of stress upon residents making them vulnerable to mental health problems.

#### *1.3.1 Violence and Crime*

Many participants believed that an uncontrollable level of violence and street crimes in their neighborhood are the main causes of mental health problems. When asked, "what do you think are the causes of mental health problems?" Participants

talked about the impact of violence and crime and the relationship with mental health problems. They reported high levels of anxiety and excessive worry about who may be the next homicide victim, and expressed concerns for the safety of their families and friends.

> "No one knows whether this will ever stop, you don't have any peace of mind, everyone is worry everyday but nobody is doing something about it." (Greene).

Other participants talked about chronic trauma and nightmares resulting from exposure to the body of dead victims of violent crimes which are common in most inner-cities where African American young males reside.

> "It's scary down here. The gangs are making peoples' lives here miserable. You can't go out like that cos you don't know who will be shot next. People are always afraid. Sometimes you even think whether something will happen on your way to school. My mom is always worrying about us when we go to play basketball. Like…., even when playing near the house, people could start a fight and start shooting. That's how bad it is -- you know" (Justin).

Another participant talked about house break-ins by criminal groups and the loss sustained from property, cash, and jewelry. He also stated that individuals affected have no recourse because it is difficult to identify the culprits.

> "…I mean nothing is secure here. Any time you leave anything can happen to your things. Like…like our house has been broken in before… they took my sister's laptop, our DVD player, and my I-pod.

My dad called the police, yet nothing was recovered" (Aguirre).

Some other participants talked about victimization by gang members. They expressed their concerns that the gangsters were operating with total impunity in their neighborhood. They seem to be worried about the breakdown of social order, the diminishing influence of government, and increasing feelings of hopelessness, an important indicator of mental health among youth in the neighborhood.

> "Yes, we lived in this project for many years and it is always like this. It's not safe to stay outside when it's dark unless you declare (make yourself known to the rough boys). Sometimes it's not safe to walk the hallways alone because they can jump you. There is nothing exciting to do here. All the time you are bored. That's why it's easy and even safer to join the flow" (Perry).

> "People in the neighborhood are scared of gangs. Some of the boys, even the girls join the gang for fear that they may be attacked by gang members. They think that being a member gives them protection because you cannot depend on the police here. Sometimes the police is not always there when things happen (Mark).

### *1.3.2 Lack of employment resources*

Participants discussed the stress of living in poor neighborhood and its relationship with mental health problems in terms of the lack of employment potentials. More than 50% of study participants talked about the impact of unemployment on their behaviors

and emotional well-being. "Lack of what to do (like jobs) can make you think stupid things", Jason said. Another commented,

> "…..Any young person with no job has no hope for tomorrow. His image is low, and his self worth is also low ….you know. If you have to worry about so many things twenty-four seven, I think you would have serious mental health problem" (Owens).

Participants described the lack of employment potential in their neighborhoods as one of the strains that increases their personal vulnerability to mental health problems. One cited lack of regular jobs as the reason he always feels "ignored and unwanted" (Javier), another participant said, "if you don't have a job nobody think you are important" (Andy).

> "….People in this neighborhood have no jobs. Nobody goes to work. All I see here is drinking (alcohol) and smoking. There is no business here to hire people except Burger King and McDonalds. Government does nothing here cos black people live here" (Davell).

> "… our parents can't provide for us (young African American males) ,. .. you know, … we feel worthless and hopeless when you think about tomorrow. This society only values what you do and not you as a human being" (Greene).

Almost all study participants believed that lack of jobs or a legitimate means of livelihood causes constant anxiety, hopelessness, and despair and hastens the onset of depressive feelings.

### 1.4 *Genetic conditions transferred from parents*

Although many participants acknowledged racism and discrimination as well as other systemic elements as causal factors for mental health problems, some participants believed that mental health problems are caused by biological conditions that are transferred from parents to their off-spring. A total of 18 participants (33%) viewed mental health problems like any other medical conditions that should be given proper medical attention. The quotes below illustrate participants' beliefs about the causes and possible treatment options for mental health problems.

> "…mental health problems sometimes run in the family and nothing cause it. Like my mother had depression because her mother had depression too, and like when I got out of jail, they told me I should attend counseling cos I had some mental health issues. I did not believe it though, but I think about how it's always hard for me to get along with people (Aaron).

Responding to the same question, "What do you think are the causes of mental health problems?" another participant stated:

> "Mental health problem is just a disease like any other type of disease. You don't know when you will have it. Your doctor can treat your mental health problem like any other medical problem. Even my social worker took me to the psychiatrist for medication . … I am fine with it cos it's helping me, you know." (Cole).

This section has identified the most common themes expressed by participants to be the causes of mental health problems. Table 3 summarized the frequencies of reported themes and identified the number and percentages of each group. The biggest difference

appears to be related to racism/discrimination and genetics. More participants in Group A identified racism/discrimination as a key cause. Conversely, more participants in Group B identified biology/genetics as a key cause.

**Table 3 Beliefs About Causes of Mental Health Problems**

| ***Types of Beliefs about causes of mental health problems*** | ***Group A (N=26) (Dropouts) (No. & %)*** | ***Group B (N=28) (Continuers) (No & %)*** | ***Total Participants (N = 54)*** **(No. & %)** |
|---|---|---|---|
| 1. Racism and Discrimination | 25 (96%) | 13 (46%) | 38 (70%) |
| 2. Dysfunctional Family Situations | 9 (34%) | 7 (25%) | 16 (29%) |
| 3. Stress of Living in Poor Neighborhoods | 25 (96%) | 24 (85%) | 49 (90%) |
| 4. Genetics | 5 (19%) | 13 (46%) | 18 (33%) |

**Theme 2. Other beliefs about mental health**

The second theme relates to how participants' beliefs about mental health and the nature of mental health problems may begin to impact their mental health service utilization decisions. The question asked during the interview to gain information was: "How are your beliefs about mental health issues different from those of your parents, your friends, and people in other cultures?" Common beliefs identified were grouped into two types: culture-specific beliefs and general beliefs.

### *2.1 Culture-specific beliefs about mental health problems*

Culture-specific beliefs are those traditional or customary beliefs that African-Americans hold about mental health problems. These beliefs guide their interpretations of the manifestations of mental health problems as well as their intervention decisions. Some participants talked about their preferences for culturally acceptable ways when dealing with mental health problem and these include denials of mental health problems that are sometimes enveloped in myths or folklores, religion and spiritual powers.

#### *2.1.1 Denial of mental health problems*

Several participants in this study doubted or denied the existence of mental health problems as issues requiring any form of intervention and as a result, they did not indicate willingness to seek or utilize mental health services. Some participants talked about mental health problems in relative terms - if you think you have problems, then you have problems; if you think you don't, then you don't – Most of these adolescents seemed to regard mental health problems as unimportant, or something that deserves little attention and think of themselves as endowed with some degree of immunity against such issues. Table 4 below presents other beliefs held by participants about mental health and the nature of mental health problems which may influence their service utilization decisions.

**Table 4. Other beliefs about mental health**

| *Types of beliefs about Mental Health* | **Dropout** *Group A (N=26) (No. & %)* | **Continued users** *Group B (N=28) (No. & %)* | *Total Participants (N = 54) (No. & %)* |
|---|---|---|---|
| 1. Denials of mental health problems | 19 (73%) | 4 (14%) | 23 (42%) |
| 2. Religion & Spirituality as protective mechanism | 5 (19%) | 9 (32%) | 14 (25%) |
| 3. General beliefs:<br>- Treatment efficacy<br>- Other general beliefs | 20 (76%)<br>13 (50%) | 8 (28%)<br>4 (14%) | 28 (51%)<br>17 (31%) |

Several participants frequently used the following expressions to illustrate their beliefs about mental health problems, "we (African Americans) don't have mental issues" (Jason), "people use mental health problems to cover-up their weakness" (Devin), "it's a nervous breakdown – it goes away on its own" (Stevens), "those things – madness - don't happen to us (African Americans)" (Walter), "they use mental health problems to put medication in your head" (Louis). One participant stated:

> "The best way to explain is that we - black people, never think we have mental issues. Our people believe you should be able to get-over what may be disturbing your mind. Yes, cos people believe if you have hard times, it should not last forever" (Johnson).

Others participants within this same group emphasized the culturally appropriate way of not sharing family problems with strangers (psychiatrists or therapists). They spoke about self reliance and will-power to handle mental health problems on their own.

> "I don't think it's a good thing for me to run to somebody anytime I don't feel good about myself, if it gets to where I need somebody, I will know" (Michael).

Many participants endorsed the cultural belief that black people are resilient and have gone through and overcome numerous hardships and environmental stressors, and that such experiences should toughen their inner strength to handle mental health problems on their own.

> "….I think you need to show some personal strength when you have any problem. I think I just need to deal with it my own way and get through it" (Perry).

Other participants expressed similar beliefs.

> "..mental health problem is a personal issue, you need to be strong in your mind and push hard for it to go away. I don't think you need any one to work in your mind for you" (Troy).

> "…..sometimes you just keep such feelings to yourself and away from outsiders because you don wanna start something in everyone mind about you, especially you don want your parents to worry and start wandering, 'Is he going crazy or something?' That is the worst thing you want to do to your family" (William).

Most participants believed the society is not genuinely concerned about helping them (black youth) even if they had real problems. They believe that the much talked about non-utilization of mental health services by black people is not really about the benefits that black people are not getting, rather, they suspect, might be with some hidden

agenda. For example, they think the counselors (agents of government) are brainwashing them in the guise of counseling to submit to the established discriminatory social order.

" Who really, really gives a damn about the black person in America?" (Bryan).

Another participant, James stated:

> "…as for me, after they told me, in their way, that I had a mental health problem, I knew where they were going and I never went back there cos I could see what the next step will be. They didn't care and I did not either."

Other participants however, acknowledged the existence of mental health problems but differ in their approach to treatment. Many of the participants talked about their religion and faith in God as an alternative to utilizing professional psychological services in dealing with their mental health problems.

### *2.1.2 Religion, spirituality, and mental health help-seeking behavior*

Religion and spirituality play a prominent role in the mental health help-seeking behaviors of African-Americans because they have strong belief in the healing power of divine intervention. Some African Americans continue to depend upon faith and prayers when dealing with their mental health problems rather than seeking professional psychological treatment. Fourteen participants in this study (25%) endorsed the culturally sanctioned strategy of developing a relationship with God through prayers as an appropriate way of dealing with mental health problems.

> "You know, God can fix everything. God is the Almighty, if you let him be your Lord in everything, He will surely help you and take care of your mental health problems too" (Cole).

> "First, I think I can trust God more than a man (the doctor) to help me with any problems I may have" (Green).

Consistent with total faith in God, some participants invoked the religious doctrine of persistence with God as a mark of strong faith and the sure way to receive God's favor.

> "When you ask God to help you, don't stop. Keep asking, and keep asking, believing that God is the only source of help. He will see your faith and help you" (Muhammed).

Some of these participants believed that mental health problems begin when one has lost his/her faith and the only way to beat mental health problems is to "go back to one's roots (Washington), that is, revive your faith and reopen the prayer route." Other participants in this group express similar belief that their prayers and faith in God could cure mental health problems:

> "…and I believe if somebody that have mental health problems talk to people like the Pastor and the church people the people will help them. Like my aunt I think if the Pastor pray for her, the problem will go away and she will feel alright again" (Andrew).

> "You got to put your faith in the Lord, girl, 'my mom believes that God is the best counselor, so we talk to the Pastor and no psychology" (Isaiah).

Even though some participants endorsed the traditional African American "faith in God" approach to resolving their mental health problems, many other participants were ambivalent about embracing this view of religion and faith.

> "God is not against medical treatment. Some church people act like football fans when it comes to faith and are quick to condemn other people actions for not praying and not believing in God. They think all church members should be praying their way out of everything and not knowing that is not always the answer"(Jacob).

Many participants believed it was alright to also consider other options in making mental health care decisions. For example, when the problem of mental health problem was directly put to the adolescent and he had to consider the risk of not doing something (like intervention) then the cultural belief seems to be shaken. When asked, "If you had a mental health problem (such as serious depression), what would you do?" One participant stated:

> "…mmm….it depends… If it is so serious that I begin to feel like am like cuckoo or I cannot take care of myself, then I might go to the hospital" (Dawson).

Among some participants in this group, there was a somewhat shared opinion that use of mental health services did not conflict with their religious belief.

> "I don't think that using mental health services is against my belief in God" (Da'quan).

Participants compared the intentions of some churches that build hospitals for psychiatrists to provide mental health treatment and that of some Pastors/Clergymen who

provide relief from mental health problems through faith in God, then both entities are complementary and not in opposition to each other. Another participant suggested a combination of both – religious faith as well as consulting with formal mental health professionals (psychiatrist or psychologist) for mental health problems.

> "I think you can seek help from your Pastor and also seek help from the hospital or psychiatrist for your mental health problems. If you do both, you can even get better faster" (Jeremy).

> "When I seek God's help for my problems, I also know that God can pass through my Pastor or the Psychologist to heal me" (Holder).

**2.2 General beliefs about mental health problems**

Many participants had general beliefs (beliefs that are not linked to particular cultural norms) about the nature of mental health problems. The most commonly expressed general belief during the interview was the ineffectiveness of mental health treatment. Some participants believed that mental health treatment does not work especially the "talk therapy". Other general beliefs expressed by participants included myths that mental health problems may be contagious; individuals with mental health problems are dangerous; or that mental health patients are not normal for they lack the capacity to control their own behaviors.

***2.2.1 Efficacy of mental health treatment services***

Many African American adolescents shy away from using mental health treatment services as the solution to their mental health problems because they believe it does not

work. Twenty-six participants (48%) questioned the efficacy of 'talk therapy' and doubted its usefulness in relieving distressful family conditions.

> "What can the psychologist tell me that will help change our family situation now?" (Jefferies).

> "I don't believe talking alone can help anybody. I know it did not help me. Somehow you got to do something for something to happen, you know…."(Shawn).

Other participants with similar beliefs about the "talk therapy" made the following comments:

> "… for me anytime I think about counseling, all I remember is driving around with my counselor talking and going to the park. When we come home, I sit on the couch and continue talking. We don't really do anything. How can that help me?" (Jason)

> "Emm ... I think counseling is not for everybody. I thought it will work for me but it didn't. I feel like I was getting nothing, every day I go, it was just talking we didn't do anything, so I stopped." (Young).

However, several participants mostly from group 'B' (continued users) had more positive beliefs about mental health problems. Participants in this group also discussed the effectiveness of mental health treatment services but differ in their outcome assessment. These participants believed that treatment services for mental health problems work and actually helped them. The quote below is an example of how most of them responded when asked, "tell me the reason you continued with counseling at the center even when others were dropping out?"

> "em.. as I just told you, I think I am doing better. I know I had some problems and I was thinking how to make them go away but since I came here I begin to see that things were changing for me….so, I think the program is good for me, it's helping me and I want to continue cos it might change my future" (Lawal).

> "The reason I continued with using services from this program was that my feelings that used to make me very uncomfortable around people, the anger in the inside of me was beginning to go away, so I knew it was the counseling that was helping in that way…" (Fox).

Some other participants responded in similar manner regarding the efficacy of treatment and pointed out their initial skepticism. For example, Marquel stated:

> "My first thought was that it's not going to work. I knew I had some problem cos my mom used to ask me, 'is something wrong with you?, tell me.' Even when I was still in the juvenile facility people keep talking about my behavior. I didn't believe them cos I didn't really like counseling. But when I tried it, it began to feel like it was working and made me feel better about myself ."

Eight participants (28%) in this group endorsed some of the negative beliefs that treatment services do not work as discussed earlier among participants in group "A" (Dropouts) but the majority in group 'B' (20 out of 28) participants believed that mental health treatment services are effective and that people should utilize them for their own good. When asked, "what should someone do if they experience mental health problem?" The most frequent responses among participants in this group were: "mental health problem is serious and need serious attention" (Jamari), "people with mental health

problems should go to the hospital" (Terrance), "anyone with mental health problem should see the doctor for treatment" (Freeman).

Within both groups participants also talked about other general beliefs that constituted barriers and prevented them from utilizing mental health treatment services.

### *2.2.2 Other general beliefs about mental health problems*

Seventeen participants (31%) had other general beliefs about mental health problems. Many of them in group 'A' (dropouts) (50%) believed that mental health problems are somewhat contagious, or have stigmatized view of mental health problems. These participants also believed that "people with mental health problems are dangerous" (Oris), "crazy" (Mendee), and could be violent" (Michael). Other general beliefs expressed included: "mental health problem is all about giving out medications" (Fox), "people can grow out of mental health problems" (Lyles), "people with mental health problems are lazy" (Lamar) and "people with mental health problems cannot be trusted" (Aguirre).

Participants in group 'B' (continuers) also talked about other general beliefs about mental health problems but were somewhat guarded when expressing their disapproval of the conduct of some individuals with mental health problems. Only four participants in group 'B' (14%) endorsed some of the negative other general beliefs about mental health problems. They seemed to be very sympathetic to mental health patients when assessing their character or lack of motivation to utilize treatment services. One participant said:

> " …you know, they did not put it on themselves.
> You never know when it will come. So, people should
> 'cut them a slack' and sometimes help them out" (Stowe).

Other participants made similar sympathetic comments:

> "..you cannot just say someone is dangerous because you don't know them. That is being mean, like you are better. Many people have mental health problem and they are not all dangerous" (Trey).

> " I don't like talking about people especially my friends cos I don't like people talking about me. They told me I had it (mental health problems), I came here so that I can feel better again. I can't say someone is crazy cos they have it… they have it, they have it , what can they do?" (Hamel).

This second theme examined participants' beliefs about the nature of mental health problems to understand whether such beliefs affected their decisions regarding mental health service utilization. Probing questions and complex discussions revealed that beliefs continue to be the central force that guides the participants' decisions making process. Many participants were in denial of the existence of mental health problems. They believed mental health problems to be "brain washing" and therefore tend not to utilize treatment services.

Some participants seemed to acknowledged mental health problems but did not consider utilizing professional mental health services as a treatment option. Other participants expressed lack of confidence in the effectiveness of mental health treatment and believed that mental health treatment simply does not work. For these reasons, they did not think psychological "talk therapy" could help them. A few other participants who did not utilize mental health services believed in divine intervention and relied solely on

prayers and faith in God for their mental health healing. These various beliefs unfortunately constituted barriers that prevented these participants from utilizing mental health services. Generally, participants in group B (continuers) were more realistic about the nature of mental health problems, more receptive to treatment services, and positive about treatment effectiveness.

However, not many participants wholly embraced the religious and spiritual approach to treatment of their mental health problems. A significant number of participants thought that a mixture of both professional psychological treatment and spiritual appeal to God through prayers was their preferred approach to the treatment of mental health problems.

**Theme 3: Social barriers (isolation/exclusion) to mental health service utilization**

The third theme relates to how participants' perception of negative attitudes of friends, families, and community members towards use of mental health services impacted their own decisions regarding use of mental health services. Questions asked to both groups during the interview to gain needed information were: (i) "Why did you drop out from counseling or from using mental health services?" (ii) "Why did you continue using mental health services even when others were dropping out?" Participants identified stigma, shame, fear, and mistrust as factors that influenced their decision-making to either dropout or continue utilizing services at the John Hope Family Renewal program. These social barriers were examined through probing questions under the sub-themes identified above as presented in Table 5 below. Participants in group A

(dropouts) seemed to express more social barriers than participant in group B (continuers).

**Table 5 Social barriers to mental health service utilization**

| **Social Barriers** | **Dropouts** *Group A (N=26) (No. & %)* | **Continued users** *Group B (N=28) (No. & %)* | **Total Participants** *(N = 54) (No. & %)* |
|---|---|---|---|
| 1. Stigma/Shame | 26 (100%) | 20 (71%) | 46 (85%) |
| 2. Fear | 16 (61%) | 10 (35%) | 26 48%) |
| 3. Mistrust | 12 (46%) | 6 (21%) | 18 (33%) |

### *3.1 Stigma/shame*

Nearly all participants in the study talked about stigma, social isolation, or exclusion as barriers to seeking and utilizing mental health services. Out of 54 participants interviewed for this study, 46 cited stigma and shame as barriers to service use; among dropouts, 100% expressed this view. Participants believed that people negatively stereotype individuals with mental health problems.

> "People look at you like you're not normal,…(pause).. they think you can't live a normal life" (Lester).

> " if they know you have mental health problem in this neighborhood, they just talk stupid stuff about you. They think you are crazy" (Shamika).

> "if you go to the psychologist, your name will be out there for the gossips and negative attitudes that people will show to you in this community" (Raymond).

Also, based on earlier data, some participants themselves expressed stigmatizing views, thus having internalized these views.

Participants described how they avoided counseling because of the stigma associated with mental health problems. They felt that the African American community is less tolerant of people with mental health problems than other communities, and thus it is more stigmatizing to have mental health problems being a black person in a black neighborhood. One participant said that it's not a good idea to talk about having a mental health problem or receiving services for mental health issues with anybody in this neighborhood because they would just think you have a weak mind, or that you are lazy, so it may even be better to keep everything to yourself and learn to deal with your problems.

> "For me, I don't tell anybody outside my family that I go to counseling. If I do, they would think I am nuts, like my head is not working right, or like I don't belong in the neighborhood. They can make me feel like I have something bad and should not come near them" (Dugan).

Many participants believed that their white friends seem to be more sympathetic towards people with mental health problems than their fellow African Americans. They talked about how African Americans discriminate against other African Americans if they know that they have mental health problems, or are receiving services for such problems. When asked, "what do people in your community think about individuals with mental health problems?" Participants' frequent responses were: "you have to be careful around them, they are psycho" (Corey), "people say they (mental health patients) cannot keep any secret and cannot hold a job" (Sharkey), "they like to tell people their problems" (Jones). One participant stated,

> " Our black people do not like people with mental health problem. The young guys do the same things and say the same things like the

> older people do. I mean even those who have their own mental health problems have bias feelings against you. Like anytime I meet with some guys who come to see the same counselor for counseling, they don't shake your hands, (with the characteristic embrace) like other brothers do. They look at you like you're…(pause)….. I don't have to talk to them either" (Justin).

Another participant said that even people who are church members in this community do not seem to like people with mental health problems especially those who go to the psychiatrist for treatment. They believe that seeing a psychiatrist for treatment was a complete lack of faith "if you are a Christian you should believe in the power of the Almighty God to take care of your problems" (Claudius).

A few participants stated that community members are more concerned with their own safety than with the safety of individuals with mental health problems. Some participants stated that they have heard many of their community members say things like, "they are not like you and me", "they are mentally depressed and can be harmful" (Jordan), "they are not regular people" (Cook).

Mental health stigma is always associated with shame and a sense of personal inadequacy. Many participants in this study who talked about mental health stigma also described a shameful mental health treatment experience. During the interview, participants talked about the shame involved when discussing very private and personal issues with their counselors. One participant told his counselor, "when we talk about my thing, I don't want to talk about my mom or my dad"(James). Repeatedly, participants used the following remarks to describe how they felt about discussing their mental health

problems with counselors or with psychiatrists: "it was embarrassing" (Rashawn), "made me feel very uncomfortable" (Jamari), "it was not the kind of thing to share with a stranger" (Taylor).

Many participants talked about shame or perceived shame particularly among their peers as one of the obstacles that deterred them from actively seeking and utilizing mental health services.

> "If my friends know that I go to counseling, they will not respect me anymore. They will think that my head is all messed up" (Johnson).

> "…many of my friends think that people with mental health problems are retarded or may be psycho. They can't finish school and be the people they want to be, like there is something wrong with them" (Cooper).

One participant talked about the shame he experienced among his peers when they reminded him of his involvement with mental health services and how he tried to save his face. In response to the question, "what do your friends think about people with mental health problems?" The quote below explains how participants felt the shame associated with mental health problems even among peers.

> "…When I used to go to the Family Renewal Center, you know, any time we walk past the building, my friends will point at the building and joke with me saying 'that's where you come meet with your crazy friends', and they both laugh, asking me, 'what do you do when you go there, nut-head? I was like embarrassed, and though I was still going to the program at the time, I tried to save my face and lied to them that I was not going there anymore" (Aaron).

### *3.2 Fear/mistrust*

African American youth particularly those released from juvenile detention facilities entertain great fear that they would be treated differently by both the mental health delivery system and the service providers and as a result they become very uncomfortable accessing and utilizing mental health services. Many participants talked about fear of being given a diagnosis that may become a reference of who they are.

> "….. because any time you go there, they (counselors) would say that you are depressed. I know I am not depressed and I don't want people to think I have a depression problem, so the next week I did not go again" (Kelvin).

> "When my mom took me one time, the counselor say that I was oppositional and another one was ADD…(pause)…I,.... I don't like people calling me what I am not…….. " (Walker).

Almost one half (48%) of study participants talked about fear of repercussion and mistrust of service providers as one of the greatest obstacles preventing them from utilizing services for their mental health problems. Participants were fearful of having a record of mental health treatment in the system. They felt that the information collected by counselors during service delivery would someday come back to hunt them.

> "those questions they ask would be in your records, like for life, and may come back to destroy you, or someday hurt your chances of getting a job or something" (Dunbar).

Others were hesitant to engage in treatment fearful that some personal information collected may be used as evidence in criminal activities they may have been involved in.

> " you can't trust them…. ,you never know, they can work together with the police even with your probation officer, and put you in big trouble" (Eric).

During the interview participants expressed fear of isolation and/or exclusion from their adolescent social networks if it became known that they were receiving services for mental health problems. They were afraid of the reaction they would get from their peers.

> "My friends think that those who have mental health problems are crazy and could do crazy things and stuff. They may not want to hang out with such people anymore because they don't want to be crazy like them" (Smith).

Many others gave fear of exclusion or isolation as the reasons for their decisions not to disclose their mental health status to others in the community. The quote below which was presented earlier is again utilized to illustrate participants' fear not only about the gossips in the community but also about being isolated or excluded by peers or other community members.

> "..For me, I don't tell anybody outside my family that I go to counseling for if I do, they may think am nuts, like my head is not working right, or like I don't belong in the neighborhood. They will make me feel like I have something bad and should not come near them" (Justin).

Another participant expressed similar fear of isolation if his friends become aware that he was receiving services for his mental health problem.

> "….the way people talk about you around here …it's disgusting…even

> your best friends. I know you don't have to care what other people think about you and stuff but you just can't help cos it's hard when everyone even at school start talking about you. It's like everybody know everything about you" (Terry)

On issues of mistrust, 18 participants (both dropouts and continued users) talked about their lack of trust in their counselors or psychiatrists to protect their privacy by not sharing their mental health treatment records with law enforcement or potential employers. Others cited disrespect, mistreatment, and most importantly, judging them unfairly based on stereotypical notions that are socially assigned to their ethnic background as the main reasons they discontinued counseling. The following comments are examples of how participants expressed their feelings:

> "….before you even show-up, they (counselors) made up their mind about you because they think they know everything about you" (Gare).

> "They (counselors) think they know what is wrong with you before you even say anything" (McFadden).

> "they believe that all black people are the same" (Harrison).

One participant stated that most mental health providers do not understand them (the youth) and their problems because they (psychiatrists/counselors) show no willingness to listen to them.

> "They don't understand your problems and they don't want to listen to you." (Marquise).

Most participants dropped out of counseling because they did not trust their counselors enough to disclose private and personal details of their life situation even though disclosure is the bed-rock of any therapeutic relationship.

> "You know, it is better to keep some family secrets, a secret. Every family has its own secret. You don't want to sell off your family to outsiders" (Mark).

Many participants said they did not trust their psychiatrists because they (psychiatrists) tend to overuse medication as the solution for any problem. Some participants believed that psychiatrists even give medication to those with common behavioral problems including conduct issues.

> "They like to give you medication even when you don't need it" (McCant).

> "I don't think medication is good for everything…Some people say medication for mental health problems is like brain-washing, or that's what it seems like to me. …You know, sometimes people who are dealing with bad situations need some support not medication (James).

Similar concerns were expressed during the interview when a participant was asked, "where would you go to if you were dealing with some emotionally distressing problems?" Following the negative response to this question, the PI followed-up with this probing question:

> PI (probe) - How about if she (his mother) suggests taking you to a psychiatrist?

Youth - "No. I don't think a psychiatrist would be better cos once they (psychiatrists) see you, they think you have problems in your head. They think everybody should take medicine. Like when I first went to counseling at Ocean Tides, my counseling took me to the psychiatrist. This doc., he don't understand, he just want to give you medication for this or for that. My counselor tried to make me take the medications, then I stopped" (dropped out) (Troy).

Although many participants expressed the feelings of mistrust about their counselors, some of the participants talked about their comfort level with their counselors. The following quotes explain the working relationships of some of the participants with their mental health counselors.

"..she (counselor) always told me how many people have changed their lives around and I really wanted to be like one of those people" (Jordan).

"I like my counselor because he always took me around. One time he took me to the baseball games" (Dawson).

"My social worker told me the medication will help you think right and I took the medication home. At home my mom said 'try it', and I did. Few days I begin to feel different. It was like am not as angry as before, like my mind was not rushing … it was like ok. I told my worker and she told me to continued till we see the doc. again…." (Javier).

"My counselor was good with me but one thing I don't like about him is telling my probation officer when I don't show up for counseling appointment" (Lester).

A few participants in group A (dropouts) also talked about positive experiences with their counselors.

> "I think my counselor was a good person but my friends made me stop going to see her because of their big mouth…" (Andrew).

> "My counselor tried to help me. Many times she came to our house to talk to me but I did not put my head to the counseling thing" (Hamel).

In theme #3, interview responses were assessed in relation to the influence of participants' perception of stigma, shame, fear, and mistrust as described in the conceptual framework to understand whether those factors affected their decision-making regarding utilization of mental health treatment services. In this section, participants acknowledged that African American communities are not so friendly with individuals with mental health problems. They also acknowledged the stigma associated with mental health services and believed that individuals who utilized mental health services would be likely to encounter negative perceptions from fellow community members. In most cases, participants admitted that those negative perceptions affected their individual's service use decisions. In particular, peers appear to have a powerful influence on these participants regarding not only the admission of emotional problems but also the receipt of formal mental health services. This module also revealed that some participants did not utilize mental health services for fear of maintaining a record of mental health treatment in the system which could be harmful to their future aspirations. Others avoided mental health service use because they were afraid that their social network members may isolate or exclude them if their mental health status becomes

public knowledge. For most participants, these negative perceptions discouraged them from accessing and utilizing psychological services for their mental health problems. More attention to social network influences is presented in the next section.

**Theme 4. Social network influence on service utilization**

The fourth theme examined the role played by participants' social network, specifically their initial contact persons, in identifying mental health problems and providing the push or encouragement to utilize or not to utilize services. Questions asked during the interview to obtain information about participants' help-seeking behaviors during any mental health episode were: i) How did you get involved with the Family Renewal Center Program? (FRCP), (ii) Did someone encourage you to seek help?

Participants acknowledged the influence of their network members in terms of their involvement during their decision-making process. When asked, "how did you get involved with the Family Renewal Center Program for services?" Participants cited family, friends, and other community members (e. g. probation officers, social workers, etc.) as network members that played significant roles in their decisions to utilize mental health services at the FRCP.

Twenty-one participants out of 26 in group "A" (dropouts) reported that they were referred by their probation officers. Two said they were referred by their social workers, and the rest (three) said they enrolled in the program with the help of their parents. For participants in group "B" (continued users/discharged), nine out of 28 reported that they were referred by their social workers, one stated that his probation officer referred him,

while the rest (eighteen) said their parents enrolled them in the program. This information is presented in table 6 as follows:

**Table 6. Mental Health service referral outcome chart (N = 54)**

| **Social network members** | **Group A (N=26)** ***(Dropouts)*** **(No. & %)** | **Group B (N=28)** ***(Continued users/ Discharged)*** ***(No. & %)*** | **Total (N = 54) (No. & %)** |
|---|---|---|---|
| Family & Friends | 3(11%) | 18(64%) | 26(100%) |
| Probation officers | 21(80%) | 1(3%) | 22(40%) |
| Social Workers | 2(7%) | 9(32%) | 11(20%) |

### *4.1 Family & Friends*

Many participants reported that their parents and friends gave them the emotional support, encouragement, and provided physical assistance (e.g. transportation), which helped them to take advantage of the services provided at the Family Renewal Center Program.

> "….my mom really pushed me a lot. She say counseling will help you. The counselors will help you put your mind together and think about finishing school and go to college, so I agree to try it. I think I have been doing better trying to stay out of trouble" (William).

> "….you know, it's hard without transport, without my mom and her car, I cannot go. Sometimes my counselor talk about it with me. I can't do nothing about it (Johnson).

> My mom take me there all the time, any time she work late. I don't go and the counselor will call … and..I won't pick it up cos I know we are going to be at it again ….." (Shantell)

Some other participants made comments regarding the input of their network members in their decision to utilize mental health service.

> "My friend made me come. He say boy, you better go do this or the judge will sent you to the group home and you will be staying with crazy boys, just do it and get over with" (Flynn).

> "Everyone around me keep pushing, my uncle said, you need to take care of yourself, and I thought maybe, you know, counseling will be good for me, so I followed my mom to start the program" (Steven).

### *4.2 Other Community Members*

Many other participants reported that their social workers as well as their probation officers provided the help they needed and encouraged them to access and utilize services. When asked, "Did someone help you to seek or utilize services"? Participants responded as follows:

> "Yea,… eh.. my social worker also told me to continue with counseling cos it will help me sort out things that was disturbing me and learn how to put them away from my mind. All the time she come to talk to me about whether I was making any progress" (Perry).

> "My probation officer found me a job and I had to continue counseling to keep the job and it was good for me. He said he would find me a better job if I complete my counseling and stay out of trouble" (Raymond).

Another participant, after a brief giggle said:

> "I had to continue attending counseling cos my probation officer was serious. He told me 'if I gat a bad report from your counselor, I ma turn you in', I was scare of going back to the judge" (Carter).

On the other hand, other participants also talked about the negative influences of their social network advisors on their decision to access and utilize mental health services. Many participants recalled how they were discouraged from attending counseling by the negative comments or actions of their advisors. Such comments like: "you don't need counseling", " it's another form of brain-washing", "you don't have to tell everybody your problems".

Some parents within the social network, for example, also discourage their children from utilizing mental health services if they themselves do not believe that treatment can be effective. One participant was asked during the interview, "how about your friends, what do they think about mental health problems?" He responded:

> "... one time when I asked my friend why he didn't show up for counseling, he said, his father won't take him cos he don't want them (counselors) to give him medicine for bad behaviors" (Walter).

As previously mentioned in the stigma/shame section, peer groups seem to be a powerful factor that prevents youths from utilizing mental health services. One participant reported how he was ridiculed by his peers when they found out that his mother took him to see the psychologist.

> "When I met my friends, one friend asked me…do you think you are cuckoo? The other said, are you crazy? Both of them continued the laughter. Hey, choir boy, they say you went to your psychology to work on your crazy head… what is wrong with it? Oh! boy, we didn't know you were drifting. After a brief silence, I only told them, it was my mom's idea" (ID# (Washington).

Similarly, other participants recalled having been told by their network members that seeking services for mental health problems was unnecessary because people can grow out of whatever mental health issues they think they may have.

In theme #4 participants endorsed the important role played by their social network members in providing input as to whether or not to use mental health services. For participants who were receiving services, family members played a role in facilitating their access to services at the Family Renewal Center program. Consistent with the Network Episode Model of service utilization, many family members encouraged as well as discouraged some participants from utilizing mental health services. In particular, the influence of peer groups acted as a double edged sword. In one instance, they provide the push towards use of mental health services, and in another instance they ridiculed participants for utilizing mental health services. For participants in this study, the activities of their social network members regarding mental health service use had

significant impact on their decisions and consequently affected their use of mental health services.

**5.2 Summary of study findings**

Research indicates that most African American adolescents do not utilize mental health services provided for them and that cultural influences may account for disparities in service use among this population (Neighbor et al., 2007). African Americans have had unique historical experiences regarding access and use of health care services and those experiences created a sense of mistrust for the health care delivery system and suspicion with negative attitudes towards professional providers of health care services (William & William-Morris, 2000).

To understand mental health service use behavior among this ethnic group, it became imperative to consider the cultural context within which they operate. As Cauce et. al., (2002) rightly pointed out, cultural beliefs are key deciding factors about whether individuals recognize the manifestations of mental health problems and make decisions regarding whether or not to seek help or utilize services. Although research findings have linked the influence of culture to mental health service use (Snowden, 2001), the differential effects of culture on help-seeking attitudes requires extensive investigation. This study contributes to the knowledge base in this area.

To answer the research questions, this study employed a qualitative research design to examine: 1) cultural factors embedded in the community (e.g., religion/spirituality, fear, mistrust, stigma, shame), and 2) advisors/consultants in the community during illness episodes (e.g., parents, family members, clergy, teachers, friends etc.) to

determine their influences on participants' attitude towards use of mental health services under the guidance of the social support and illness career components of the Network-Episode Model of mental health help-seeking (Pescosolido, 1991,1992).

Criterion sampling procedures were utilized to recruit fifty-four African-American adolescent males who met the study criteria from the Family Renewal Center Program of John Hope Settlement House. Themes and sub-themes that emerged were comparatively examined. A matrix display showing group differences in beliefs resulting in differences in service utilization between both groups of participants is presented (Table 7). Data collected in this study and systematically analyzed provided the bases for answering the stated research questions.

***Research question 1***: What prevents some African-American adolescent males from utilizing mental health services provided for them after they are released from juvenile justice facilities?

Based on the data presented, many participants did not utilize mental health services because of the following culturally influenced beliefs: 1) Participants denied that mental health problems existed. They refused to view mental health problems on the same level as other treatable diseases and as such they did not see the needed for any treatment service. 2) Participants believed that mental health problems are caused by conditions created by racism, racial discrimination and other environmental stressors including negative interpersonal relationships. Thus, they argued that intervention aimed at reducing human sufferings caused by mental health problems should be directed at its

root causes – the environment, rather than providing counseling services for the individuals who are the victims. 3) Some participants did not utilize mental health services post detention because they lacked confidence in the effectiveness of mental health treatment services. Most of them believed that the treatment services do not work therefore they did not see the need to utilize them. 4) For a few other participants, although they acknowledged mental health problems, they preferred the culturally sanctioned coping strategies and relied mostly on their religious beliefs.

**Table 7. Comparative influences on participants' service use attitudes**

| ***Themes & Sub themes*** | ***Group A (N=26) (No. & %)*** | ***Group B (N=28) No. & %)*** | ***Total Participants (N = 54) (No. & %)*** |
|---|---|---|---|
| ***1. Beliefs about causes of mental health problems.*** | | | |
| - Racism & Discrimination | 25 (96%) | 13 (46%) | 38 (70%) |
| - Dysfunctional family situations | 9 (34%) | 7 (25%) | 16 (29%) |
| - Stress of living in poor Neighborhoods | 25 (96%) | 24 (85%) | 49 (90%) |
| - Genetics | 5 (19%) | 13 (46%) | 18 (33%) |
| ***2. Other Beliefs About Mental Health*** | | | |
| - Denials of mental health problems | 19 (73%) | 4 (14%) | 23 (42%) |
| - Religion & Spirituality | 5 (19%) | 9 (32%) | 14 (25%) |
| ***General beliefs:*** | | | |
| - Ineffective treatment | 20 (76%) | 8 (28%) | 28 (51%) |
| - Other general beliefs | 13 (50%) | 4 (14%) | 17 (31%) |
| ***3. Social Barriers*** | | | |
| - Stigma/shame | 26 (100%) | 20 (71%) | 46 (85%) |
| - Fear | 16 (61%) | 10 (35%) | 26 (48%) |
| - Mistrust | 12 (46%) | 6 (21%) | 18 (33%) |

These participants believed that faith in God through prayers would see them through their mental health problems rather than utilizing professional mental health services. 5) Participants also encountered mental health stigma, perceived shame from community reaction, fear of isolation or exclusion, mistrust of mental health services system, and professional service providers. These cultural beliefs, perceived negative social repercussions, and alternative coping strategies led some participants to deny or hide their mental health problems which unfortunately constituted barriers that not only prevented some participants from utilizing mental health services but also accounted for within-group disparities in service utilization.

**Research question 2*:*** How does culture shape the attitudes of African-American adolescent males selectively in their decision to use or not to use mental health services post-release?

Based on the data presented, there is evidence indicating that culture does, selectively shape the attitudes of African-Americans adolescents when deciding whether or not to utilize mental health services. Some aspects of culture in this case being the preferred traditional African American ways of coping with mental health problems such as religious beliefs in prayers to God for divine intervention which many participants endorsed during the interview.

In this study some participants were influenced especially by parents to embrace the religious faith approach to coping with mental health problem, a culturally sanctioned approach to dealing with mental health issues, but other participants were ambivalent

about the faith approach rather they felt that faith should be a supplement to formal professional treatment services.

Due to the influence of culture, many participants (42%) denied the existence of mental health problems or its causes but attributed their emotional problems to other acceptable cultural explanations, such as "loss of faith in God", which greatly affected their desire to seek or utilize mental health services. The cultural beliefs system greatly influenced the decision-making of participants and significantly shaped their attitudes towards unwillingness to use mental health services.

Social networks are also a key element of cultural patterns. For instance, the advice of consultants and advisors embedded in the community who act as first responders to advise participants on the need to seek help for mental health problems are inherently colored by their cultural norms. As indicated in this study, some social network members encourage participants to seek treatment services in certain instances while others actually discourage them based on their cultural beliefs. This observation is consistent with the Network Episode Model (Pescosolido et al., 1991, 1992) that at any time in the illness career the network advisors may or may not be consistent in their advice. However, the data did not provide enough evidence to conclude that cultural influence could be held as the sole causal factor for within-group disparity in mental health service use among this population.

It should also be noted that cultural influence on attitudes, differences in beliefs, or choices of mental health treatment options among participants in this study did not always fall within group lines. For example, nearly the same percentage of participants

in each group (96%) in group A, and (85%) in group B endorsed the belief that mental health problem is caused by the stress of living in poor neighborhoods. This suggests that even though participants in group B also believed that mental health problems are caused by external environmental factors like participants in group A, many of them (in group B) still sought treatment services for their mental health problems. The next chapter more fully discusses the study findings within the context of the literature and the theoretical framework.

# CHAPTER VI

# DISCUSSION

This chapter presents a discussion of the study findings in the context of the research literature. Study implications, limitations, and suggestions for future research are also presented.

Previous studies have examined underutilization of mental health services among African-Americans but the majority of the studies focused on service use patterns of older adults. The few studies that investigate adolescent mental health help-seeking behaviors provided little information in terms of linking service utilization with the role of culture and social network influences. They did not pay adequate attention to within-group disparities in mental health service use, particularly those involved with the juvenile justice system.

Qualitative methodology and the Network Episode Model (NEM) theoretical framework were utilized to investigate how within-group disparity in mental health service use among African American male adolescents released from juvenile detention is related to the influence of culture on their attitude towards mental health help-seeking.

The result found that participant's beliefs that mental health problems are caused by external factors (e.g. racism or neighborhood stressors), rather than individual personal factors (e.g. genetic) negatively impacted their help-seeking attitudes and prevented them from seeking and utilizing mental health treatment services provided for them post-incarceration. This study finding clarifies the link between the influence of factors embedded in the community and individual belief systems with regards to

decision-making about use of mental health treatment services. Findings also provide awareness of how African-American adolescent males evaluate treatment services, their views about mental health problems, as well as the impact of stigma and other social and cultural barriers on their attitudes towards mental health help-seeking.

Overall, findings from this study add to the knowledge base on the topic by utilizing qualitative interview to capture rich details from youths' perspective and by using a theoretical framework (NEM) that links several key concepts. As demonstrated in this study, qualitative research offers a sound methodological framework for developing an understanding as to how African American youth construct meanings in relation to their environment and previous experiences as they respond to the issue being studied. For example, some participants' personal stories revealed the stark realities of police racial profiling which is generally perceived as law enforcement activity and how the practice is perceived by African American youth as a trigger for mental health problems. The finding that this activity is discriminatory, intimidating, and designed to achieve social control over minority groups provides important information for planning remedial interventions. Obtaining this sort of information is only possible because this method of enquiry allows the researcher to tailor immediate probing questions and the participants to elaborate in detail.

A qualitative approach utilizes open-ended questions. With open-ended questions, participants are free to respond, from their own perspective and using their own words to express their feelings thereby producing information that is rich, culturally salient, and explanatory. Without qualitative methods, it would be difficult if not impossible to

achieve insight into dysfunctional family relationships which some participants believed to have caused them mental health problems. As one of the study participants' interview response revealed about his toxic relationship with his step-father, such information would not have been uncovered in a survey data.

The interpretive aspect of qualitative research methodology helps make important contributions to the development of new knowledge because it enables pertinent information collected regarding individual or group values, customary beliefs, or traditional norms, to be interpreted at much greater detail. This uncovers personal or collective viewpoints regarding political and economic neglect as well as other challenges that African Americans endure in their neighborhoods and the established link that they make to their mental health issues.

Qualitative methods were well suited for this study since it provided the window through which the researcher can see the participants' internal construction of their worldview – an important determinant of their decisions towards mental health care. In-fact, the inductive, interpretive, and related applications of qualitative methodology are the methods' strengths and areas of unique contributions in developing insight into the influence of contextual realities that shape the youths' attitude regarding mental health issues.

Although I made some comparisons in the study between the dropouts and those who continued with service use, I should mention here that qualitative data can only suggest differences. The reasons I identified for why some youth dropout or continue with service use are only possible suggestions – the reality is more complicated. For

example, even those youth who did not believe in treatment effectiveness continued to utilize services and vice versa.

Regarding the theoretical framework, the Network-Episode Model as a whole has for a long time been used to explain help-seeking behaviors as it was specifically designed. On the whole, findings from this study fit with the NEM's core principles including the assertion that "dealing with any health problem or physical disability is a social process that is managed through the contacts (social networks) that individuals have in the community, the treatment system, and social services agencies, including support groups or churches".

In this study, the Illness Career and the Social Support System components of the model were utilized to explain: 1) what the individual does during any mental health episode (e.g., the contacts they make) in their attempt to deal with their mental health problems; 2) how the cultural indicators embedded in the community as identified in the conceptual framework of the study are linked to the individual's decision-making process for or against utilizing mental health services; 3) the role of social support system regarding individual's ability or need for assistance in accessing and utilizing mental health services.

As the study findings shows, the social support component of the model (e.g., parents, friend, or peers) played an important role encouraging, connecting, or providing transportation for the youth to help them utilize mental health services.

However, though this model provides a comprehensive analysis of contingencies that play a role during an individual's illness career, it focuses on the embeddedness of

help-seeking in the environment rather than on the factors that come into play when individual actually enters treatment. Thus, it does not offer an understanding of the factors that should be directly considered in the development of interventions. This is an important flaw of this model since individuals would like to know what they are working on (e.g., behavior change) and what outcome to expect. Findings from this research study suggest the NEM might be adapted to include explanations on those factors that would enhance engagement in therapy once an individual enters treatment. More specific results of the study are discussed further below.

### 6.1 Racism and discrimination as a barrier to mental health service use

Some participants in both groups failed to utilize mental health services because of their belief that mental health problems are caused by racism and discrimination. Findings from this study indicate that almost all participants in the dropouts and less than half of the continued users believed that racism and discrimination caused mental health problems. As a result of this belief system, more of the participants who dropped out failed to see the need to seek or utilize mental health services as compared to those who continued. They viewed mental health problems not as a disease but as a different form of racial dominance, so they tended to accept their emotional pains as part of their life-long oppressive experiences requiring no treatment services. This finding is supported by Ward et al., (2009) who examined beliefs about mental illness among 185 African American women and found that participants believed that racism and discrimination caused depression. Other studies have found racism and discrimination to be "generally associated with poor health status", but the "association was the strongest in the case of

mental health compared to physical health" (William, Neighbors, and Jackson, 2003; Pieterse, Todd, Naville, & Carter, 2012). With this as the overriding belief system, it is not surprising that young people are not inclined to participate in treatment.

What may mitigate the feelings of racial oppression and engage African Americans in mental health treatment services could probably be a more realistic view of the association between racism and mental health problems. The findings from this study and the growing appreciation of the role of racism and discrimination in the psychological health of African Americans lend more support to theorists who are calling for experiences of racism to be considered within the context of trauma (Carter, 2007). Given their historical experience with mental health care, Carter (2007) asserts that among African Americans, negative psychological responses to racism carry many features associated with trauma, such as anxiety and interpersonal sensitivity, so trauma should be a fitting context within which to discuss mental health problems affecting African Americans. In support of this proposal and contributing to the trauma theory, Helms, Nicolas, & Green (2010) believed that racism and ethnoviolence should be considered as catalysts for Post Traumatic Stress Disorder (PTSD), recommending that practitioners be trained to conduct culturally responsive and racially informed interventions with African Americans, particularly when symptom presentations are ambiguous. Assessing mental health problems as race-related trauma within the African American population would therefore, have the effect of mitigating their suspicious feelings to engage them in treatment and thus increase treatment services utilization.

## 6.2 Efficacy of mental health treatment services and mental health service use

Findings from this study indicate that many participants (particularly the dropouts) did not utilize mental health treatment services because they believed services do not work. They expressed greater lack of confidence in the effectiveness of mental health treatment services than the continued users. This finding is not surprising given the prevalent beliefs regarding racism/discrimination as root cause. According to the data, more participants among the dropouts believed that mental health treatment services do not work while only a few participants among the continued users agreed with that assessment. This means that an equal number of participants among continued users also believed that treatment services work, and can help resolve their mental health problems.

Disparities in mental health service use among the study participants are likely tied to their personal beliefs. Many participants lacked confidence in the effectiveness of mental health treatment because of the nature of the treatment services. They did not believe that "talk therapy" can help restore their emotional disturbances or cure diseases such as depression or anxiety disorder. Other participants especially the dropouts believed that treatment for mental health problems is all about giving out medication and as a result many do not want to see a psychiatrist for fear that they will be put on medications. Due to these personal reasons, many participants did not believe that treatment services could help them, instead turned to other coping strategies for addressing their mental health problems such as denying that the problem exists or believing that it will go away on its own. However, an equal number of participants believed that mental health treatment is effective and has helped reduce their own

symptoms. The problem of lack of confidence in treatment also means lack of knowledge. If African-American youth are presented with facts about the nature of mental health problems, and the need to obtain treatment for such problems, the service utilization gap can significantly be reduced.

**6.3 Religion/Spirituality and mental health service use**

One of the most striking findings in this study was the apparent shift by African American male adolescents from total dependence on religion as a coping strategy for their mental health problem as has been the case with older African Americans. Contrary to expectations, this study did not find support for the view that African American adolescents depend upon and use religion/spirituality as a coping resource for their mental health problems. Although parental influence sometimes persuades them to access and utilize services, the majority in this study did not embrace the sole religious doctrine (prayer and faith) for resolving mental health issues. According to the data only twenty-five percent of the study sample endorsed the culturally sanctioned coping strategy of faith in God with prayers as the most appropriate way of dealing with mental health problem. As the finding indicates, participants in this study did not discuss faith generally as a means of dealing with their emotional distress. It may be that the study finding reflected a generational shift brought about by the changing cultural values. In this study, references to religion and spirituality in relation to mental health coping strategies continued to filter indirectly through parental activities into the discussion of treatment service utilization among continued users. This finding is partially supported by Lindsey et al., (2006) who found that problems solving through prayer or seeking support from

the church did not play a significant role in the lives of depressed African American boys who reside in urban, high-risk communities. This finding also revealed that the benefits of religion/spirituality such as Divine Healing in the treatment of mental health problem do not automatically transfer from parents to children just because of their ethnic affiliation. This is consistent with the findings of Jang and colleagues (2006) that the benefits of religiosity do not exist uniformly across all African Americans but vary by the level of adherence to traditional culture. This finding highlights the importance of individual differences among African American adolescents and point to the common mistake made by clinicians and other mental health professionals of treating members of a racial or ethnic group as one homogeneous group.

**6.4 Social network and mental health service use**

Study findings show family and peers to be powerful influences on participants' decisions-making regarding mental health service utilization. According to the data presented on Table 9, sixty-four percent of continued users referred for services by family members and friends engaged and continued with services while among the dropouts, only eleven percent referred by family or friends dropped out. This finding amplifies the important role of family and friends as the initial contact persons (gateway providers) embedded in the community as they identify mental health problems, refer, encourage or discourage service utilization in the event of any mental health problem (Stiffman & colleagues, 2004).

Data also show that the dropout rate for participants referred for services by probation officers were higher compared to dropout rate for participants referred for

services by social workers. One possible interpretation is that participants referred by probation officers were not engaging in treatment because some of them were not convinced the probation officers were looking for and protecting their interest and thus did not follow their (probation officers') directives. The high dropout rate from the probation officers' referrals may be the result of strict compliance standards of the probation department and overbearing techniques of monitoring and reporting compliance (e.g. contempt violation or turning them in). These threats of compliance may make the youth more suspicious of their intentions with a negative effect on relationship building.

Study findings also indicates that peer influences on attitudes of participants regarding use of mental health services was very challenging because they acted as a double-edged sword. While some continued users acknowledged support they received from their friends that enabled them to access and continue with service utilization, some dropouts viewed most of their friends as not only unsupportive but also as those who would ridicule and shame them for utilizing mental health services. This finding supports Lindsey and colleagues (2006) who noted that adolescent boys who were in treatment said, although they received emotional support from their friends, and were able to talk to friends about their problems, additional analyses of the group revealed that most were reluctant to tell their friends that they were receiving formal mental health services, fearing that friends would poke fun at them. Both findings are consistent with the Network Episode Model of mental health service utilization (Pescosolido & Boyer, 1999) which asserts that members of the community (including family and friends) can work in

concert or in opposition to produce the 'push' toward or away from service use. The contrast in peer relationship regarding the influence it has on mental health care service use as revisited in the stigma/shame section of this chapter suggests some connection with within-group disparities in service utilization observed among African American male adolescents released from juvenile detention facilities.

Further, the study also revealed that some parents/guardians in this study did not support use of mental health services by their wards. They actually discouraged them from accessing services due to certain personal beliefs about mental health problems. For example, during the interview one study participant quoted his friend's parent as saying, "I don't want them to give him medication for bad behavior", when he wanted to know why his friend did not show up for counseling. A previous study by Draucker (2005) found similar opposition by parents in his study on processes of mental health service use by adolescents with depression. In that study, some parents were actually opposed to mental health treatment and respondents reported as follows: "my parents were really negative about counseling", "my dad just refused to take me", "my mother is highly against it", "my father thinks therapy is a farce", or "my father just doesn't believe in it" (p.6). This finding coincided with the NEM's explanation of the role of social network members (including parents) that network advisors during any mental health episode may or may not be consistent in their advice (Pescosolido & Boyer, 1999).

**6.5 Stress of living in poor neighborhood and mental health service use**

According to the data, a very large percentage of the participants (90%) in this study believed that the stress of living in poor neighborhoods caused mental health

problems. Large percentages were found in both groups. They argued that they had no internal biological malfunctioning that could trigger in them a sense of chronic sadness, hopelessness, anxiety, or insecurity rather it was the manifestations of environmental conditions under which they lived that made clinicians conclude they needed mental health treatment services. As a result, these participants did not think they had reasons to seek and utilize mental health services.

Study finding that the stress of living in poor neighborhood caused mental health problems and as such participants did not need treatment services for themselves is supported by several researchers. For example, Cutrona & colleagues (2006) examined stress processes in neighborhoods and found that neighborhoods with poor-quality housing, few resources, and unsafe conditions impose stress on residents that lead to depression. Specifically, they pointed out that the stress imposed by adverse neighborhoods increases depression above and beyond the effects of the individual's own personal stressors, such as poverty, and negative events within the family or work-place. This conclusion actually downplays dysfunctional family situations as a cause of mental health problems.

In addition, the argument that environmental policies should be the appropriate response to alleviate stress of living in poor neighborhood and thus eliminate mental health problems is supported by the outcome of the Chicago experiment – Moving To Opportunity (MTO). This Chicago program was designed to provide rent subsidies to low-income people in poor neighborhoods and randomly assigned them to live in different kinds of neighborhoods to escape the effects of neighborhood conditions on

families' well-being and children's mental health. The outcome revealed that the youth and adults showed better mental health when they moved from impoverished neighborhood to middle-class neighborhoods (Rosenbaum & Harris, 2001). This experiment clearly demonstrates that some environmental problems such as crime, unemployment, poor housing, etc. associated with low-income people, in this case African Americans, should actually be attributed to toxic effects of low-income neighborhoods.

**6.6 Social barriers and mental health service use**

The study provided evidence that mental health stigma prevented many participants from utilizing mental health treatment services. Due to the qualitative nature of this study, it was possible to get a better sense of how these minority youth deal with the problem of stigma and other social barriers as they attempt to access and utilize treatment services for their mental health problems. For example, during the interview, participants described their concerns over the gossiping network that exists in their neighborhoods regarding mental health treatment issues and the fear of isolation from their social network members if their mental health status becomes public knowledge. These concerns had a profound negative influence on some participants and effectively discouraged them from utilizing treatment services.

According to the data, more than half the participants (85%) point to their experience of stigma as a negative influence on their decision to utilize mental health services. As indicated, a large number of participants in both groups cited mental health stigma as the reason for not utilizing mental health treatment services. This finding is

supported by Conner et al., (2010) who found that perceptions and experiences with stigma were high among study participants and was a strong deterrent to seeking mental health treatment among African American adults. Similar studies supporting this finding include Roeloffs & colleagues (2003), Pescosolido et al. (2007), Barksdale & Molock (2008). However, a few participants were less concerned with stigma or learned to brave its consequences and continued with services use either because of the type of support they received from their social network members or because of the severity of their mental health problems.

Further, this study also found that 33% of participants avoided use of mental health treatment services because they did not trust their service providers or the mental health system. As reported, many of the participants were not comfortable disclosing personal information to their counselors particularly those involved with the court system and this greatly affected their ability to engage in therapy. This is consistent with other research (Townes et al., 2009; Sue & Sue, 2003). In order to build trust between mental health service providers and African-Americans adolescent males, clinicians and other professional providers should be open to discussing disclosure and its legal requirements with the clients from the initial assessment so that clinicians who may utilize probing questions during fact finding interviews may not be misinterpreted.

Some participants, particularly the dropouts, endorsed the African American value of keeping strangers away from family and personal affairs believing that such issues were better handled within the family and not shared with outsiders. Those participants who held unto this belief or coping strategy had difficulty staying engaged with their

counselors long enough to achieve service goals. This resulted in many incidences of dropouts and premature service terminations. This finding is consistent with Scott & Davis (2006) who found that 50% of young black males in foster care somewhat or strongly agreed that "blacks should be careful about what they say in the presence of White mental health professionals since they try to use it against you", and at least a third (33.8%) somewhat or strongly agreed that "It is best for Blacks to be on their guard when dealing with White mental health professionals" (p.729).

In this study, the point of departure from previous study finding is that participants did not in any way try to undermine the integrity of their counselors or indicate any preference for culturally compatible therapist. It should be noted that positive outcome from mental health treatment service is predicated on the individual's (i.e. client) willingness to self disclose; that is discuss their personal or family issues freely with the therapist. However, it is not uncommon given the documented history of social and medical exploitation of African Americans (Gamble, 1997), and the fact that most of the participants have records that may be criminal in nature, for African American adolescents to activate the cultural mistrust element of their feelings (Whaley, 2001) when counselors probe into their family and personal life in therapy.

Overall, findings from this study reveal a complex relationship between African American male adolescents and the cultural, social, and environmental barriers that prevent them from utilizing services for their mental health problem. For example, while some participant in this study continued to share parental views about mental health problems, others, through the influence of popular culture seem not to entirely embrace

the beliefs of their parents regarding mental health issues. These differences had a profound effect on their help-seeking behaviors. But taken as a whole, data provided by this study also suggests that it may be difficult to ignore the influence of culture on the attitudes of African American male adolescents towards mental health help-seeking particularly those released from juvenile justice facilities.

### 6.7 Implications for social work practice

The study found, among other things, that some African American adolescent males endorsed negative views about mental health treatment and mental health service providers. Many other participants doubted the efficacy of mental health treatment services, while others claimed that their counselors did not understand them, suggesting that the individual seeking help did not have confidence in the helper to adequately address his problem. As a result, they did not see the need to seek professional help. These findings have several practice implications for clinicians in particular and the social work profession in general. One implication is that clinicians and therapists working with this population should be willing to explore participants' perceptual barriers to service utilization such as treatment effectiveness, race/ethnicity, or mental health stigma. This initial open and honest interaction can help elevate the level of provider's sincerity and trustworthiness, which encourages treatment engagement and promotes the therapeutic alliance.

To increase mental health service utilization, providers should address the issue of perceived treatment ineffectiveness by selecting and utilizing therapeutic models that have been proven to work best with this population. For example, clinicians should be

willing to utilize the Multi-systemic Therapy (MST) which has been considered to be most effective with juveniles involved in post-release programs with documented improvements in family functioning (Randall, et al., 1999). MST is an intensive family and community based treatment focusing on the juvenile's surrounding environment (neighborhood, family, peers, school, etc.) with the goal of reducing the rate of antisocial behaviors, enhancing the youth functioning, while increasing service utilization. This model has been applied to youth with a variety of clinical problems including: juvenile violent offences, juvenile substance-abuse offences, and mood disturbances with suicidal tendencies (Randall, et al., 1999). This therapeutic model is recommended here because according to Cortes (2004), the home-based treatment is effective because it helps the family who may not trust the mental health field to develop better relationship with the therapist while maintaining some type of control. As a result it reduces the attrition rate, and increases service utilization.

Study findings show that mental health stigma and lack of adequate knowledge about the nature of mental health problems significantly reduce utilization of mental health services which may account for disparities within the sub-group in service use. As indicated, some participants held the erroneous view that mental health problem is dangerous because it could be contagious while perceived mental health stigma encouraged many participants to avoid service utilization. This implies that the participants in particular and the African American community in general lack adequate information and knowledge about the nature of mental health issues. These findings suggest that mental health providers and community organizations, including the church,

should work collaboratively with health policy-makers to provide community based trainings to help members of this group become aware of the nature of mental health problems, the negative effect of mental health stigma, and the need for professional treatment. These trainings should target parents, family members, as well as groups such as the local police departments, church organizations, and religious leaders, who according to Pescosolido and colleagues (1998,1999) constitute the initial contact persons (gateway providers) within the communities that the individual consults for advice in their attempt to cope with their mental health problems.

To increase mental health service use among this population post release, the juvenile justice system has to be part of the equation. All the participants in this study were system involved and as such the case management team in the juvenile justice system should have the responsibility of helping to create a trusting therapeutic relationship between the youth and community-based service providers to minimize dropout rate. This could be accomplished by allowing case workers in the system to develop a service link for each youth in transition prior to their formal release from detention to familiarize the youth with the potential service provider. Such arrangement would allow the youth to establish a relationship with the service provider before formal release, promote trust, enhance cordial therapeutic relationship, and prevent premature service terminations. In addition, the juvenile justice system should partner with the mental health profession to create and implement mental health education programs for youth in the juvenile justice system to counter the myths about the nature of mental health problems and treatment options. Hopefully, such education campaigns would help

expose most of the faulty reasoning about mental health problems and encourage the use of professional services for mental health problems.

Further, study findings confirmed the dual role played by social network members in either encouraging participants to utilize mental health treatment services or discouraging them from service use. In particular, study findings show that negative peer influences have become a barrier to service utilization. To counter this problem, administrators of juvenile detention facilities should begin the sharing of information about mental health problems as earlier suggested even while these youth are still in detention so that by the time of release, they would become aware that treatment services are designed for their individual well-being. Hopefully, this would go a long way to ward off the negative stigma associated with mental health and treatment utilization among our youth.

**6.8 Limitations of the study**

The present study provides important findings and implications which must be considered in light of the following limitations: First, the sample of this study is small (n = 54) and not representative of African American adolescent males released from juvenile justice facilities. In addition, participants in this study were recruited from a social service agency that caters solely for inner-city youth thereby creating a select sample that consisted predominantly of city dwellers therefore limiting consideration of other African-American adolescents who live in suburban areas even though they may have equally been released from juvenile detention facilities. Further, participants in this study described themselves as African-Americans but during in-depth interviews a few of

them revealed that they were actually African-Americans of Caribbean ancestral origin – a likely factor that may impact attitude towards use of services. Therefore, study findings should be interpreted with caution and not generalized to the entire sub-population.

Second, given the size and non-representativeness of the sample, consumers of the study findings should not attempt to draw a causal inference based upon the findings, such as speculating that racism, ineffective treatment, or social barriers alone caused disparities in mental health services use among African American male adolescents released from juvenile justice facilities.

Therefore generalization of findings to all African-American adolescents released from juvenile detention facilities should not be encouraged.

Third, the study focused more on public stigma - that is stigma held by the general public as a barrier to mental health service use and did not give much weight to self-stigma – the internalized impact of public stigma (Corrigan, 2004). If both types of stigma were equally assessed among all participants in the study it probably would have provided a richer understanding of the types of stigma that have more impact in shaping the help-seeking behavior of the study participants.

**6.9 Conclusion and Suggestions for future research**

Despite aforementioned limitations, this study made several important contributions to our understanding of mental health service utilization behaviors of African American male adolescents released from juvenile justice facilities. The present study has provided evidence that the attitude of African-American youth towards mental health service utilization is affected by what they believe to be the causes of mental

health problems, social factors such as stigma, fear, mistrust, and the stress burden of poor neighborhoods. As suggested by the social support and illness career components of the Network Episode Model, this study demonstrates the important role played by the initial contact persons in the adolescent's mental health service utilization decision-making. The study findings expand our knowledge of within-group disparities in mental health service use and provide a springboard for future research in minority mental health and the influence of culture on their service use behaviors.

The present study focused mainly on cultural influence on attitude of post-incarcerated African American male adolescents towards use of mental health treatment services without examining other major factors that could shape behaviors regarding mental health treatment services. Although environmental factors were identified, in-depth analysis was not possible. Therefore, future research needs to consider a wide spectrum of influential factors that shape mental health help-seeking behaviors of African-American youth especially the negative influence of peer relationships on their attitudes towards mental health service utilization.

# APPENDICES

APPENDIX A

**Approval letter from Superintendent (RI Training School)**

## Re: RBC Graduate Work - (Ignatius Samuel)

Hide Details

From Bill Barnette

To IGNATIUS SAMUEL

July 29, 2010

Mr. Ignatius Samuel
157 Dover Street
Providence, RI 02908

Your request for support to conduct a research study on why some youths released from the training school do not take advantage of programs such as the John Hope Settlement House program, which are designed to help them cope with their problems and work towards becoming productive members of the society, has received careful consideration.

As proposed, the study has significant merit because of its potential to both shed some light on the cause of recidivism and inform our service delivery system. Therefore, we will support your project and facilitate contact between you and the potential study participants. Please ensure that ethical as well as privacy issues governing the protection of human subjects in research are compiled with as required by federal regulations.

We appreciate your interest in our youth population and look forward to working with you.

Sincerely,

William Barnette

Deputy Superintendent * Administration
Rhode Island Training School

# APPENDIX B

## Dissertation Research Information Sheet

**Dissertation Research Information Sheet**

**Disparities in mental health service use among African American adolescent males released from juvenile detention facilities**

**Ignatius Samuel, MSW, LCSW**

This dissertation research "Factors that influence utilization of mental health services by African-American youth released from juvenile detention" is being conducted by a doctoral student at Boston University School of Social Work. The Family Renewal Center program at John Hope Settlement House is helping with this project. All male African-American youth who have either dropped out from the Family Renewal Center program, are still receiving services, or have been officially discharged from the program are invited to take part in this research.

The purpose of the research is to learn more about why some male African-American youth released from juvenile detention with mental health problems take advantage of mental health treatment services designed to help them cope with their problems but others do not, even though both groups may experience similar emotional distress. All youth selected for this research study will take part in an interview which will utilize open-ended questions. Youth will be asked to share their feelings about their involvement with the juvenile justice system, their beliefs (personal and cultural) about mental health problems and treatment, how such beliefs affect their perception of mental health, the treatment system, and how such perception shape their attitude about seeking and using treatment services. Interviews will be conducted only once at the youth's home, except if they prefer another location. The interviews will last about an hour and will be audio recorded. The study will also review the youth case files at the Family Renewal Center if the youth and parent provide permission.

All participants will each receive a $10 gift card to Walmart or Target as a way of saying "thank you" for participating in the research study.

The decision whether or not to take part in this research study is entirely voluntary. A decision not to take part in this research will not in any way affect the services received from the Family Renewal Center Program or any other agency. All information collected in this research study will be treated as confidential. Forms used to collect information will have code numbers in place of names of participants. No pictures will be taken, and whatever discussion you have with the researcher will not be shared with the program staff.

All those who are interested in taking part in this study should please leave their names and phone numbers with the Family Renewal Center Counselor. I will be happy to talk with you about the research and to answer any questions you may have.

I hope you will consider taking part in this exciting study.

# APPENDIX C

## Qualitative Interview Guide

# Disparities in mental health service use among African American adolescent males released from juvenile detention

## Interview Guide

In this interview, I hope to learn more about why some African-American youth access and use mental health services after they are released from juvenile detention but others do not. There are no right or wrong answers to any question I will ask. Whatever you say will be confidential to the extent allowed by law and no staff of the Family Renewal Center will know what you told me. You can tell me when you don't want to answer a question and you can stop the interview at any time if you do not want to continue.

Cultural factors

I am going to use the term "African-American" to refer to people of African descent. Is that okay with you or is there another term you prefer? Different cultures have different beliefs about mental health issues -- for example, when someone is depressed, overwhelmed, or so sad that he/she cannot go on with his/her everyday life. I'm interested in African-American views on mental health problems.

1. What do you think are the causes for mental health problems?

2. What should someone do if they have a mental health problem?

3. Who should they go to when they need help for a mental health problem?

4. How are your thoughts about mental health issues different from those of:

   Your parents?

   Your friends?
   People in other cultures

Attitudes Towards Help-seeking

5. If you had a physical health problem (such as strep throat):

   - What would you do?
   - Who would you contact?

   Your parents?

   Your pastor/spiritual healer?

   Someone else?

6. If you had a mental health problem (such as serious depression):

    - What would you do?
    - Who would you contact?

        Your parents?
        Your pastor/spiritual healer?
        Psychiatrist/counselor?
        Someone else

Use of Mental Health Services

7. How did you get involved with the Family Renewal Center Program?
    - Did you think you needed help?
    - Did someone encourage you or make you seek help?
    - What did you think was the problem?
    - What did you hope would happen when you signed on for this program?

8. I'd like to hear about your experiences with the Family Renewal Center Program and the juvenile justice system:
    - Can you tell me one thing that was <u>helpful</u> about the Family Renewal Center Program?
    - And, one thing that was <u>not helpful</u>?
    - Can you tell me one thing that was <u>helpful</u> about involvement with the juvenile justice system?
    - And, one thing that was <u>not helpful</u>?
9. What are the reasons you [continued with OR dropped out from] using mental health services?

Concluding Questions

10. Is there anything you think adults who help youth with mental health problems should know in order to be really helpful to young people?

11. Anything specific about how to help African-American males to <u>use services</u> after juvenile detention?

Thank you!

## References

Abram, K. M., Choe, J. Y., Washburn, J. J., Romero, E. G., & Teplin, L. (2009). Functional impairment in youth three years after detention. *Journal of Adolescent Health,* 44, 528-535.

Abram, K.M., Choe, J. Y., Washburn, J.J., Teplin, L.A., King, D.C., & Dulcan, M. (2008). Suicidal ideation and behaviors among youth in juvenile detention. *Journal of the American Academy of Child & Adolescent Psychiatry,* 47(3):291- 300

Abrantes, A.M., Hoffman, N.G., & Anton, R. (2005). Prevalence of co-occurring disorders among juveniles committed to detention centers. *International Journal of Offender Therapy and Comparative Criminology,* 49(2), 179-193.

Administration on Children and Families (2002). Summary results of the 2001 and 2002 child and family service review. Available at: www.acf.hhs.gov/programs/cb/cwrp/2002cfsrresults.htm.

Agency for Healthcare Research and Quality (AHRQ). National Healthcare Disparities Annual Reports, 2008a, 2008c, 2009. Rockville, MD.

Ajzen, I., & Fishbein, M. (1980). Understanding attitudes and predicting social behavior. Englewood Cliffs, NJ: Prentice-Hall.

Alegria, M., Jackson, J.S., Kessler, R.C., & Takeuchi, D. (2008). Collaborative Psychiatric Epidemology surveys (CPES), 2001-2003. Inter-University consortium for Political and social Research. Ann Arbor, MI. Available at: http://www.icpsr.unich.edu;cocoon/ICPsr/TERMS/20240.

Alegria, M., Vallas, J., & Pumariega, A. (2010). Racial and ethnic disparities in pediatric mental health. *Child and Adolescent Psychiatric Clinics of North America,* 19(4): 759-774.

Alegria, M., Perez, D. J., & Williams, S. (2003). The role of public policies in reducing mental health status disparities for people of color. *Health Affairs*, 22(5), 51-64.

American Academy of Child and Adolescent Psychiatry [AACAP], 2002). Statement from the American Academy of Child and Adolescent Psychiatry for the Senate Health, Education. Labor and Pension committee hearing on IDEA enforcement. Washington, DC.

Andersen, R.M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior,* 36(1), 1-10.

Anglin, D. M., Alberti, P. M., Link, B.G., & Phelan, J.C. (2008). Racial differences in beliefs about the effectiveness and necessity of mental health treatment. *American Journal of Community Psychology,* 42: 17-24.

Anglin, D. M., Link, B. G., & Phelan, J. (2006). Racial differences in stigmatizing attitudes about people with mental illness: Extending the literature. *Psychiatric Services,* 57, 857-862.

Altschuler, D.M., & Brash, R. (2004). Adolescent and teenage offenders confronting the challenges and opportunities of reentry. Youth Violence and Juvenile Justice, 2(1),72-87.

Alvidrez, J., Snowden, L.R., & Kaiser, D.M. (2008). The experience of stigma

among black mental health customers. *Journal of Health Care for the Poor and Underserved*,19(3), 874- 893.

Artilles, A. J. & Trent, S. C. (2000). Representations of culturally/linguistically diverse students. In C. R. Reynolds, & E. Fletcher-Janzen (Eds.), Encyclopedia of Special Education, (2nd., Vol.1, pp. 513-517). New York: John Wiley & Sons.

Atdjian, S., & Vega, W. A. (2005). Disparities in mental health treatment in U.S. racial and ethnic minority groups: Implications for psychiatrists. *Psychiatric Services,* 56(12),1600-1602.

Baker, M., & Menken, M. (2001). "Time to Abandon the Term mental illness". *BritishMedical Journal,* 322 (729):937.

Barksdale, C. L., & Molock, S. D. (2008). Perceived norms and mental health help-seeking among African American college students. *Journal of Behavioral Health Services Research,* 36(3), 285- 299.

Bonin, J., Fournier, L., & Blais, R. (2007).Predictors of mental health service utilization bypeople using resources for homeless people in Canada. *Psychiatric services,* 57(7), 936-941.

Bowen, M.E., & Gonzales, H.M. (2008). Racial/ethnic differences in the relationship between the use of health care services and functional disability: The health and retirement study (1992-2004). *The Gerontologist,* 48(5), 659-667.

Braden, J..B., Zhang, M.S., Fan, M., Unutzer, J., Edlund, M. J., & Sullivan, M. D.

(2008). Mental health service use by older adults: The role of chronic pain. *Am. Journal of Geriatric Psychiatry*, 16(2), 156-167.

Bradley, E.H., McGraw, S.A., Curry, L., Buckser, A., King, K.L., Kasl, S.V., et el., (2002). Expanding the Andersen model: The role of psychosocial factors in long-term care use. Available at: www.findarticles.com/p/articles/mi_m4149/is_5_95105506/

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research inPsychology,* 3: 77-101. Available at: www.QualResearchPsych.com

Broman, C.L. (1996). Coping with personal problems. In H.W. Neighbors & J.S. Jackson(Eds.), Mental Health in Black America (pp.117-129). Thousand Oaks, CA: Sage.

Cauce, A.M., Coronado, N., & Watson, J. (1998). Conceptual, methodological, and statistical issues in culturally competent research. In M. Hemandez & A.R. Isaac(Eds.), promoting cultural competence in children's mental health services (pp.127-151). Baltimore: Brookes Publishing.

Bui, K., & Takeuchi, D. (1992). Ethnic minority adolescents and the use of Community mental health care services. *American Journal of Community Psychology*, 20: 403-416.

Bunger, A.C., Stiffman, A.R., Kirk, A. F., & Shi, P. (2009). Child welfare workers' connectivity to resources and youth's receipt of services. *Advances in Social Work,* 10(1), 19-38.

Burns, B., Costello, E., Angold, A, et al. (1995). Children's mental health service use across service sectors. Health Affairs, 14: 147-159.

Burns, B.J., Phillips, S.D., Wagner, H.R., Barth, R.P., Kolko, D.J., Campbell, Y. et al. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child& Adolescent Psychiatry,* 43: 960-970.

Bunger, A.C., Stiffman, A.R., Kirk, A. F., & Shi, P. (2009). Child welfare workers' connectivity to resources and youth's receipt of services. *Advances in Social Work,*10(1), 19-38.

Carter, J.H. (2002). Religion/spirituality in African-American culture: an essential aspect of psychiatric care. *Journal of the National Medical Association,* 94(5): 371-375.

Cauce, A.M., Domenench-Rodriquez, M., Paradise, M., Cochran, B.N., Shea, J.M., Srebnik, D.,& Baydar, N. (2002). Cultural and contextual influences in mental health help-seeking: A focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology*, 70(1),44-55.

Cauffman, E. (2004). A statewide screening of mental health symptoms among juvenile offenders in detention. *Journal of American Academy of Child and Adolescent Psychiatry*, 43(4),430-439.

Chassin, L. (2008). Juvenile justice and substance use. *The Future of Children* 18(2), 165-183.Cheng, D., Leong, F.T., & Geist, R. (1993). Cultural differences in psychological distress between Asian and Caucasian American

students. *Journal of Multicultural Counseling & Development,* 21(3), 182-190.

Chen, J., & Rizzo, J. (2010). Racial and ethnic disparities in use of psychotherapy: Evidence from U.S. National survey data. *Psychiatric Services*, 61: 364-372.

Cheng, D., Leong, F.T. & Geist, R. (1993). Cultural differences in psychological distress between Asian and Caucasian American students. *Journal of Multicultural Counseling &Development,* 21(3): 182-190.

Child Welfare League of America (2002). Promising approaches in child welfare. *U.S. Dept. of Health and Human Services*. Administration for children and families. Washington, DC.

Chow, J. C., Jaffee, K., & Snowden, L. (2003). Racial/Ethnic disparities in the use of mental health services in poverty areas. *American Journal of Public Health: Research and Practice*, 93(5), 792- 797.

Conner, K. O., Lee, B., Mayers, V., Robinson, D., Reynolds, C. F., Albert, S., & Brown, C. (2010). Attitudes and beliefs about mental health among African American older adults suffering from depression. *Journal of Aging Studies*, 24(4), 266-277.

Corbie-Smith, G., Thomas, S. B., & St. George, D.M. (2002). Distrust, Race, and Research. *Arch of International Medicine,* 162(21), 2458-2463.

Corenlius, L. J. (2000). Having limited choices for medical care. Does it lead to delays in seeking care for minority populations? In C. Houge (Ed), Minority

health in America. Baltimore: John Hopkin University Press.

Cortes, L. (2004). Home-based family therapy: A misunderstanding of the role and a new challenge for therapists. *The Family Journal:* Counseling and therapy for couples and families, 12920, 184-188.

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist,* 59(7), 614-625.

Corrigan, P.W. & Watson, A.C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice*, 9, 35-53.

Cook, B.L., McGuire, T., & Miranda, J. (2007). Measuring trends in mental health care disparities, 2000-2004. *Psychiatric Services*, 58: 1533-1540.

Cummings, J.R., Ponce, N.A., & Mays, V.M. (2010). Comparing racial/ethnic differences in mental health service use among high-need subpopulations across clinical and school-based settings. *Journal of Adolescent Health*, 46: 603-606.

Cutrona, C.E., Wallace, G., & Wesner, K. A. (2006). Neighborhood characteristics and depression: An examination of stress processes. National Institute of Health: I*nstitute for Social and Behavioral Research*, N. Loop Dr. Suite 500, IA: Ames.

Cutrona, C.E., Russell, D.W., Brown, P.A., Clark, L.A., Hessling R. M., & Gardner, D.A. (2005). Neighborhood context, personality, and stressful life events as predictors of depression among African American women. *Journal of Abnormal Psychology*, 114: 3-15.

Department of Health and Human Services (2001). Mental health: culture, race, and ethnicity – A Supplement to mental health" A Report of the Surgeon General. USDepartment ofHealth and Human Services, Rockville, MD.

Desai, R. A., Goulet, J. L., Robbins, J., Chapman, J. F., Migdole, S. J., & Hoge, M. A.(2006).Mental health care in juvenile detention facilities: A Review. *Journal of the American Academy of Psychiatry and the Law*, 34(2), 204-214. Available online athttp://www.jaapl.org/cgi/content/full/34/2/204

DeNavas-Walt, C., Proctor, B.D., Lee, C.H. (2005). Income, poverty, and health insurance coverage in the United States: 2004 U.S. Census Bureau, Current Population Report, p. 60-229, Washington, DC: U.S. Government Printing Office.

Dixon, L., Green-Paden, L., Delahanty, J., Lucksted, A., Postrado, L., & Hall, J. (2001). Variables associated with disparities in treatment of patients with schizophrenia and comorbid mood and anxiety disorders. *Psychiatric Services,* 52: 1216-1222.

Dobalian, A., & Rivers, P. A., (2008). Racial and ethnic disparities in the use of mental health services. *Journal of Behavioral Health Services & Research, 35(2), 128-141*

dosReis, S., Zito, J.M., Safer, D.J., & Soeken, J.L. (2001). Mental health services for youths in foster care and disabled youths. *American Journal of Public Health*, 91: 1094-1099.

Draucker, C.B. (2005). Processes of mental health service use by adolescents with

depression. *Journal of Nursing Scholarship*, 37(2), 155-162.

Duncan, L.E., & Johnson, D. (2007). Black undergraduate students attitude toward counseling and counselor preference. *College Student Journal,* 41(3), 696-719.

Elster, A., Jarosik, J., GanGesst, J., & Fleming, M. (2003). Racial and ethnic disparities inhealthcare for adolescents. *Archives of Pediatrics & Adolescent Medicine,* 157(9): 867-874.

Evashwick, C., Rowe, G., Diehr, P., & Branch, L. (2005). Factors explaining the use of health care services by the elderly. *Journal of Community Health,* 7(2): 80-92.

Fade, A.S. & Swift, J.A. (2010). Qualitative research in nutrition and dietetics: Dataanalysis issues. *Journal of Human Nutrition & Dietetics,* 24, pp. 106-114. TheBritish Dietetic Assn. Ltd.

Fazel, S., Doll, H. & Langstrom, N. (2008). Mental disorders among adolescents in juvenile detention and correctional facilities: A systematic review and metaregression analysis of 25surveys. *Journal of American Academy of Child andAdolescent Psychiatry*, 47, (9), 1010-1019.

Feldmann, J.M. (2008). Caring for incarcerated youth. Current *Opinion in Pediatrics,*20(4), 398-402.

Fishbein, M. & Ajzen, I. (1980). Understanding attitude and predicting social behavior. Englewood Cliffs, NJ: Prentice-Hall.

Fisher, J.D. (1988). Possible effects of reference group-based social influence on

AIDS-risk behavior and AIDS prevention. *American Psychologist,* 43: 914-920.

Fombonne, E., Wostear, G., Cooper, V., Harrington, R., & Rutter, M. (2001). The Maudsley long-termfollow-up of child and adolescent depression:

1. Psychiatric outcomes in adulthood. *British Journal of Psychiatry,* 179(3), 210-217.

Gamble, V. (1997). Under the shadow of Tuskegee: African American and health care. *American Journal of Public Health*, 87(11), 1173-1178.

Garland, A.F., Lau, A.S., Kristen, M.Mc., Hough, R.L., & Landsverk, J.A. (2005). Racialand ethnic differences in utilization of mental health services among high-risk *American Journal of Psychiatry,*162: 1336-1343.

Gilbert, N., Terrell, P. (2005). Dimensions of social welfare policy. (6th Eds.), Boston: Pearson Education, Inc.

Glover v Johnson (1998). No. 77-71229. U.S. Court of Appeals for the 6th Circuit.

Golzari, M., Hunt, S. J., & Anoshiravani, A. (2006). The health status of youth in Juvenile detention facilities. *Journal of Adolescent Health*, 38, 776-782.

Gong, F., Gage, S.L., & Tacata, L.A. (2003). Helpseeking behavior among Filipino-Americans: A cultural analysis of face and language. *Journal of Community Psychology*, 31, 469-488.

Gonzalez, J.M., Alegria, M., & Prihoda, T. J. (2005). How do attitudes towards mental health treatment vary by age, gender, and ethnicity/race in young adults? *Journal of Community Psychology,* 33(5), 611- 629.

Gough, N. (2000). Methodologies under the microscope. Paper presented at Deakin University Postgraduate Association research conference. Deakin University, Sydney, Australia.

Green, J.W. (1995). Cultural awareness in the human services: A multi-ethnic approach.(3rd Ed).Needham Heights, MA: Allyn & Bacon.

Grinnell, R.M. (1997). Social research and evaluation. (4th Eds.) Itasca, Illinois: Peacock Publishers Inc.

Grob, E.N. (1994). The Mad among us: A history of the care of America's mentally ill. Cambridge, MA: Harvard University Press.

Guba, E. G., & Lincoln, Y.S. (1994). Competing paradigms in qualitative research. In: J.K. Denzin & Y.S. Lincoln (eds.), *Handbook of Qualitative Research,* ThousandOaks, CA: Sage, pp. 105-117.

Gudino, O.G., Lau, S.A., Yeh, M., McCabe, K. M., & Hough, R. L. (2009). Understanding racial/ethnic disparities in youth mental health services. *Journal of Emotional and Behavioral Disorders, 17(1), 3-16.*

Guerra, N.G., & Jagers, R. (1998). The importance of culture in assessment of children and youth. InV.C. McLoyd & L. Steinberg (Eds.), Studying minority adolescents: Conceptual, methodological and theoretical issues (pp. 123-142) Mahwah, NJ: Erlbaum.

Gupta, R.A., Kelleher, K J., Stevens, J., & Ceullar A. (2005). Delinquent youth in corrections: Medicaid and reentry into the community. Pediatrics, 115(4), 1077-1083.

Hale, J..L., Householder, B.J., & Green, K.L. (2003). The theory of reasoned action. In J. P. Dillard & M. Pfau (Eds.): The persuasion handbook: Developments in theory and practice pp.259-286). Thousand Oaks, CA: Sage.

Halfon, N., Zepeda, A., & Inkelas, M. (2002). Mental health services for children in foster care (Public Statement No. 4). Los Angeles: University of California, Los Angeles, Center for Healthier Children, Families and Communities.

Hatzenbuehler, M.L., Keyes, K. M., Narrow, W.E., Grant, B.F., & Hasin, D.S. (2008).Racial/ethnic disparities in service utilization for individuals with co-occurring mental health and substance-use disorders in the general population: results from the National epidemiologic survey on alcohol and related conditions. *Journal of Clinical Psychiatry*, 69(7), 1112-1121.

Have, M. ten, Graaf, R.de, Ormel, J., & Vilagut, G. (2009). Are attitudes toward mental health help-seeking associated with service use? Results from the European study of epidemiology of mental disorders. Available online at: www.Springerlink.com.

Hazen, A.L., Hough, R.L., Landsverk, J.A., & Wood, P.A. (2004). Use of mental Health services by youths in public sectors of care. *Mental Health Services Research,* 6(4):213-226.

Hegge, L. et al., (2001). Children's Mental Health Ontario. Report on evidence based practice for depression in children and adolescents. Findings from

literature and clinical consultations.

Hinshaw, S.P. (2005). The stigmatization of mental illness in children and parents: Developmental issues, family concerns, and research needs. *Journal of Child Psychology and Psychiatry,* 46(7), 714-734.

Ho, J., Yeh, M., McCabe, K., & Hough R.L. (2007). Parental cultural affiliation and youth mental health service use. *Journal of Youth Adolescence*, 36: 529-542.

Hodges, K. (1994). Child and adolescent functional assessment scale. Ypsilanti: Eastern Michigan University, Department of Psychology.

Hunt, L. (1984). Politics, culture, and class in the French Revolution. Berkeley: University of California Press.

Hwang, W., Abe-Kim, J., & Takeuchi, D. (2002). Predictors of help seeking for emotional distress among Chinese Americans: Family matters. *Journal of Consulting and Clinical Psychology,* 70(5), 1186-1190.

Institute of Medicine (1993). Committee on monitoring access to personal health care services: Access to health care in America. Michael Millman (Ed). National Academy Press, Washington, DC.

Jackson, V.(2002). In our own voices: African American stories of oppression, survival and recovery in the mental health system, pp 1-36, p.4-8. Available@Http://www.mindfreedom.org/mindfreedom/jackson

Janag, Y., Borenstein, A.R., Chiriboga, D.A., Philips, K., & Mortimer, J.A. (2006). Religiosity, adherence to traditional culture, and psychological well-being

Among African American elders. *The Journal of applied Gerontology*, 25(5), 343-355.

Jang, Y., Chiriboga, D.A., & Okazaki, S. (2009). Attitudes toward mental health services: Age-group differences in Korean American adults. *Journal of Aging and Mental Health* , 13(1): 127-134.

Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet needs for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry,*159(9), 1548-1555.

Kenney, G., Cook, a., & Dubay, L. (2009). Timely analysis of immediate health policy issues. Washington, DC: *The Urban Institute.*

Keesing, R.M. (1974). Theories of culture. Pp. 73-97 in *Annual Review of Anthropology 3.* Palo Alto: Annual Reviews, Inc.

Kerker, B.D., & Dore, M.M. (2006). Mental health needs and treatment of foster youth: Barriersand opportunities. *American Journal of Orthopsychiatry*, 76(1): 138-147.

Kim, B.S.K., Omizo, M.M. (2003). Asian cultural values, attitudes towards seeking professional psychological help, and willingness to see a counselor. *Counseling Psychologist,* 31(3),343-361.

Kodjo, C. & Auinger, P., (2003). Racial/ethnic differences in emotionally distressed adolescents receiving mental health care. *Journal of Adolescent Health,* 32: 132-133.

Koenig, H.G. (2009). Research on religion, spirituality, and mental health: A

review. *Canadian Journal of Psychiatry,* 54(5): 283-291.

Koppelman, J. (2005). Mental health and juvenile justice. Paper presented at National Health Policy forum. The George Washington University, Washington, DC.

Landerman, L.R., Burns, B.J., Swartz, M.S., Wagner, H.R., & George, L.K. (1994). The relationship between insurance coverage and psychiatric disorder in predicting use of mental health services. *American Journal of Psychiatry*, 151, 1785-1790.

Larson, M., Sharma, S., & Miller, K. (2002). Children's mental health services in Medicaid: Report to the Center for mental health services, Rockville, MD: Substance Abuse and Mental Health Services Administration.

LeCook, B., McGuire, T.G., Lock, K., & Zaslavsky, A.M.(2010). Comparing methods of racial and ethnic disparities measurement across different settings of mental health care. *Journal of Health Services Research,* 45(3): 825-847.

Leong, F.T.L., Wagner, N.S., & Tata, S.P. (1995). Racial and ethnic variations in help-seeking attitudes. In. J.G. Ponterotto, J.M. Casas, L.A.,Suzuki, & C.M. Alexander(Eds.), *Handbook of Multicultural Counseling (*pp. 428-432). Thousand Oaks, CA: Sage.

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

Lindsey, M.A., Joe, S. & Nebbitt, V. (2010). Family matters: The role of mental

health stigma and social support on depressive symptoms and subsequent help seeking among African American boys. *Journal of Black Psychology*, 36(4): 458-482.

Logan, D., & King, C. (2001). Parental facilitation of adolescent mental health service utilization: A conceptual and empirical review. *Clinical Psychology: Science &Practice*, 8(3), 319-333.

Lopez, S.R. (2002). A research agenda to improve the accessibility and quality of mental healthcare for Latinos. *Psychiatric Services*, 53(12) 1568-1573.

Lowe, T. B. (2006). Nineteenth century review of mental health care for African Americans: a legacy of service and policy barriers. *Journal of Sociology & Social Welfare.* Available at: www.thefreelibrary.com

Lytch, C.Y. (2008). Not just the blues: Depression and African American women. *Community Connections.* Available at: www.pbhcare.org .

Madrid v Gomez (1995). 899 F Supp 1146. 9617277v2. U.S. Court of Appeals for the 9th Circuit.

Maulik, P.K., Mendelson, T., & Tandon, S.D. (2010). Factors associated with mental health services use among disconnected African-American young adult population. *Journal of Behavioral Health Services & Research,* 38(2): 205-220.

Maxwell, J.A. (2005). Qualitative research design: An interactive approach. (2nd Eds.). Thousand Oaks, CA: Sage Publications Inc.

Mechanic, D. (2003). Is the prevalence of mental disorders a good measure of the

need for services? *Health Affairs*, 22(5), 8-20.

McGoldrick, M., Giordano, J., & Pearce, J.K. (Eds.).(1996). Ethnicity and family therapy (2nd edition). NY: Gilford Press.

McGuire, T., & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: Policy implications. *Health Affair,* 27 (2), 393-403.

McMackin, R. A. & Pittel, E. (2007). A public health approach to address the mentalhealth needs of juvenile offenders. *Commission Report.* Massachusetts Department of Public Health (Lemuel Shattuck Hospital). Jamaica Plain, Boston.

McReynolds, L.S., Wasserman, G.A., DeComo, R.E., John, R., Keating, J.M. & Nolen, S. (2008). Psychiatric disorder in a juvenile assessment center. *Crime & Delinquency*, 54(2), 313-334.

Mears, D. P. & Travis, J. (2004). The dimensions, pathways, and consequences of youth reentry. *Research Report.* Washington DC: Justice Policy Center, The Urban Institute.

Miller, J.R. (2004). Attitudes and beliefs lawyers have about seeking professional Mental health services. Doctoral dissertation, Marquette University, Milwaukee, Wisconsin.

Mojtabai, R., Olfson, M., Mechanic, D. (2002). Perceived need and help-seeking in adults with mood, anxiety, or substance use disorders. *Archive of General Psychiatry*, 59(1): 77-84.

Morisky, D.E. (1980). Understanding attitudes and predicting social behavior. Englewood Cliffs, NJ: Prentice-Hall.

Moses, T. (2009) Self-labeling and its effects among adolescents diagnosed with Mental disorders. *Social Science & Medicine* , 68(3), 570-578.

Mullan, B. & Westwood, J. (2010). The application of the theory of reasoned action to school nurses' behavior. *Journal of Research in Nursing,* 15(3), 261-271.

Munson, M. R., Floersch, J. E., &Townsend, L. (2009). Attitudes towards mental health services and illness perceptions among adolescents with mood disorders. *Child Adolescent Social Work Journal,* 26(5): 447-466.

National Center for Mental Health and Juvenile Justice: Collaborating to achieve and communicate positive public health and public safety outcomes. *Bureau of Justice Assistance*, U.S. Department of Justice, Baltimore, MD.

National Institute on Alcohol Abuse and Alcoholism (2005). Module 10H: Ethnicity, Culture and Alcohol. Available @ http://pubs.niaaa.nih.gov/publications/Social /Module10

National Institute on Alcohol Abuse and Alcoholism (1990). Alcohol alert No. 09-1990. Available at http://pubs.niaaa.nih.gov/publications/aa09.htm

National Survey of Child and Adolescent Well-Being (NSCAW) (2003). Baseline reportfor one-year-in-foster-care sample. Retrieve from: www.acf.hhs.gov/program/core/ongoing- research/afc/wellbeing-reports.html

Neal, A.M., & Turner, S.M. (1991). Anxiety disorders research with African-

Americas:Current Status Psycho Bull. 109: 4—0410.

Nebbitt, V.E. & Lombe, M. (2008). Assessing the moderating effects of depressive symptoms on antisocial behavior among urban youth in public housing. *Child and Adolescent Social Work Journal, 25: 409-424.*

Neighbor, H.W., Woodward, A.T., Bullard, K.M., Ford, B.C., Taylor, R.J., & Jackson, J.S. (2008). Mental health service use among older African Americans: the National Survey of American Life. *American Journal of Geriatric Psychiatry* , 16(12): 948-956.

Neighbor, H.W., Caldwell, C., Williams, D. R., Nesse, R., Taylor, R.J., Bullard, K.M. et al., (2007). Race, ethnicity, and the use of services for mental disorders: Results from the National Survey of American Life. *Archive of General Psychiatry,* 64: 485-494.

Neuman, W.L. (2003). Social research methods: Qualitative and quantitative approaches. (5th Eds.), Boston: Allyn & Bacon.

Oetting, E.R., Donnermeyer, J.F., Timble, J.E., & Beauvaris, F. (1998). Primary socialization theory: Culture, ethnicity, and cultural identification. The links between culture and substance use. *IV substance use & misuse,* 33(10): 2075-2107.

Office of Juvenile Justice and Delinquency Prevention (2004). *Juvenile Justice Bulletin.* S. Department of Justice. Office of Justice programs, Washington, DC.

Olafsdottir, S., & Pescosolido, B.A. (2009). Drawing the line: The cultural

cartography of utilization recommendations for mental health problems. *Journal of Health and Social Behavior*. 50: 228- 244.

Olfson, M., Cherry, D.K., & Lewis-Fernandez, R. (2009). Racial differences in Visit duration of outpatient psychiatric visits. *Archives of General Psychiatry* ,66(2):214-221.

Olfson, M., Shaffer, D., Marcus, S. C., & Greenberg, T. (2003). Relationship between antidepressant medication treatment and suicide in adolescents. *Archives of General Psychiatry*, 60: 978-982.

Ozechowski, T. J., Liddle, H. A. (2000). Family-based therapy for adolescent drug abuse: Knowns and unknowns. Clinical Child and Family Psychology Review, 3(4):

Paskar, L., Abram, K. & Teplin, L. (2009). Utilization and effectiveness of mental health services for detained youths with substance use disorders. Paper presented at the annual meeting ofthe American Psychology-Law Society. Retrieved: http://www.allacademic.com/meta/index.html.

Patton, M. Q. (2002). Qualitative research & evaluation methods. (3rd Ed.). Thousand Oaks, CA: Sage Publications, Inc.

Pescosolido, B.A., Fettes, D. I., Martin, J. K., Monahan, J. & McLeod, J. D. (2007). Perceived dangerousness of children with mental health problems and support for coerced treatment. *Psychiatric Services,* 58:610-625.

Pescosolido, B. A., Perry, B. C., Martin, J.K.., et al. (2007). Stigmatizing attitudes and beliefs about treatment and psychiatric medications for children with

mental illness. *Psychiatric Services,* 58: 611-612.

Pescosolido, B.A., & Boyer, C.A. (1999). How do people come to use mental Health services? Current knowledge and changing perspectives. In A. Horwitz & T. Scheid(Eds). A Handbook for the study of mental health: Social context, theories, and systems (p. 392- 411). New Yor: Cambridge University Press.

Pescosolido, B.A., Gardner, C.B., & Lubell, K.M. (1998). How people get into mental health services: Stories of choice, coercion and "muddling through" from "first timers." *Social Science and Medicine*, 46(2), 275-286.

Pescosolido, B.A., Wright, E.R., Alegria, M. & Vera, M. (1998). Social networks and patterns of use among the poor with mental health problems in Puerto Rico. *Medical Care*, 36(7):1057-1072.

Pieterse, A. L., Todd, R.N., Neville, H. A., & Carter, R.Y. (2012). Perceived racism and mental health among Black American Adults: A meta-analytic review. *Journal of Counseling Psychology*, 59(1): 1 – 9.

Portes, A., Kyle, D., & Eaton, W.W. (1992). Mental illness and help-seeking behavior among mariel Cuban and Haitian refugees in South Florida. *Journal of Health and Social behavior,* 33, 283-98.

President's New Freedom Commission on Mental Health (2003). *Commission report.* Subcommittee on criminal justice: Available at http://www.mental healthcommission.gov/report/final report. pdf. Accessed August 12, 2010.

Public Law 93-415. U.S. Code, 5031-5042. The Federal Juvenile Justice and

Delinquency Prevention Act, 1974. Available online at www.nicic.org/Library/000045

Pumariega, A.J., Rogers, K., Rothe, E. (2005). Culturally competent systems of care for children's mental health: Advances and challenges. *Community Mental Health Journal,*41(5), 539-555.

Pumariega, A., Glover, S., Holzer, C., & Nguyen, H. (1998). Utilization of mental Health services in a tri-ethnic sample of adolescents. *Community Mental Health Journal*, 34: 145-156.

Randall, J., Henggeler, S., Pickrel, S., & Brondino, M. (1999). Psychiatric comorbidity and the 16-month trajectory of substance-abusing and substance-dependent juvenile offenders. *Journal of the American Academy of Child and Adolescent.*

Rapp-Palicchi, L. & Roberts, A. R. (2004). Mental illness and juvenile offending. In A.R. Roberts (Ed.). *Juvenile Justice Source Book: Past, Present, and Future*. Pp. 289-308.Available at http://uscourts.gov/fedprob/September 2006/Sisyphus.html

Rawal, P., Romansky, J., Jenuwine, M., & Lyons, J.S. (2004). Racial differences in the mental health needs and service utilization of youth in the juvenile justice system. *Journal of Behavioral Health Services & Research*, 31(3), 242-254.

Regier, D.A. (2003). Mental disorder diagnostic theory and practical reality: An Evolutionary perspective. *Health Affairs,* 22(5): 21-27.

Ringeisen, H., Casanueva, C.E., Urato, M., & Stambaugh, L.R. (2009). Mental

health service use during the transition to adulthood for adolescents reported to the Child Welfare System. *Psychiatric Services,* 60(8): 1084-1091.

Robertson, A.A., Dill, P.L., Husain, J., & Undesser, C., (2004). Prevalence of mental illness and substance abuse disorders among incarcerated juvenile offenders in Mississippi. *Child Psychiatry and Human Development,* 35(1), 55-74.

Roeloffs, C., Sherbourne, C., Unutzer, J., Fink, A., Tang, L., & Wells, K.B. (2003). Stigma and depression among primary care patients. *General Hospital Psychiatry*, 25: 311-315.

Rogers, K. M., Pumariega, A. J., Atkin, D. L., & Cuffe, S.P. (2006). Conditions associated with identification of mentally ill youths in juvenile detention. *Community Mental Health Journal*, 42(1),25-39.

Rogler, L., & Cortes, D. (1993). Help-seeking pathways: A unifying concept in mental healthcare. *American Journal of Psychiatry, 150, 554-561.*

Rosenbaum, E., Harris, L. E. (2001). Low-income families in their new neighborhoods. The short-term effects of moving from Chicago's public housing. *Journal of Family Issues*, 22(2): 183-210.

Ross, C. E. (2000). Neighborhood disadvantage and adult depression. *Journal of Health and Social Behavior*, 41: 177-187.

Ryan, J. (2009). The Children's health insurance program (CHIP): The fundamentals. National health policy forum. George Washington University, Washington, DC. Available online atwww.nhpf.org

Rusert, B. (2009). A study in nature: The Tuskegee Experiments and the New South Plantation. *Journal of Medical Humanities,* 30(3): 155-71.

Sable, M.R., Schwartz, L.R., Kelly, P.J., Lisbon, E., & Hall, M.A. (2006). Using the theory of reasoned action to explain physician intention to prescribe emergency contraception. *Perspectives on Sexual and Reproductive Health*, 38(1), 20-27.

Salzman, A. (2005). Special education and minorities. The New York Times, November 20, 2005.

Satcher, D. (2001). *Mental Health*. A report of the Surgeon General. Washington, DC.U.S.GovernmentPrinting Office.

Savitt, T.L. (2002). Medicine and slavery: The disease and health care of Blacks in Antebellum,Virginia. (Revised Ed.). University of Illinois Press.

Schaefer, R.T. (2000). Sociology: A brief introduction. (3rd Ed.). Boston: McGraw-Hill HigherEducation.

Schwartz, R.C., & Feisthamel, K.P. (2009). Disproportionate diagnosis of mental disorders among African American versus European American clients: Implications for counseling theory, research, and practice. *Journal of Counseling and Development,* 87: 295-301.

Scott, L. D. & Davis, L. E. (2006). Young, black, and male in foster care: Relationship of negative social contextual experiences to factors relevant to mental health service delivery. *Journal of Adolescence*, 29, 721-736.

Scott, L.D., Munson, M.R., McMillen, J.C., & Snowden, L. R. (2007).

Predisposition to seek mental health care among Black males transitioning from foster care. *Child Youth Service Review,* 29(7): 870-882.

Secker, J., Wimbush, E., Watson, J. & Milburn, K. (1995). Qualitative methods in Health promotion research: Some criteria for quality. *Health Education Journal, 54: 74-87.*

Sentell, T., Shumway, J., & Snowden, L. (2007). Access to mental health treatment by English language proficiency and race/ethnicity. *Journal of General Internal Medicine*, 22(Supp. 2): 289-293.

Sheppard, B.H., Hartwick, J., & Warshaw, P.R. (1988). The theory of reasoned action: A meta- analysis of past research with recommendations for modifications and future research. *Journal of Consumer Research*, 15(3): 325-343.

Shufelt, M.S. & Cocozza, J.J. (2006). Youth with mental health disorders in the Juvenile justice system: Result from the multi-state prevalence study. *Research and Program Brief*. National Center for Mental Health and Juvenile Justice. Washington, DC.

Smith, L., Peck, P., & McGovern, R. (2004). Factors contributing to the utilization of mental health service in a rural setting. *Psychological Reports*, 95, 435-442.

Smedley, B.D., Stith, A.Y., &Neslon, A.R. (Eds.) (2003). Unequal treatment: Confronting racial and ethnic disparities in health care. Washington: National Academies Press.

Snowden, L.R., Masland, M. C., Fawley, K., & Wallace, N. (2009). Ethnic differences in children's entry into public mental health care via emergency mental health services. *Journal of Child and Family Studies,* 18: 512-519.

Snowden, L.R. & Yamada, A. (2005). Cultural differences in access to care. *Annual Review of Clinical Psychology*, 1: 143-166.

Snowden, L.R. (2003). Bias in mental health assessment and intervention: Theory and evidence. *American Journal of Public Health,* 93: 239-243.

Snowden, L. (2001). Barriers to effective mental health services for African Americans. *Mental Health Services Research*, 3(4), 181-187.

Snyder, H.N. (2004). An empirical portrait of the youth reentry population. *Youth Violence and Juvenile Justice*, 2 (1), 39-55.

Stiffman, A. R., Freedenthal, S., Dore, P., Ostmann, E., Osborne, V., & Silmere, H. (2006). The role of providers in mental health services offered to American-Indian youths. *Psychiatric Services,* 57(8), 1185-1191.

Stiffman, A.R., Pescosolido, B.A., & Cabassa, L.J. (2004). Building a model to understand youth service access: The Gateway Provider Model. *Mental Health Service Research,* 6: 189- 198.

Stockdale, S.E., Lagomasino, I.T., Siddique, J., McGuire, T., & Miranda, J. (2008). Ethnic disparities in detection and treatment of depression and among psychiatric and primary health care visits, 1995-2005. *Medical Care*, 46, (7), 668-677.

Strauss, A.L. & Corbin, J. (1998). Basics of qualitative research: Techniques and

procedures for developing grounded theory. Thousand Oaks, CA: Sage.

Sue, D.W., & Sue, D. (2003). Counseling the culturally diverse: Theory and Practice. New York: Wiley.

Sue, S. (1999). Science, ethnicity, and bias: Where have we gone wrong? *American Psychologist,* 54: 1070-1077.

Sue,S., Fujino, D.C., Hu. L., Takeuchi, D.T., & Zane, N.W.S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology*, 59, 533-541.

Suite, D. H., Bril, R. L., Primm, A., Harrison-Toss, P. (2007). Beyond misdiagnosis, misunderstanding and mistrust: Relevance of the historical perspective in the medical and mental health treatment of people of color. *Journal of the National Medical Association, 99(8): 879-885.*

Sussman, L.K., Robin, L.N., Earls, F. (1987). Treatment-seeking for depression by black and white Americans. Social science & Medicine, 24: 187-196.

Swindler, A. (1986). Culture in action: Symbols and strategies. *American Sociological Review*,51(20, 273-286.

Szasz, T.S. (1960). The myth of mental illness. *The American Psychologist*, 15(2), 113-118.

Teplin, L. A., Abran, K. A., McClelland, G. M., Washburn, J. J., Pikus, A. K. (2005).Detecting mental disorder in juvenile detainees: Who receives services? *American Journal of Public Health,* 95(10) 1773-1780.

Terrell, F., & Terrell, s. (1981). An inventory to measure cultural mistrust among Blacks. *The Western Journal of Black Studies,* 5(3), 180-185.

Tidwell, R. (2004). The "No-show" phenomenon and the issue of resistance among African-American female patients at an urban health care center. *Journal of Mental Health Counseling.* Available at www.thefreelibrary.com

Thomas, J., Gourley, G. K. & Mele, N. (2005). The availability of behavioral health services for youth in the juvenile justice system. *American Psychiatric Nurses Association Journal,*11(3), 156. Online at http://find.galegroup.com.ezproxy.bu.edu/itx/start.doprodId=AONE>.

Thompson, R., Dancy, B.L., Wiley, T.R., Perry, S.P., & Najdowski, C.J. (2011). The experience of mental health service use for African American mothers and youth. *Issues in Mental Health Nursing, 32(11): 678-686.*

Townes, D.L., Chavez-Korell, S., & Cunningham, N.J. (2009). Reexamining the relationships between racial identity, cultural mistrust, help seeking attitudes, and preference for a black counselor. Journal of Counseling Psychology, 56(2): 330-336.

Tucker, C. & Dixon, A.L. (2009). Low-income African American male youth with ADHD symptoms in the United States: recommendations for clinical mental health counselors. *Journal of Mental Health Counseling.* Available at: www.thefreelibrary.com

Turner, E.A., & Liew, J. (2010). Children's adjustment and child mental health service use: The role of parents' attitudes and personal service use in an

upper middle class sample. *Community Mental Health Journal,* 46, 231-240.

U.S. Department of Health and Human Services (2001). Mental health: A report of the Surgeon General. Rockville, MD: US Dept of Health and Human Services.

Varon, S.R. & Riley, A.W. (1999). Relationship between maternal church attendance and Adolescent mental health and social functioning. Psychiatric Services, 50: 799-805.

Veysey, B.M. (2003). Adolescent girls with mental health disorders involved with the juvenile justice system. National Center for Mental Health and Juvenile Justice. 9NC-MHJJ.

Vogel, D.L., & Wester, S.R. (2003). To seek help or not to seek help: The risks of self-disclosure. *Journal of Counseling Psychology*, 50(3): 351-361.

Ward, E.C., Clark, L., & Heidrich, S. (2009). African American Women's belief, Coping behaviors, and barriers to seeking mental health services. Qual Health Resources. National Institute of Health. Available at www.sagepub.com/journalsPermissions.nav.

Washington, H. (2006). Medial apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present New York, NY: Doubled day.

Wasserman, G.A., McReynolds, L.S., Schwalbe, C. S., Keating, J. M., & Jones, S. S. (2010). Psychiatric disorder, comorbidity, and suicidal behavior in

juvenile justice youth. *Criminal Justice and Behavior,*37: 1361-1376.

Weinstein, N.D. (1993). Testing four competing theories of health protective behaviors. *Health Psychology ,* 12: 325-333.

Werner, P., & Mendelsson, G. (2001). Nursing staff members' intentions to use physical restraint with older people: testing the theory of reasoned action. *Journal of Advanced Nursing* 35(5) 784-791.

Westermeyer, J. (1987). Cultural factors in clinical assessment. *Journal of Consulting and Clinical Psychology*, 55(4): 471-478.

Whaley, A. L. (2004). Paranoia in African-American men receiving inpatient Psychiatric treatment. *Journal of the American Academy of Psychiatry and the Law*, 32:282- 92.

Whaley, A.C. (2001). Cultural mistrust of White mental health clinicians among African Americans with severe mental illness. *American Journal of Orthopsychiatry*, 71(2): 252- 256.

Whaley, A.L. (2001). Cultural mistrust and the clinical diagnosis of paranoid schizophrenia in African American patients. *Journal of Psychopathology and Behavioral Assessment*, 23(2): 93-100.

White, H.R., Shi, J., Hirschfield, P., Mun, E.Y., & Loeber, R. (2010). Effects of institutional confinement for delinquency on levels of depression and anxiety among male adolescents. *Youth Violence and Juvenile Justice,* 8(4): 295-313.

William, D. R., & Williams-Morris, R. (2000). Racism and mental health: The

African American experience. *Eth. Health,* 5(3-4), 243-268.

Wittink, M,N., Joo, J.H., Lewis, L.M., & Barg, F.K. (2009). Losing faith and using faith: Older African Americans discuss spirituality, religious activities, and depression. *Journal of General Internal Medicine,*24(3), 402-407.

Young, D. W., Dembo, R., & Henderson, C. E. (2007). A national survey of substance abuse treatment for juvenile offenders. *Journal of Substance Abuse Treatment,* 32,255-266.

Zhang, N., & Dixon, D.N. (2003). Acculturation and attitudes of Asian international students towards seeking psychological help. *Journal of Multicultural Counseling and Development* 31, 205-222.

Zwillich, T. (2000). US healthcare system missing most mentally ill children and adolescents. Washington, DC: Reuters Medical News. Available at http://psychiatry.medscape.com/reuters/prof

**Curriculum Vitae**