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Walden University

College of Social and Behavioral Sciences

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Patricia Parker

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Walden University
2015

Abstract

Mental Health Treatment Adherence and Minority Clients' Perception of

Clinician Cultural Awareness

by

Patricia Parker

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

May 2015

Abstract

Psychological counseling is known to be an effective option for people in need of emotional support. Previous research has shown counseling to be valuable among various age, sex, religious, socioeconomic, and racial groups. Despite its successes, members of certain demographic groups reportedly end supportive psychological therapies early. The purpose of this study was to investigate the experiences of 10 self-identified African American and Hispanic clients who prematurely terminated therapy. A particular focus of this investigation was the clients' perceptions of clinician cultural awareness. This phenomenological study yielded descriptive data in a context sufficient for analysis with the use of broad or axial coding systems. Participants indicated that the experience of benign and malign forms of cultural insensitivity precipitated their decision to terminate treatment early. Findings supported that therapists need to have greater cultural sensitivity toward the specific needs of African Americans and Hispanics in the therapy room. Additionally, some of the data was lacking in richness, which may indicate the possibilities that clients from these groups lack (a) full awareness of their roles within the power system of therapy, (b) may need encouragement to articulate a more critical point of view, or (c) the luxury to introspect about the nature of their experiences, which inhibits their responses. Based on these possibilities, future recommendations are presented for gathering richer data from minority clients who terminate therapy early. Improving cultural sensitivity, which may be a matter of respect and transparency more than culturally specific knowledge, has implications for social change by leading to higher retention and, therefore, better treatment outcomes in therapy.

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Dedication

I would like to dedicate this dissertation to my family.

Acknowledgments

I would like to take this opportunity to thank both my chairperson, Dr. Tiffany-Rush-Wilson, and Dr. Jay Greiner, both of whom have always shown confidence in me. They have offered their patience, remarks, propositions, and understanding. I would also like to mention my mother, Eunice Parker, and brother, Jesse Parker, both of whom have always believed in me for all my hard work. My family, including my other brothers and sister, has endlessly supported me during my life and academics. This support has helped me in making positive decisions for my life. I would also like to mention my peers and coworkers; I appreciate their collaboration and expert advice on every circumstance. I am also grateful towards my university and my department, including administrators, faculty members, and fellow students, for their support throughout this study.

Table of Contents

List of Tables	v
List of Figures	vi
Chapter 1: Introduction	1
Background	1
Statement of the Problem.....	5
Nature of the Study	6
Research Questions.....	6
Purpose of the Study	7
Theoretical Framework.....	8
Definitions.....	10
Assumptions, Delimitations and Limitations.....	15
Assumptions.....	15
Delimitations.....	15
Limitations	16
Significance of the Study.....	16
Summary and Transition.....	17
Chapter 2: Literature Review.....	19
Overview of the Literature.....	19
Cultural Psychology and Racial/Ethnic Needs	20
Mental Health Care Experiences of African Americans.....	24

Methods of Addressing Cultural and Social Disconnects in Mental Health Care.....	29
African American and Hispanic Response to Psychotropic Medications	31
Summary	33
Chapter 3: Research Method.....	35
Introduction.....	35
Role of the Researcher	37
Research Questions	39
Sample and Sample Selection	39
Inclusion and Exclusion Criteria.....	40
Instrumentation	41
Data Collection	42
Data Analysis	43
Ethical Considerations	44
Summary	45
Chapter 4: Results	46
Introduction.....	46
Descriptive Statistics.....	47
Overview.....	47
Cross-Tabulations and Other Two-way Graphs	52
Coding and Data Analysis	57
Coding and Data Analysis: RQ1.....	57

Key excerpts from participants' narratives	57
Coding and Data Analysis: RQ2.....	60
Key excerpts from participants' narratives	60
Coding and Data Analysis: RQ3.....	61
Key excerpts from participants' narratives	62
Discussion of Themes.....	64
Professionalism.....	65
Misalignment	66
Discrepant Themes and Cases	68
Summary of Results.....	69
Conclusion	69
Chapter 5: Discussion, Conclusions and Recommendations	71
Introduction.....	71
Summary of Findings.....	71
Limitations	71
Relevance of Findings to Previous Research.....	74
Recommendations for Future Research.....	77
Reflection and Conclusion.....	80
References.....	82

Appendices:

Appendix A: Client Perception of Mental Health Counselor’s Culture Awareness	
Interview.....	95
Appendix B: Transcripts of Interviews.....	97
Curriculum Vitae	130

List of Tables

Table 1. <i>Themes for RQ1</i>	60
Table 2. <i>Themes for RQ2</i>	61
Table 3. <i>Themes for RQ3</i>	63
Table 4. <i>Sub-themes and Themes in the Study</i>	69

List of Figures

Figure 1. Histogram of age of the sample48

Figure 2. Pie chart, ethnicity.....49

Figure 3. Pie chart, gender.....49

Figure 4. Pie chart, place of birth.50

Figure 5. Pie chart, educational attainment.50

Figure 6. Pie chart, current occupation.....51

Figure 7. Pie chart, first language spoken by subject.51

Figure 8. Pie chart, other languages spoken by subject.....52

Figure 9. Subject’s self-reported English proficiency on a 10-point scale.....53

Figure 10. Mean age of African Americans and Hispanics in the study.....53

Figure 11. Mean age of males and females in the study.54

Figure 12. Mean age by first language spoken.....55

Figure 13. Scatter plot, age by English fluency.....55

Figure 14. Mean English fluency of males and females in the study.....56

Figure 15. Mean English fluency by ethnicity.56

Chapter 1: Introduction to the Study

Background

African American and Hispanic people who enter into counseling are sensitive to the level of cultural awareness evidenced by their clinicians. Results from cultural psychology research have supported this finding for some time because cultural psychology is always embedded in social interactions. As described by Nadir and Hand (2006),

Sociocultural perspectives examine the roles of social and cultural processes as mediators of human activity and thought. In contrast to many pure psychological perspectives that focus on human cognition and behavior at the individual level, sociocultural psychological theories locate the fundamental unit of analysis for the examination of human behavior as activity, or cultural practices. This notion of activity offers a unit of analysis that affords an understanding of the complex intertwining of the individual and the cultural in development. (p. 458)

To this end, in the practical, clinical context of cultural psychology, it is necessary to recognize the role of social engagements such as ethnicity, race, values, and beliefs, as well as other shared interactions in the development of a personal sense of identity. As noted by Banai et al. (2005), a sense of identity that is made possible through a strong ability to develop one's personality and values is one that can move the individual toward a consolidation of their cohesive self-structure. This self-structure, which can be achieved on a psychological level through mental health care, also includes factors such as values,

meaning, talents, and skill. Without a strong cultural identity, and without the recognition of the values of their cultural and racial context within a therapeutic environment, individuals may lack the ability to self-actualize, even when other therapeutic factors are evident. On a fundamental level it is important for mental health service providers to develop proficiencies applicable to multicultural client conceptualization, assessment, and intervention. Failing to account for worldview difference may put mental health service providers at risk of being ineffective and possibly harming their client (Paredes, 2007). This study highlighted the importance of the need to recognize cultural differences.

It has been demonstrated that cultural barriers and biases from mental health care professionals may be a factor in the level of the quality of services that mental health clients receive (Michalopoulou & Falzarano, 2009). There is evidence on several fronts that African American clients are more likely than European American clients to report less effective or less satisfying interactions with their mental health service providers (Michalopoulou & Arfken, 2009; Michalopoulou & Falzarano, 2009; Michalopoulou et al., 2009). For Hispanic Americans as well, similar dissatisfying interactions in a therapeutic context have been reported (Quimby, 2010). This lower quality of interaction, either in perception or in reality, may be traced back to a less-than-adequate level of cultural competency from mental health service providers (Paredes, 2007). Racial concordance between clients and clinicians is more likely to result in the perception of

better interpersonal care for African American clients (Michalopoulou et al., 2009) as well as Hispanic clients (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2011).

The challenge in providing care may, in part, stem from a lack of clarity in the current American Psychological Association (APA) ethics codes (APA, 2002). There are limitations on the way that the APA code of ethics is able to address diversity perspectives and multicultural concerns, likely because these codes have not been updated in almost 20 years. While the foundational principles underlying the ethical codes demonstrate that there is a need for professional practice that embraces and supports difference, both with clients and with collegial activities, it is also clear that there are challenges within the codes that do not provide for specificity in managing diversity. For example, under code 3.01, Unfair Discrimination, the APA calls for psychologists to ensure that they do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any other basis of discrimination proscribed by law. This code relates to the requirement for mental health service providers to practice without prejudice towards clients or towards the information that they are provided in therapy sessions that may include clients' diverse values and actions. As well, in code 3.06, Conflict of Interest, psychologists are required to ensure that they approach relationships professionally when their own interests could impair their objectivity, competence, or effectiveness in performing their functions. Similar ethical standards apply to counselors (ACA, 2005), marriage and family therapists (American

Association for Marriage and Family Therapy, 2001) social workers (National Association of Social Workers, 2008), and psychiatrists (APA, 2010).

Taken together, these codes provide the basis for a psychologist to not only be open to diversity, but also to guarantee professionalism in the case of a conflict of interest (APA, 2002). Presumably, this could include a conflict between a psychologist's personal beliefs about an aspect of diversity, such as value judgments due to the psychologist's personal point of view. Nonetheless, the codes are not specific enough. While one may assume that a psychologist would always remain neutral and professional, this is not always possible. It may be in the best interest of the client, in such cases, for the psychologist to recognize this and recuse himself or herself from treating clients who may not benefit from his or her services. This is especially important because, despite the code of ethics, requirement to pay attention to differences in client needs regarding race, culture, and ethnicity in psychological treatment, research suggests that these factors are often overlooked or ignored in the realm of psychology (Ponterotto, 2001).

Because of the disconnection between professional practice and sociocultural research in psychology, a number of key challenges have developed over time. Research findings have demonstrated that traditional psychological research in the United States envisages a standard client as European American instead of from any other ethnic, cultural, or racial group (Ponterotto, 2001). There is evidence that the biological ethnic differences that occur in response to standard medications are likely not to be taken into consideration when a person is treated in a psychopharmacological manner (Herbeck,

2004). On another level of inquiry, current research findings demonstrate that people of color drop out of mental treatment after the first session significantly more than others, due to the fact that mental health care professionals who are culturally unfamiliar with the importance of race and ethnicity in the lives of people of color can contribute to an ethno-racial gap in clinical practice (Montalvo, 2009). These challenges, both pharmacological and sociocultural, mean that the level of efficacy for psychological care for people from African American and Hispanic backgrounds is likely to be lower than that of people from European American backgrounds and, therefore, that implicit racial bias can mitigate client commitment to ongoing participation in therapy.

Statement of the Problem

The problem addressed in this study was the lack of cultural awareness among mental health care practitioners (also referred to as counselors for the sake of this study), including psychologists, counselors, clinical social workers, and psychiatrists, which leads to a higher dropout rate in treatment among African American and Hispanic clients. As discussed in the literature (Dana, 2005; Mulvaney-Day et al., 2011), some clients do not experience their clinicians as having an understanding of their cultures. These clients have indicated that, as a result, they stopped coming to treatment. Previous research findings have supported this perception as being problematic and have indicated that people of color tend to prematurely terminate therapy and are less likely to maintain contact with treatment facilities (Dana, 2005). This means that the decision to leave therapy is a result of the relationship between the client and therapist. There may,

therefore, be a lack of trust in the therapeutic relationship because of ethnocentrism and stereotyping, as well as residual prejudice or racism (Dana, 2005). This study addressed the low retention rate in therapy from the point of view of the lived experiences of African American and Hispanic clients (Dana, 2005; Mulvaney-Day et al., 2011). The literature indicates that there is a need for further qualitative research that will lead to increased understanding about this issue so that a higher quality of care can be provided to these clients over the long term (Mulvaney-Day et al., 2011).

Nature of the Study.

In this qualitative study, I investigated the lack of cultural awareness among mental health care professionals and the dropout in mental health treatment among African American and Hispanic participants who report that they were previously in counseling. Using their perceptions, these participants were interviewed using three research questions.

Research Questions

RQ1. What cultural barriers do African American and Hispanic clients in treatment perceive about the cultural competence of their clinicians (regardless of the clinician's race)?

RQ2. What cultural values or factors in identity are perceived to be important to African American and Hispanic clients in treatment?

RQ3. Which variables contribute to the dropout of African American clients and Hispanic clients?

Purpose of the Study

The purpose of this phenomenological study was to explore how participants' perceptions of their mental health care professionals' lack of cultural awareness and sensitivity discouraged their willingness to continue in treatment. If a greater understanding of the variables that contribute to an alarming dropout rate for people who self-identify as members of these two groups can be identified, then significant advocacy efforts can be implemented toward social change. For example, in 2011 it was noted that a nationally representative study of 2,107 African Americans found that this group used informal care from ministers more often than formal mental health care provided by psychologists and others within the specialty mental health sector...A telephone survey of 829 adult primary care patients found that African Americans were less likely and Latinos more likely than non-Latino Whites to find counseling an acceptable treatment for depression, and African Americans and Latinos were more likely than non-Latino Whites to think that Counseling brought up too many bad feelings. (Mulvaney-Day et al., 2011, p.32)

Minorities require a stronger voice to support mental health initiatives within their communities. It was a goal of this study to identify perceived barriers to mental health support (both internalized barriers and socially imposed barriers) that can be defined as a step toward dismantling them and their resulting deleterious effects.

Theoretical Framework

There are two theoretical foundations for this study, one based in the broader academic research area of critical race theory (CRT), and one connected with cultural psychology. Both are explained in the following paragraphs.

CRT addresses issues of oppression, domination, and control in a psychological setting. Critical theory, as a basis for CRT, examines research outcomes by determining “what is right” and “what needs to be changed.” CRT examines the inequities of society between European American people and people of color, such as factors pertaining to an over identification of people of color as dropping out of psychological care. The rationale for CRT is that with regard to assessment inequalities, Hilliard (1991) noted, with respect to people of color, “science becomes racist and its tools such as psychological assessments become weapons” (p. 19). Historical messages of inferior intelligence quotients (IQs) suggest that poor African American and other racial minorities such as Hispanics are shown by mainstream society to function below the norm, and therefore are treated differently with respect to medical care (Dana, 2005). Preexisting perceptions therefore further perpetuate attitudinal or racial discrimination among African Americans and disadvantaged populations.

Research regarding race suggests the need for more investigation and further study through qualitative research methods. Qualitative research on this topic is further evidenced in Hilliard (1991); Parker, Dayhle, and Villenas (1999); Ladson-Billings and Tate (2006); DuBois (1903); and West (1993). According to Stone-Mediatore (2000),

inequalities between individuals are defined as “marginalized experience” (p. 111) as indicative of the systematic omission and obscure denial of lived experiences of individuals, which means that there is a need for people whose lives have been marginalized to provide their own narratives to academic research. Lived experiences are documented by journals, life stories, testimonials, and essays, but discredited by “hard scientists.” However, qualitative research, because it engages a similar mechanism of data transmission and collection as the known oral traditions used across the African diaspora and Hispanic culture, is the most appropriate method to conduct this research inquiry (Parker et al., 1999; Stone-Mediatore, 2000).

The theoretical framework that guided this study was derived from aggregate research findings of several notable models of cultural psychology, including those with a focus on multiculturalism. Sue, Ivey and Montalvo’s (2009), Paraedes’s (2007), Pedersen’s (1997) and Ponterotto’s (2001) theories on multicultural counseling indicated that a client’s racial or cultural identity influences how problems are defined and helps to dictate or define appropriate counseling goals for that individual client. Furthermore, Ponterotto has made the argument that mental health care professionals need to be able to perceive culture as fundamentally connected to the consciousness of all human beings; in this way, it is a focal point for all psychological processes. It is arguable that the most important factor in developing a therapeutic alliance is culture (Sue, 2010).

Definition of Terms

It is important that the reader is familiar with several terms used throughout this dissertation. In order to facilitate this understanding, the following definitions are provided to assist the reader.

African American/Black: An African ethnic group whose members are citizens of the United States. They remain one of the most biologically diverse groups in the United States because of the historical intermingling of scores of African ethnic groups, Native Americans, and Europeans. The term *African American* is something of a misnomer, as the many people of African descent in Canada, Mexico, Brazil, Cuba, Venezuela, Peru, Colombia, the Antilles, Costa Rica, Nicaragua, and Uruguay, which like the United States are part of the Americas, are not included in the term. Nevertheless, the term has been used to designate people of African descent who are domiciled in the United States since 1865. Prior to that year, African Americans were not Americans, and therefore most saw themselves only as Africans. There were, however, a few free African Americans who called themselves “colored citizens” when, in fact, they did not possess the rights of the American citizens (Asante, 2004).

Chicano or Chicana/os: People of Mexican descent born in the United States, also known as Mexican Americans. Chicana/os are also called *la raza* (the race), *la raza de bronce* (the bronze or brown race), or *la raza cosmica* (the universal race). Given current and projected demographic changes for the Chicana/o community in the United

States, it is necessary to develop a deeper understanding of the history, culture, and present-day status of Chicana/os (Gallaido, 2006).

Cuban/ Cuban Americans: These individuals share many of the core values that are often attributed to Hispanic populations. Each group, however, is distinctive in its history. Cuban Americans have had unique experiences during the past 40 years, and these experiences have affected the way they have adapted and become acculturated to the United States.

Culture: This refers to rules, codes, beliefs, and practices that orient, educate, and motivate families and individuals toward a range of socially acceptable behaviors (Gallaido, 2006).

Ethnicity: This refers to a common ancestry through which individuals have evolved shared values and customs (Gallaido, 2006).

European American/ White: This refers to an ethnic group of people of non-Hispanic European descent whose members are citizens of the United States (Asante, 2004). This is the rubric used for all White persons of non-Hispanic, nonracIALIZED ethnic backgrounds in this study.

Hispanic/Hispanic Americans: These are individuals whose ancestors came from Latin American countries, such as Mexico, Puerto Rico, Cuba, the Dominican Republic, and other South and Central American countries, such as Colombia, Nicaragua, and Costa Rica. Hispanic Americans are one of the fastest growing ethnic minority groups in

the United States. Hispanic Americans represent a very heterogeneous group of people in terms of race, ethnicity, region, and socioeconomic status (Gallaido, 2006).

Internalized culture: This influences the formation of our worldviews; the latter is broadly defined as a set of presuppositions underlying our views about the world and our place in it (Coleman, 2010).

Latino/Latina: Currently the preferred term to refer to people of Latin American heritage. The term is seen as more inclusive of the racial and ethnic diversity that make up Hispanic Americans. The term *Latino/a* represents the least common denominator among all peoples of Latin America and recognizes the romance languages (Spanish, Portuguese, and French) that are the native languages of most Latin Americans.

Mexican American/ Individuals of Mexican descent: This is the largest ethnic group of Latino/as in the United States. Differences in language, immigration experience, generational status, and social and political concerns have created a vastly heterogeneous group. Because of these different cultural, social, and psychological influences, Mexican Americans hold a mixture of attributes, attitudes, behaviors, and values (Segura-Herrera, Gloria, & Nichols, 2006).

Multicultural counseling competence: This pertains to counselors' attitudes, beliefs, knowledge, and skills in working with individuals from a variety of cultural, racial, ethnic, gender social class, and sexual orientation groups (Ponterotto, 2010).

Pharmacodynamic: This refers to the mechanism of actions of a pharmacological compound affecting a physiologic system (Scjarzeberg, 2003).

Pharmacogenetics: This refers to the interplay of genetic factors in the metabolism of a particular medicine (Falicov, 2011).

Pharmakinetics: This is the study of the bodily absorption, distribution, metabolism, and excretion of drugs (Anzaldua, 2010).

Race: A classification of humans into large and distinct population or groups by factors such as heritable phenotypic characteristics or geographic ancestry, but also often influenced by and correlated with traits such as appearance, culture, ethnicity, and socio-economic status. In the early 20th century the term was often used, in its biological sense, to denote genetically human populations that can be marked by common phenotypic traits (Ponterotto et al., 2001).

Racial/ethnic group identification: This specifically refers to a psychological attachment to one of several social categories available to individuals, when the category selected is based on “race” or skin color, common history, language, nationality, culture, ancestry, and so on (Ponterotto et al., 2001). The importance of racial/ethnic group identity is rooted in its presumed influence on the ways that individuals conduct their lives and interact with others. Members are believed to share an implicit understanding of what it means to be a member of a designated racial group but not all possible members of the group identify, nor do all members identify equally (Ponterotto et al., 2001).

Racialization: Racial formation theory is the sociological concept that race is best defined as a socially constructed identity which has links to social, economic, and political actions. The cultural experience of being a person of color in the United States is

deeply affected by this social context. This sense of identity, and the difference between European American, African American, and Hispanic forms of identity and experience in particular, has become a part of U.S. collective consciousness. Race is therefore something that is fluid, in that “the racial order is organized and enforced by the continuity and reciprocity between micro-level and macro-level of social relations” (Omi & Winant, 1986, p. 67). Racialization, in this context, is the way in which some individuals, regardless of the color of their skin or their ethnicity, are perceived and treated outside the social, economic, and political power system in the United States.

Theory of multicultural counseling: This indicates that counselors’ or clients’ cultural / racial identity will influence how problems are defined, and dictate or define appropriate counseling goals or processes. Sue (2010) considered how culture influences the process and goals of counseling, moreover, in acknowledging the unique role of varied sociopolitical realities such as racism, sexism, and personal freedom as adequate goals of therapy. Coleman’s (2010) view on internalized culture indicated that understanding and transcending internalized culture and its central components, namely factors such as internalized racism and low self-esteem, is essential. Internalized culture functions like a cognitive map to guide through the social terrain. These psychological variables include cultural influences operating within the individual that shape personality formation and various aspects of psychological functioning.

Assumptions, Delimitations, and Limitations

There are several assumptions, delimitations, and limitations associated with this research study. Each is listed in the following paragraphs.

Assumptions

In this study, I assumed that the focus on experiences alone rather than empirical data was sufficient to answer the research questions fully. Because the interview results depended solely on participants' perceptions of events, all results included some subjectivity, and there was no verifiable guarantee of accuracy.

In this study, I assumed that there were factors other than cultural competency among mental health care professionals that also affected the success of African American and Hispanic clients in therapy.

In this study, I assumed that all mental health care professionals who have treated the participants in the past are aware of the APA standards for ethics and diversity. Further, it was assumed that as long as people perceived themselves to be a part of Hispanic and African American social, racial and ethnic groups, they were likely to interact with the world according to the social context of these groups and were therefore considered for inclusion in the study.

Delimitations

The study was delimited to African American and Hispanic participants who had discontinued therapy.

Limitations

There are limitations in defining individuals for this study based on their own identity rather than on defined characteristics. Because of the fact that there are different racial identities that are connected with the terms *Hispanic* and *African American*, these are not clearly defined categories.

The participants were from one geographic area. Because the study was limited to one location, including this community context and the institution alone, it was limited in its generalizability.

This investigation was also limited to one instrument, namely the interview protocol detailed in Appendix B. This means that there may be factors that are not captured in the study.

Significance of the Study

In this study, I intended to provide a voice to those African American and Hispanic clients who have dropped out of treatment in the past, as well as to encourage therapists to become more culturally competent by exploring their own issues around cultural diversity. In terms of professional application, with the data generated from this study, I allowed mental health care clients to have agency in defining their own experiences and I facilitated knowledge for current and incoming clinicians.

This study filled a gap in the literature due to the fact that marginalized experiences of African American and Hispanic mental health care clients are indicative of the systematic omission and obscure denial of lived experiences of individuals (Stone-

Mediatore, 2000), and more qualitative oral histories are required to enhance the existing data on these types of experience (Michalopoulou & Arfken, 2009; Sue, 2010).

Finally, based on the results of this study, I hope that participants can gain a stronger voice to support mental health initiatives within their communities. Furthermore, it was a goal of this study to identify perceived barriers to mental health support (both internalized barriers and socially imposed barriers) that can be defined as a step toward dismantling them and their resulting deleterious effects on a broad sociocultural level.

Summary and Transition

The purpose of this phenomenological qualitative study was to explore the participants' perceived experiences with their therapists' lack of cultural awareness and impact on dropout in mental health treatment. In Chapter 2, I present a discussion of the relevant research literature and expand the conceptual framework. In the literature, I explore cultural psychology as well as CRT as related to the experiences of African American and Hispanic mental health care clients; note was also made of current gaps in the practical application of theory in clinical practice. Historical oppression and racial injustices in society examined in this chapter provided the means to think more critically about psychological issues and how specific racial issues in practice and social policies in medical care allow for systematic racism to take place. Chapter 3 presents the research methods. This chapter highlights the rationale for choosing a phenomenological qualitative methods approach to answering the research questions asked herein. Following is a discussion on the research design, participant recruitment methods,

instruments developed and used, ethics, data collection, data analysis, and data security.

The results of the study are presented in Chapter 4, and the conclusion is presented in Chapter 5.

Chapter 2: Literature Review

Overview of the Literature

This chapter contains a review and discussion of multicultural psychological research retrieved from journals and dissertations. The chapter begins with an analysis of the cultural psychology literature, which provides a foundation for the common approaches to multicultural counseling processes. The literature on multicultural counseling self-efficacy and competency among mental health care professionals was also taken into consideration. Specific challenges experienced by African American and Hispanic clients receiving mental health care were considered, and specific pharmacokinetic or pharmacodynamics variability among different racial and ethnic phenotypes were examined.

A major critique of the clinical application of cultural psychology, namely multicultural counseling, has been the lack of empirical and theory-driven psychological research; research has tended to be based on practical tenets rather than those grounded in social justice (Salas-Provance & Reed, 2010). Current research indicates that there are fundamental limitations in the data regarding multicultural forms of psychological treatment (Molina, 2010). According to Hall and Maramba (2001), several studies that have been influential in this field, which have included ethnic minority groups have not been able to address the challenges in clinical practice that are related to the needs of ethnic minority clients. Nasir and Hand (2006) wrote that it is sometimes problematical to gather the diverse elements of cultural psychology through research because of its

complexity. Because cultural psychology comprises both internal and external elements, it involves ideas linked to psychological development but also social and personal communication processes. To this end, the search of the literature for this study was broad. It included library databases such as those at Walden University, Immaculata College, Indiana University, and Tempe University, as well as the Poland Research Center on the Psychobiology of Ethnicity and the Department of Psychiatry, Dissertation Abstracts International Section.

Cultural Psychology and Racial / Ethnic Needs

As Shiraev and Levy (2009) noted, on a cross-cultural level, attitudes help individuals to understand and make sense of the world and the challenges faced. This is because, on a fundamental level, mirroring oneself in another human being provides individuals with psychological safety, and, in this way, the dynamics of the counselor-client dyad can act to reinforce positive or negative feelings in a mental health care client (Banai et al., 2005). Cultural attitudes can therefore serve an ego-defensive function in order to assist in feeling better. Shiraev and Levy noted that cognitive balance and cognitive dissonance theories suggest that people are apt to seek consistency among the attitudes of their family members and close acquaintances. As a result, individuals are also likely to make distinctions between the world within them and the world outside them. Barriers to intercultural communication can include “anxiety, assuming similarity instead of difference, ethnocentrism, prejudice, nonverbal misinterpretations, and specific

language challenges” (Jandt, 2006, p. 71). This means that both individual traits and environmental circumstances can shape self-perception in a variety of ways.

The reason that individuals have a need for cultural sameness is that, as Gomez, Seyle, Huici, and Swann (2009) demonstrated, people are likely to want to create collective identities, which connect their self-views with group membership in order to reinforce their personal sense of self. In this way, cultural psychology is very much tied to the psychology of the self. In other words, people have a tendency to make the effort to confirm their self-identities, such as the qualities that make them unique, but Gomez et al. (2009) suggested that these self-identification efforts are also linked to group processes rather than internal processes alone. Researchers have begun to become familiar with this purpose in self-identity, but have not tested whether the qualities that people value are also present within their social groups (Gomez et al., 2009). In other words, there is a need to recognize the abstractness of the relationship between the individual and his or her chosen social group. The fundamental idea, however, is that the process of a person being able to verify their own self-identity is more important than many other psychological needs. For this reason, the cultural or multicultural ability of the counselor may be of primary importance in mental health care.

The foundation for this need for a cultural connection between client and counselor was noted as early as the 1970s in scholarly research, when CRT began to inform the psychological literature. Snyder, Tanke, and Bersheid (1977) were some of the first researchers to examine the self-fulfilling influences of social stereotypes on social

interaction in the form of dyads, such as counselor-client dyads. This research demonstrated that dyads can fortify dormant forms of social controls through the introduction of stereotypes in psychological care. Their theory is that “a perceiver’s actions based upon stereotype-generated attributions about a specific target individual may cause the behavior of that individual to confirm the perceiver’s initially erroneous attributions” (Snyder et al., 1977, p. 656), which can in due course affect a client’s understanding of his or her personal values as well as his or her self-identity. This is because healthy narcissistic development is also, therefore, connected to one’s ability to formulate a strong relationship to one’s social group and to reflect the ideas of the group back on itself. To those outside the cultural dyads, this is, as noted by Nasir and Hand (2006), called stereotype threat, which is the perceived threat of racial stereotypes being imposed on an individual, and which can decrease an individual’s ability to self-actualize. It becomes imperative, therefore, that counselors develop means by which mental health care services are responsive to diverse needs and different cultural norms, especially those who may have been affected by endemic racism and social exclusion.

Nonetheless, as noted by Cole (1996), healthy narcissistic development can also include a diverse group of psychological influencers rather than a simple, single-culture influence. Although individuals may have strong cultural alliances, being exposed to other cultures can allow them to be flexible. The challenge is that the social meanings which underlie psychological processes can prevent this flexibility from occurring. For example, Kanagawa, Cross, and Markus (2001) noted that for individuals from cultures

which support a more collective way of life, such as Asian American, African American, and Hispanic individuals, the idea of the self is most typically understood as being flexible, open and situation-specific. Whereas in the broader European American U.S. culture, the idea of the psychological self is understood as being set and personal. This does not mean that the psychological self cannot and does not change, but instead that it is socially or culturally bound. What this does mean is that there may be fundamental communication differences between counselors who are from one culture and clients who are from another. Kanagawa et al. (2001) found that although there were cultural differences regarding how they presented themselves, both groups changed their self-identity, more or less, when in a social situation. This means that there is the potential for clients to shift their responses in a multicultural counseling environment, which presents further challenges in that clients may not have the ability to communicate their true feelings. In other words, even if there is no evidence of stereotyping or prejudice, multicultural counseling may not produce the kind of results needed by clients in a mental health care environment.

At the same time, stereotyping or prejudice does exist in counseling environments. The definition of psychological prejudice, according to Blauner (1994), is evidence of underlying or invisible “hostile feelings and beliefs about racial minorities and the web of stereotypes justifying such negative attitudes” (p. 3). Dovidio, Kawakami, and Gaertner (2002) demonstrated that stereotyping and prejudice is linked to the human need to organize the information they have about their environment and the people with

whom they interact, and by putting people into categories, there is a psychological process which allows individuals to save time in thinking about how to approach that person based on synaptic connections in the brain tied to social values. Dovidio et al. (2002) noted that while this subconscious process can serve as a shortcut, it can also lead to assumptions that are wrong, because of the fact that influences on opinions about race are often very subtle. Attitudes about race and culture are often expressed in ways that are not open and honest, so it is possible to create a negative way of thinking about a person of color even if it is not explicitly pronounced.

The challenge in addressing prejudice is that it is fundamentally hidden and often occurs even when people in positions of power and control are aware of its existence and are making an effort to counteract stereotyping. Sommers (2006) explained that in the social context of prejudice there is a great deal of psychological power in group dynamics, which is why stereotyping or prejudice exists despite the fact that people know that it is wrong, and do not want to participate in it. Sommers (2006) noted that the prejudice of European American individuals against African American individuals is the most important example to explore because of the fact that it is so extensive on a social level in the United States in particular, but that other prejudices against Hispanic individuals are also growing in strength in recent years.

Mental Health Care Experiences of African Americans

The result of the multicultural disconnect between counselors and clients in mental health care provision is that there has been a decrease in the propensity of clients

of color to remain in care for as long as necessary (Atkinson & Lowe, 1995; Hemant & Thornton, 2010; John, 2007; McLoyd & Dodge, 2011; Noguera, 2010). On a broad level, psychiatric epidemiologic studies have demonstrated that it is most likely for racial and ethnic minority mental health care clients in the United States to utilize a wide variety of mental health care providers (such as psychiatrists, psychologists, counselors, and social workers in mental health settings; McLoyd & Dodge, 2011). Ethnic and racial minorities are also more likely to look for mental health care support from religious representatives rather than from professional mental health care workers (John, 2007). In addition, African American and Hispanic individuals were more likely than those in other racial groups to believe that counseling increased negative psychological responses (Noguera, 2010).

Given the level of discomfort reported in the literature about African American and Hispanic individuals with respect to mental health care, research has also indicated that these clients are more likely to continue with care if they are able to work with a mental health care professional from the same ethnic or racial background. As a whole, the APA (2011) findings support that race-concordant visits were likely to produce better results, in terms of time spent in care and client perception of mental health care success. These results align with more specific studies on the perceptions of African American and Hispanic individuals on the value of race-concordant mental health care. Research findings support that African Americans are likely to attend more sessions of treatment with a race-concordant therapist (Hermant & Thornton, 2010) and that Hispanics being

treated for mental health issues through social services with ethnic and language-based counselor matching were likely to have a much lower level of therapy dropout within their four sessions of therapy (Rinderle & Montoya, 2010).

Research points to the fact that both of these groups, namely African American and Hispanic individuals, report a need for more personalized services within a mental health care environment, and that European Americans are likely unable to provide that kind of service (Gloria & Peregoy, 1996; Jenkins, 1991; Kennedy, 2003; Rogoff, 2011; Stolzenberg, 2010). Clinical observations expand upon the findings from these large studies. For example, African Americans are less likely to want to focus on problem solving in a mental health care setting, and instead are likely to benefit from the development of a more interpersonal relationship between themselves and their counselor (Jenkins, 1991). Similar findings have been evident from clients with a Hispanic background, where an impersonal and focused clinical approach to care is likely not to be accepted (Gloria & Peregoy, 1996; Kennedy, 2003; Stolzenberg, 2010). Much of the success of a personalized therapeutic approach among these racial and ethnic groups can be linked back to the ability of the counselor to focus on communication and listening rather than instruction (Ridley, Mendoza, & Kanitz, 1994; Rogoff, 2011; Stolzenberg, 2010).

Much of the ability of a client to trust his or her counselor can be linked back to endemic experiences of racism and stereotyping (Ridley et al., 1994), which means that the lack of congruency between client and counselor can be tied to clients' perceptions of

race and culture as well as that of counselors'. An individual's experiences of racism and oppression over his or her lifetime may exacerbate the differences between client and counselor, because many of the psychosocial norms expected of people of color have been defined by a European American social power context (Ridley et al., 1994). As one African American respondent in a recent study stated, "Most doctors are arrogant, stuck-up, self-centered and have attitudes of wanting to be above their clients" (Kennedy, 2010, p. 6). What this demonstrates is that there is a fundamental challenge at the heart of the counselor-client dyad, and that clients felt that it was the responsibility of mental health care professionals alone to adjust their cultural normative position in relationship to their own needs.

Coleman (2010) suggested, therefore, that the identity of an individual of color is strongly influenced by his or her personal and social perceptions of their experiences of racism and oppression, and that, in this way, there is a need for individuals of color to produce systemic control in an environment where their personal values and self-perception may be at risk due to endemic racism. The psychological development of the individual in care is dependent on their ability to achieve their own personal goals in alignment with their self-concept, and this may not be possible in environments in which their racialized experiences are not taken into account (Coleman, 2010; Kennedy, 2010; Ridley et al., 1994, 2010). As a result, it may not be possible in some instances for people of color to benefit from mental health care which is not supplied by a race- or ethnic-

concordant counselor (Coleman, 2010; Greene, 2005; Kennedy, 2010; Ridley et al., 1994).

The experience of race and ethnicity in a mental health care environment often goes deeper than the psychological experience of the client. As noted by Greene (2005), the politicization of ethnocentric or race-focused acts allows people to form codes of behavior which, in their exclusion of people of color, are able to enable specific socio-economic objectives. These continue to reinforce the current power dynamic which supports European American hegemony (Blauner, 1994). These concepts have likely become intertwined and intensified through a mixture of growing racialization and conservative public policies enacted in the wake of 9/11 (Greene, 2005). While African Americans have historically been the most at risk for racism, Lacayo (2010) also noted that 23% of Americans now believe that Hispanic individuals are the most discriminated against group of citizens in the United States at the present time, and are subject to cultural policing in almost all of their social activities (Lacayo, 2010).

As Romero (2007) described this challenge from a CRT perspective, there is a link between assimilation, European Americanness and power tactics that can override the social experiences of people of color, including social experiences in the health care system. In other words, there is a need to recognize that there is an inherent risk, rather than simply a perceived risk, in people of color receiving care from European American individuals who are part of the endemic power structure. As Romero wrote,

Focusing on assimilation not only conceals White privilege; it also frames

research questions away from examining racial, economic, and political privilege among European Americans, ethnic Americans, and native and foreign-born groups of color. Consequently, policy recommendations generated from the focus on assimilation maintain the status quo, ignore White privilege, and set the agenda to disadvantage racialized groups further. (p. 25)

What this means is that there is a lack of focus given to the fact that there are inherent power imbalances between people of color and European American people on a policy level which can have an impact on the ability of people of color to ensure that they are protected both socially and psychologically over the long term. These challenges need to be taken into account in developing a socially viable response to the fears of African American and Hispanic clients with respect to multicultural mental health care (Greene, 2005; Romero, 2007).

Methods of Addressing Cultural and Social Disconnects in Mental Health Care

Given all of the challenges in providing multicultural mental health care to African American and Hispanic clients in the United States, the literature provides suggestions on how these may be mitigated in clinical practice. All counselors need to integrate cultural conceptions of clients' values, beliefs, and family cultural and traditional history into clinical practice (Ponterotto, 2010). Despite the fact that many counselors are not aware of the value of multiculturalism in practice, current research suggests that all counselors need to be multiculturally competent. To do so, counselors must be able to recognize themselves as cultural and racial beings (Ponterotto, 2010).

This will allow counselors to ensure that they are able to participate in care with a level of cultural encapsulation that will enrich their mental health service delivery through a culturally informed and culturally sensitive approach to care.

At the same time, research has demonstrated that even when training has taken place so that counselors are better equipped for developing multicultural competencies, it is not necessarily effective in practice (Coleman, 2010). This may be linked to the fact that there are very specific cultural markers in place within African American and Hispanic communities which may not be accessible to individual counselors without these specific racial or ethnic backgrounds (Coleman, 2010; Haney-Lopez, 2011; Ponterotto, 2010). As a whole, people of color are likely to prefer therapists who have a professional knowledge about the kinds of institutional barriers that may have an impact on their use of mental health care services (King, 2007). Most Hispanics denote that proper social approach for the delivery of mental health care should be relaxed and indicate sympathy (Dana, 2005), with a lack of focus on social hierarchy (Haney-Lopez, 2011).

As a whole, although many factors contribute to a lack of retention in therapy among African American and Hispanic mental health care clients, a lack of cultural awareness, cultural insensitivity, and cultural biases (Montalvo, 2009), as well as racial disparities and a lack of knowledge of ethnic differences and special needs in patients (Lin, 2000), seem to be outstanding among the factors for early termination of care. Part of the challenge is that a color-blind approach to therapy, which has been advocated in

the past, has not proven to be particularly effective in meeting the needs of people of color (APA, 2011; Burkard & Knox, 2010; Marin, 2010). Burkard and Knox (2004) demonstrated that racial color-blindness in the clinical practice of psychologists actually resulted in a lower level of empathy for a mental health care client. This was true whether the client indicated race as a psychological issue, and was not dependent on the racial phenotype of the client. In addition, the APA (2011) reported that a color-blind approach to therapy can result in counselors assigning a higher level of personal blame and responsibility to African American clients with respect to their psychological issues.

Some of these issues can be resolved with a greater level of racial consciousness on behalf of both the counselor and the client (Marin, 2010). This is demonstrated in practice when racial consciousness about European Americans and African Americans are the same for the counselor and client, but contradictory attitudes can have negative effects on the outcomes of therapy. As well, a progressive therapeutic relationship, namely that which is present when the client is at least one stage more advanced in terms of racial consciousness than the counselor, can lead to client racial identity development over the short and the long term (Marin, 2010).

African American and Hispanic Response to Psychotropic Medications

A secondary, but also salient factor, in providing mental health care in a multicultural environment is the fact that people with different racial or ethnic backgrounds are likely to be affected differently by the kinds of psychotropic medications that are often prescribed (J. Gonzalez, 2010; Gutierrez & Rogoff, 2010; Jenkins, 2010;

U.S. Bureau of the Census, 2011; Wright & Leung, 2010). These factors are often not taken into account during clinical practice because there is an assumption on the part of mental health care professionals that there are no physical differences between people of different racial or ethnic backgrounds (U.S. Bureau of the Census, 2011; Wright & Leung, 2010).

As a whole, research has demonstrated that African Americans are likely to metabolize antipsychotic medications more slowly than European Americans, which can result in a more intensive response to these medications, both in terms of time and efficacy, and Hispanic individuals are likely to need an even lower dosage of these drugs than African Americans (U.S. Bureau of the Census, 2011). African American patients with depression may also be more responsive to the effect of tricyclic antidepressants, which may be related to significant ethnic difference in pharmacokinetics and absorption rates with respect to the use of tricyclic antidepressants (N. Gonzalez, 2010).

African Americans are likely to be treated with the same dosages that are commonly used for European American patients despite this pharmacokinetic or pharmacodynamics variability efficacy (U.S. Bureau of the Census, 2011). In addition, the literature demonstrates that people of color who have received anti-psychotic prescriptions and care in the past are more likely to be hospitalized and treated with higher dosages of medications (Wright & Leung, 2010). Research also indicates that both African Americans and Hispanics who have bipolar disorder are more likely to be labeled with schizophrenia (Wright & Leung, 2010).

Summary

The academic literature reviewed in this chapter indicates that effective mental health treatment for people of color depends upon clear knowledge of the impact of racial and cultural variation, challenges and opportunities, as well as productive interactions between patients and mental health providers. In this chapter, I provided an analysis of the cultural psychology literature, as well as an assessment of the limitations and opportunities present in common approaches to multicultural counseling processes. The literature on multicultural counseling self-efficacy and competency among mental health care professionals was taken into consideration, and specific challenges experienced by African American and Hispanic clients receiving mental health care were considered. An assessment of the psychosocial context of care provided insight into why race matters in the clinical environment. Finally, the specific pharmacokinetic or pharmacodynamics variability among different racial and ethnic phenotypes was examined.

The literature demonstrated that developing a range of mental health care services to address the needs and preferences of a diverse clientele needs to be a central tenet of patient-centered clinical processes. An increased focus on communication and the importance of the counselor and client dyad may help reduce differential health outcomes across racial and ethnic groups. Understanding how diverse patients may differ in their expectations for care and preferences for interactions with their counselor is a critical component of developing models for patient-centered partnerships that can reduce disparities in health and mental health service delivery over both the short and the long

term. Addressing these issues can lead to social change because there are systemic limitations in the current mental health care environment, which prevent people of color from receiving the highest level of care possible.

Chapter 3: Research Method

Introduction

The objective of this chapter was to present the chosen qualitative phenomenological methodology and its rationale, as well as to present its detailed data collection and analysis process. I believed that a qualitative methodology would enable the exposure of salient factors that lend themselves to client-centered mental health care among people of African American and Hispanic backgrounds and fulfill the objective of this particular study, namely to look closely at what African American and Hispanic clients say they require from a mental health care provider in building a successful therapeutic relationship. A qualitative approach to this objective is appropriate for this study because of its emphasis on the examination of the human experience (Crestwell, 2009). Moreover, gaining insight through the exploration of a social or human explanation of social issues can be facilitated through qualitative research (Crestwell, 2009). The qualitative researcher, through the utilization of respondents' lived experiences, analyzes results to achieve a holistic picture of human life and human psychology (Guzman, 2011).

Among the distinct methods of inquiry in qualitative research, the phenomenological approach was deemed most suitable because such inquiry focused on the participants' lived experiences. Phenomenology allowed me to engage with the participants' perception of their lived experiences, which helped to give meaning and understanding to the phenomenon under investigation (Moerer-Urdahl & Creswell,

2004). Through interviews, African American and Hispanic participants' experiences and perceptions about therapists were documented and explored, and an examination of the phenomenon of dropout in mental health care treatment among African American and Hispanic clients helped to bring a substantive understanding of cultural psychology in clinical practice to bear.

Current research makes the argument that a phenomenological approach to qualitative research can lead to an increased level of personal feelings of security for African American and Hispanic study participants because it is more likely to be culturally sensitive (Comas-Diaz, 2010). Creswell (2009) also demonstrated that the qualitative framework for phenomenological study is the best method available in qualitative research which is able to link together the ideas of participants who have shared the same experiences associated with the phenomenon. To this end, themes can be developed and explored that can illustrate the lived experiences of participants in a way that informs the research literature in a more substantive way than through standard qualitative interviewing techniques (Moerer-Urdahl & Creswell, 2004). By analyzing a series of in-depth interviews with clients seeking care in public specialty mental health clinics in a phenomenological manner, I was able to identify differences in the meaning of these themes with respect to what clients from diverse groups prefer in a relationship with a mental health care provider.

Among the other leading methods of inquiry in qualitative research as defined by Creswell (2009), namely the grounded theory formation, biography, ethnography, and

case study approach, the phenomenological approach was identified as most applicable for the present study because of the fact that this form of inquiry focuses on the participants' lived experiences, which are necessary to inform the existing literature, as noted by Comas-Diaz (2010). The grounded theory paradigm is aimed specifically at gathering data as a means of generating or discovering a theory; this approach was not acceptable because existing theories are already extant in the literature, and it is the more practical context of clinical experience that needs to be examined. An ethnographic approach was appropriate because the aim of this study was also directly linked to live experiences of the participants. A chronological examination of participants' lives was outside of the scope of this study which means that a biographical approach was not likely to be an effective strategy for assessment of participants' perspectives. The case study approach was not appropriate for this study because this research process is likely to be more effective for psychological analysis when it can be completed on a longitudinal basis, which would not enhance the outcomes of this research. For these reasons, the phenomenological approach was assumed the most effective means of gathering the data needed to produce findings on lived experiences in mental health care for African American and Hispanic clients.

Role of the Researcher

In qualitative research, the participants are captured through the vision of the primary investigator, and in this way the researcher has a vital impact on the reporting of the study (Creswell, 2009). As a researcher, I have reflected back on my 25 years of

experience as an African American mental health counselor and family therapist, and I have found that my passion and concern with African American and Hispanic clients has been derived through my clinical experiences of working with and talking to the many clients who have dropped out of treatment because they perceived that their counselors lacked cultural awareness. As an African American female with cultural beliefs and societal experiences similar to many of my clients, my focus has been the development of a phenomenological study of my extended patient base with a special emphasis on cultural awareness. As I began to study clinical psychology in my doctoral program, I developed a point of view on cultural awareness due to my own personal life experiences and encounters with others who seemed to lack cultural awareness. Through this reflection and academic inquiry, I began to explore the impact of a lack of cultural awareness among clinicians and its effects on the success of clients from diverse racial, ethnic, and cultural backgrounds.

The credibility of the research depends on the competence, skills, and techniques of the researcher; therefore, balancing the researcher's assumption concerning the issue under investigation is of the essence, especially within the context of phenomenology. Githens (2007) explained that immersing oneself in the experiences relayed during in-depth interviews requires sharing the experience of the narrative with participants. As an African American female who fits all the criteria outlined in this phenomenological study, my own perception is that lack of cultural awareness among mental health clinicians, including psychiatrists, has a significant impact on the dropout rate in

treatment among African American and Hispanic clients. Moustakas's (1994) epoche is a method that brackets a researcher's presupposed knowledge and belief systems to help one abstain from judgments, theories, and preconceived frameworks that would taint the self-reported data participants. With this in mind, the epoche technique was started at the onset of research and sustained throughout the research. Therefore, I approached the process by utilizing an aspect of epoche called reflective mediation (Moustakas, 1994), which allowed past and present preconceptions and knowledge regarding knowledge obtained from the literature review and past presuppositions to repeatedly enter and leave my consciousness until a sense of closure was achieved. The final step of reflective meditation required me to label, write down, and review the prejudgments within the lead researcher's consciousness diminished and was released (Moustakas, 1994).

Research Questions

RQ1. What cultural barriers are perceived by African American and Hispanic clients in treatment?

RQ2. What cultural values or factors in identity are perceived to be important to African American and Hispanic clients in treatment?

RQ3. Which variables contribute to the dropout of African American and Hispanic clients?

Sample and Sample Selection

In this study, I used criterion sampling to yield 10 adult volunteers who self-identified as Hispanic or African American (five from each group) and agreed to be

participants. Demographic information regarding race, age, gender, ethnicity, and contact information were also gathered for selecting participants. Criterion sampling was focused on race and ethnicity in order to engage five Hispanic and five African American participants, which posed limitations in the study due to the small number of participants. Therefore, I could only attempt to engage broad demographic variation outside of race and ethnicity. At the same time, there were limitations in defining individuals for this study based on their own identity rather than on defined characteristics. Because of the fact that there are different racial identities that are connected with the terms *Hispanic* and *African American*, these are not clearly defined categories. Nonetheless, it was also assumed that as long as people perceive themselves to be a part of these social, racial and ethnic groups, they are likely to interact with the world according to the social context of these groups and were therefore considered for inclusion in the study.

Participants were recruited via flyers posted in a mental health agency. The agency in question, which is a mental health clinic in the eastern United States that offers soundproof capabilities, was chosen for its suitability to conduct interviews. While I generally use an office at this practice, none of my clients were included as participants in this study. The chosen 10 participants met me at individually prescheduled times. The location was central and easily accessible by both public transportation and other means.

Inclusion and Exclusion Criteria

Several criteria needed to be met for inclusion or exclusion in this study. To be included in this study one had to be an adult (age 18 and over), self-identify as Hispanic

or African American, have a history of being in treatment for a mental health concern, and report having dropped out of treatment after at least one session.

Exclusion criteria for the study included being under 18 years of age, not self-identifying as either African American or Hispanic, and not currently seeking supports from a mental health professional. Participants who did not speak English as their first primary language were not included in the study. Participants were not excluded based on sex or gender.

Instrumentation

The primary instrument for this study was a qualitative interview guide created exclusively for this research process and included in Appendix A. This interview protocol had semi-directed questions only. Five semi-directed questions were asked in order to begin the conversation, and additional questions were asked if necessary to clarify participant responses or prompt spontaneous responding. Qualitative interview data contained participants' experiences, opinions, feelings, and personal information. In a phenomenological study, "the participants...must be individuals who have all experienced the phenomenon being explored and can articulate their lived experiences" (Creswell, 2009, p. 119). The semi-directed interviews produced first-person, expert, natural data from participants who had an ability to provide information on their lived experiences of the phenomenon being studied, namely the kinds of negative cultural experiences that led them to leave mental health care.

Data Collection

Participants who volunteered to take part in the study were contacted to schedule convenient interview appointments. After permission was obtained, the participants were given any additional needed or requested information. While participants were told about the purpose of the study in advance, interview questions were not shared with participants until they reached the interview room. Each participant was given an appointment for his or her interview time, each of which was scheduled during a one-hour period. The actual length of the interviews was between 15 and 40 minutes. Participants were given the information that a follow-up interview might be required in order to clarify any unclear information in the interview data so that triangulation can occur. The protocol was the same for each interview. Each participant was asked a series of semi structured interview questions about his or her background, lived experience during his or her mental health care in the past, and subsequent perceptions about leaving care. Changes to the questions being used for the interview occurred during the research process in order to guarantee that the contributions of the participants accurately represented the needs of the research, as each individual had a different way of spontaneously responding to questions.

I used a tape recorder for the participant interviews. Tape recordings were then submitted to a professional transcriptionist for transcribing each interview; although first names were used in some of the interviews, this transcriptionist did not receive any personal data about participants and signed a confidentiality consent form as well. Interview transcripts were presented to me in three forms: original digital recording,

digital copy, and hard copy of the interview. Given the research methodology, only verbalized cues or comments were included as raw data in the recording and transcription, although field notes were taken at the time of the interviews in order to ensure that all non-verbalized information was also captured. Having each interview transcribed verbatim and keeping detailed notes helped to establish descriptive validity for this study. In addition, to determine internal validity and ensure triangulation of the data, participant confirmation of the interview notes once they were transcribed helped me to gain an in-depth understanding of the participants' lived experiences and their perceptions regarding their therapists' lack of cultural awareness.

Data Analysis

As noted by Creswell (2009), how participants were chosen for a study may “help the researcher to generate or discover a theory or specific concepts within the theory” (p. 205). Transcripts must be examined via a rational phenomenological framework (Churchill, 2006). Data were also collected and analyzed concurrently as well as after the interviews. The data analysis model which was used was one which is both empirical and phenomenological (Churchill, 2006), and which has been vetted on a practical level by Robbins and Parlavocchio (2006). The data analysis process for this research was made up of seven distinct steps. These included: “(a) reading the descriptions, (b) delineating meaning units, (c) organizing the meaning units, (d) seeing the meaning units psychologically, (e) situating structural descriptions, (f) identifying general themes, and (g) constructing a general situated structure” (Robbins & Parlavocchio, 2006, p. 333).

What this means is that textual descriptions of each interview were developed with verbatim examples from the transcribed interviews. From this, a composite structural description and major themes were developed, drawing on the meanings and essences of the experience, representing the participant group as a whole.

The development of categories and themes of information enabled me to look for patterns within the data, and to gain an understanding of the phenomena under investigation. Themes that appeared to be common to most participants were identified and further interpreted and analyzed for their meaning. The final stage of examination was pulling all of the information together through synthesis. Once the themes were solidified, it became possible to draw conclusions about the meaning of the data. These were compared to the original research questions and recommendations for clinical practice were made.

Ethical Considerations

Before starting, I ensured compliance with the AAMFT, Walden's IRB (IRB approval number #06-14-13-0015088), and APA. The confidentiality and anonymity processes of the interview were explained to the participants, questions about the nature of the interview were answered, and consent forms were explained as well. Participants were asked to sign informed consent documents. A letter that includes a guarantee of confidentiality and additional information accompanied this process. Participants were reminded that participation was voluntary and anonymous outside of the interview room, and the decision to withdraw from the interview had no penalty. Participants were

provided with the contact information off a local counselor or health care agency in the expectation that some may find that the process brings up feelings of depression or grief about experiences. If a participant became overwhelmed and unable to manage the interview topic, the interview was terminated and the participant referred to a health care provider directly. It is important to note that I adhered to all ethical standards of Walden University, as well as those of both the APA and the AAMFT. Further, applicable laws governing mental health research were also followed.

Summary

In this chapter, I outlined the approaches to the methodological processes that were used to ensure that the study was able to collect and delineate the desired information, which was to discover the lived experiences of the African American and Hispanic mental health care clients and present their experiences through phenomenological research. A qualitative phenomenological interview framework was determined to be the most appropriate method to examine the research problem at hand. The considerations behind the sample of the chosen population, the data collection and analysis procedures, the study's use of instrumentation, and its reliability and validity were described in this chapter. By examining a series of in-depth interviews with African American and Hispanic mental health care clients, the overarching objective was to identify differences in what clients from diverse ethnic, racial or cultural groups prefer in a therapeutic relationship with their chosen mental health care provider.

Chapter 4: Results

Introduction

The purpose of this phenomenological study was to explore how participants' perceptions of their mental health care professionals' lack of cultural awareness and sensitivity discourages their willingness to continue in treatment. This purpose was addressed through asking 10 participants at a therapeutic setting in Philadelphia, PA five predesigned interview questions in addition to a number of ad lib questions:

1. Was it important that your counselor asked about your morals, values, and lifestyle? What cultural values or factors do you perceive to be important in treatment?
2. What do you believe your counselor thought about your race, customs, values, and lifestyle?
3. Have you discussed your customs and values with your counselor, and how did the counselor communicate with you about these issues?
4. How likely are you to stay in treatment if you believed that your counselor cared about your customs and values, did this affect whether you stayed in treatment?
5. What were your thoughts and feelings if you believed your counselor did not understand or discuss your life customs and values?

The purpose of asking these five interview questions, in addition to the ad-lib questions, was to be able to answer the following three research questions posed in the study:

RQ1. What cultural barriers do African American and Hispanic clients in treatment perceive about the cultural competence of their clinicians (regardless of the clinician's race)?

RQ2. What cultural values or factors in identity are perceived to be important to African American and Hispanic clients in treatment?

RQ3. Which variables contribute to the dropout of African American clients and Hispanic clients?

Based on the aforementioned purposes, the fourth chapter is structured as follows. First, there is a presentation of descriptive statistics relating to the sample. Second, there is a presentation of coding and data analysis based on the interview data. Third, there is a presentation and discussion of themes derived from the coding and data analysis. Fourth, there is a discussion of discrepant themes and cases in the data. Finally, a conclusion summarizes the main findings, limitations, and characteristics of the study.

Descriptive Statistics

Overview

There were 10 participants in the study. Figures 1-10 present graphical summaries of the participants' age, ethnicity, gender, place of birth, education, occupation, first language, other language, parental language, and self-rated English fluency (on a scale of

1-10). The sample was relatively older, with a mean age of 43.84 (SD = 14.346), almost equally split between males (n = 4) and females (n = 6), and included several (n = 7) individuals not born in the United States. The average educational attainment of the sample was low, with the majority (n = 7) not having attended college. In addition, most (n = 7) of the sample was unemployed. There was a nearly even split between speakers of English as a first language (n = 4) and speakers of Spanish as a first language (n = 6), with one participant being bilingual. Most (n = 7) of the participants ranked themselves as speaking English with perfect fluency. Finally, all of the participants stated that the ethnicity of the therapists whom they had ceased to see was White.

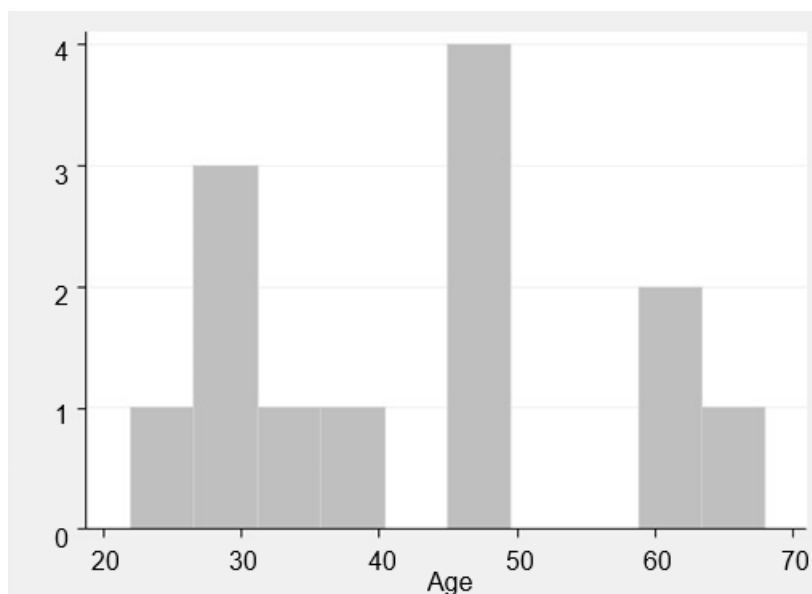


Figure 1. Histogram of age of the sample (M = 43.84, SD = 14.346).

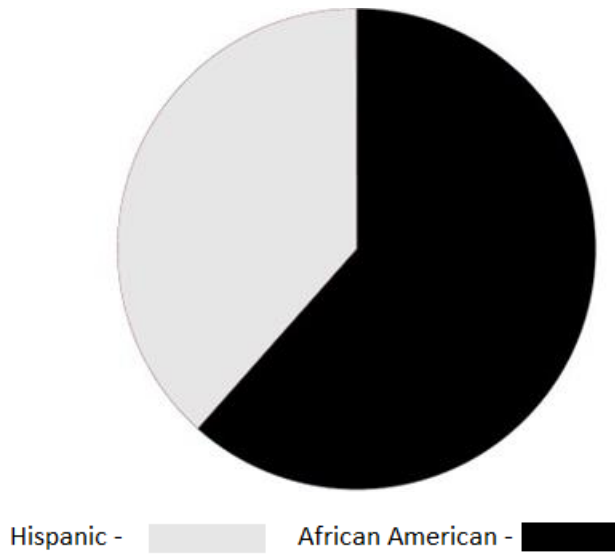


Figure 2. Pie chart, ethnicity.



Figure 3. Pie chart, gender.

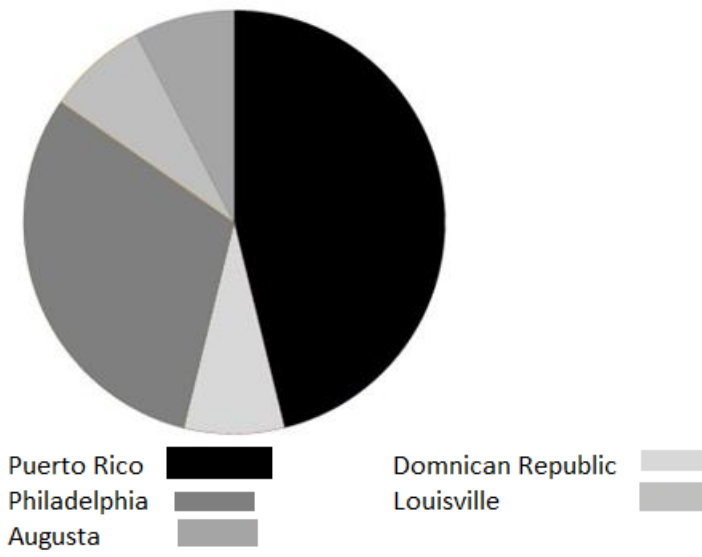


Figure 4. Pie chart, place of birth.

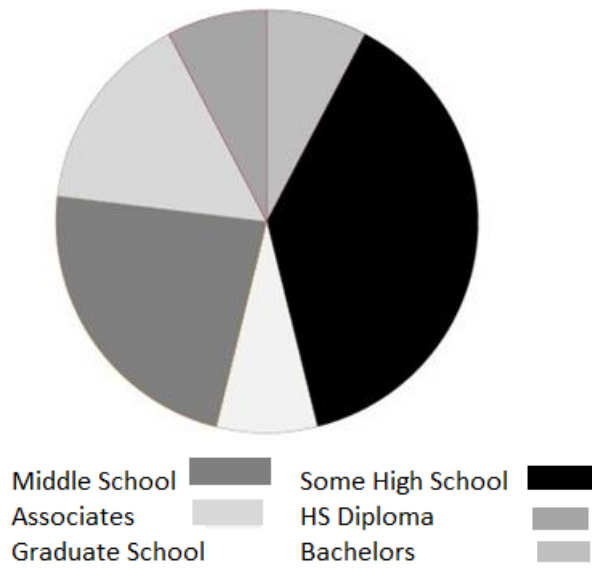


Figure 5. Pie chart, educational attainment.

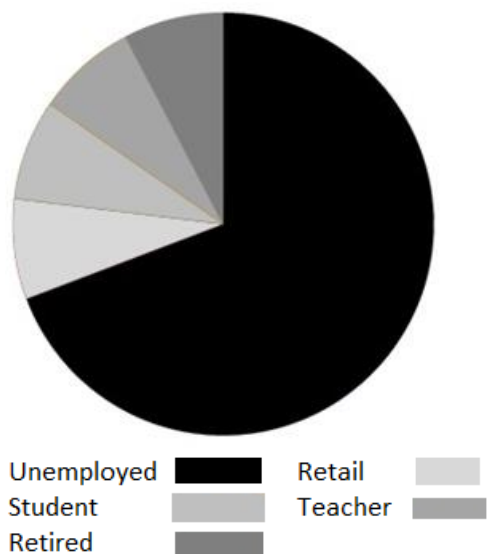


Figure 6. Pie chart, current occupation.

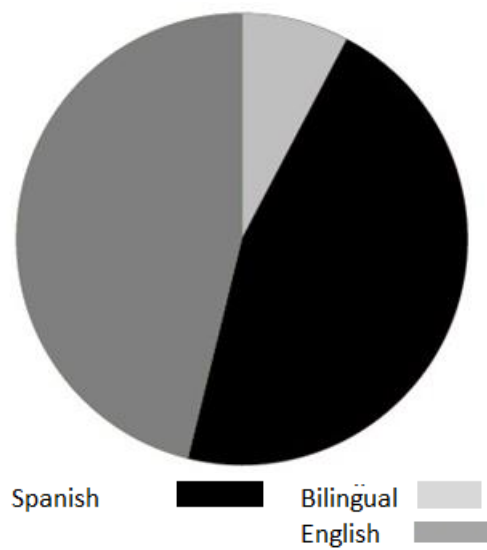


Figure 7. Pie chart, first language spoken by subject.

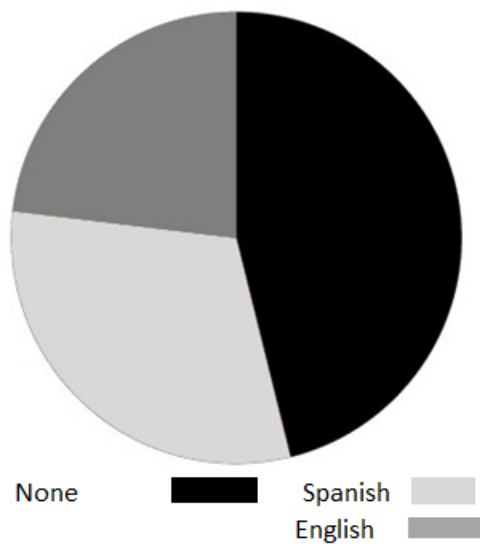


Figure 8. Pie chart, other languages spoken by subject.

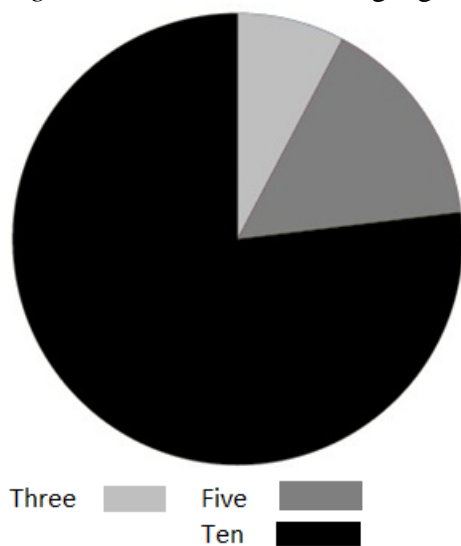


Figure 9. Subject's self-reported English proficiency on a 10-point scale.

Cross-Tabulations and Other Two-Way Graphs

After collecting descriptive statistics on each of the 10 main variables in the study, five cross-tabulations and a scatter plot were conducted. The first three cross-tabulations pertained to ethnicity by age, gender by age, and first language by age. The next two cross-tabulations pertained to English fluency by gender and English fluency by

race. The scatter plot graphed the relationship between self-reported English fluency and age. These procedures were conducted in order to determine whether, using bivariate analysis, more could be learned about the sample by going beyond the univariate analyses of the 10 variables in the overview of descriptive statistics. An α of .10 was adopted for all independent samples t tests. First, it was found that the age of African Americans in the study ($M = 55$, $SD = 13.379$) was significantly ($p = .0185$, $t = -2.7607$) greater than the age of the Hispanics ($M = 36.875$, $SD = 10.3017$) in the study.

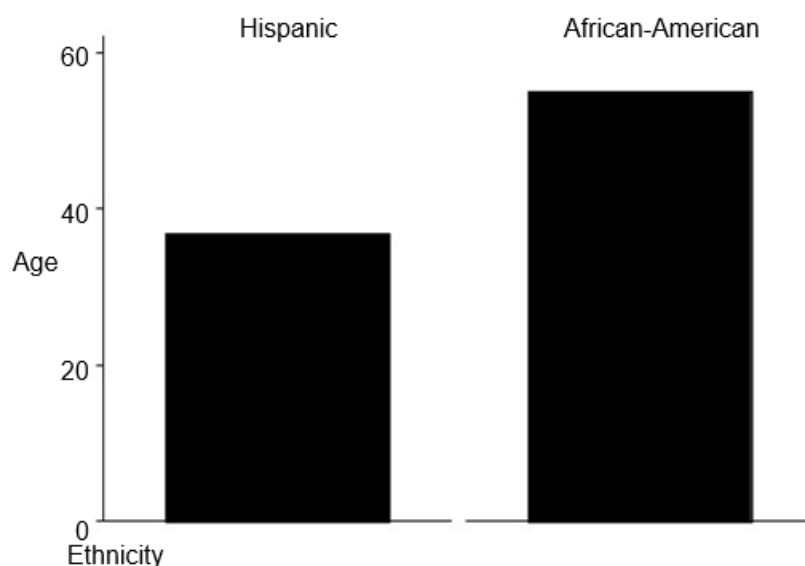


Figure 10. Mean age of African Americans and Hispanics in the study.

Second, it was found that the age of females in the study ($M = 48.428$, $SD = 5.09$) was not significantly ($p = .2282$, $t = -1.2761$) greater than the age of the males ($M = 38.5$, $SD = 14.57$) in the study.

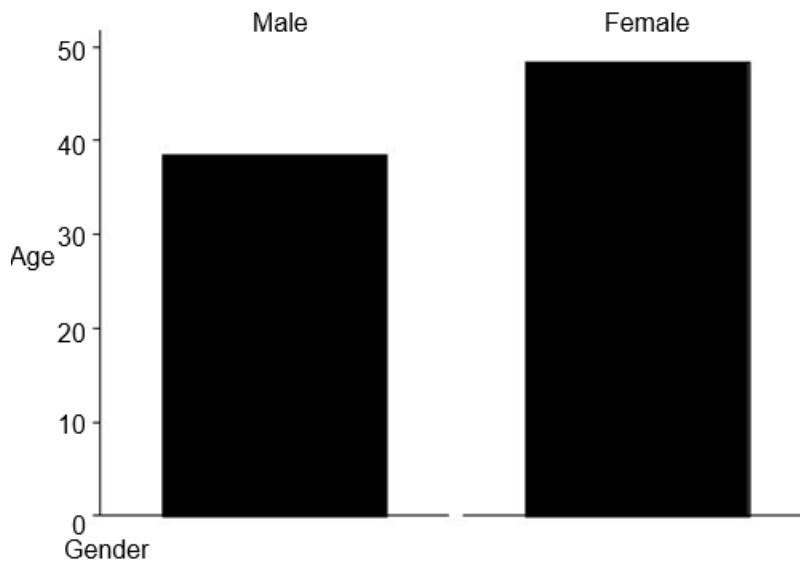


Figure 11. Mean age of males and females in the study.

Third, in keeping with the finding that the Hispanics in the study were significantly younger than the African American studies in the study, it was found that the age of Spanish first-language speakers ($M = 36.17$, $SD = 10.304$) was significantly ($p = .092$, $t = -1.867$) lower than the age of English first-language speakers ($M = 50.67$, $SD = 15.996$). One of the participants was bilingual; this participant was 49. The findings associated with the first three cross-tabulations offered further demographic insight into the sample, indicating that it was bifurcated between younger Hispanics and older African Americans, a bifurcation that also reflected itself in older English-first speakers and younger Spanish-first speakers.

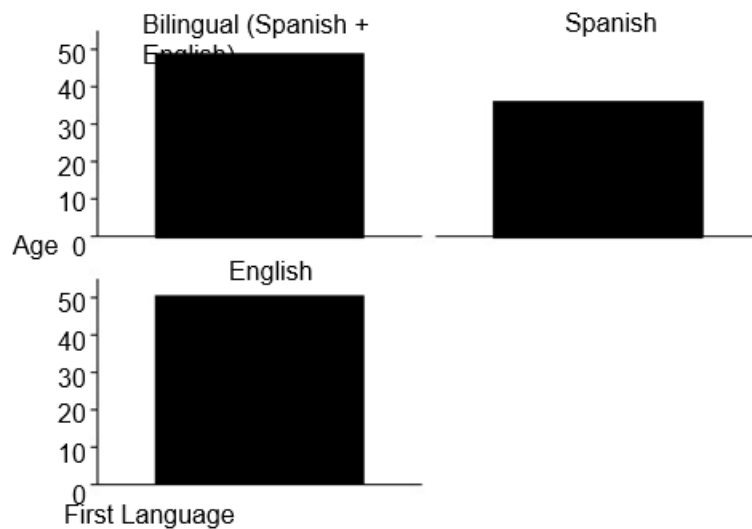


Figure 12. Mean age by first language spoken.

Fourth, a scatter plot revealed that there was no detectable relationship between age and self-rated English proficiency:

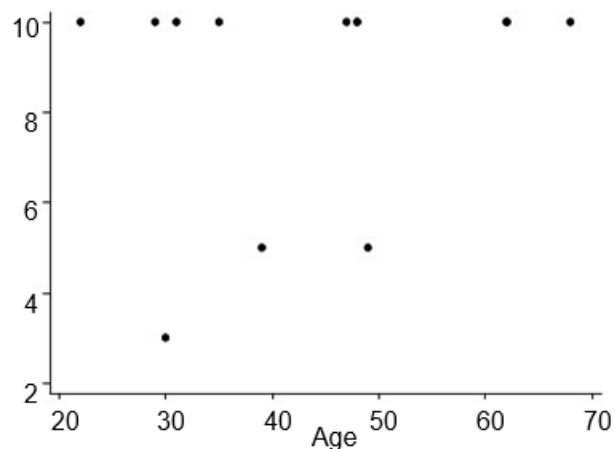


Figure 13. Scatter plot, age by English fluency.

Fifth, it was found that the English fluency of males ($M = 9.166$, $SD = 2.04$) was not significantly ($p = .5546$, $t = .6094$) greater than the English fluency of the females ($M = 8.28$, $SD = 1.97$) in the study.

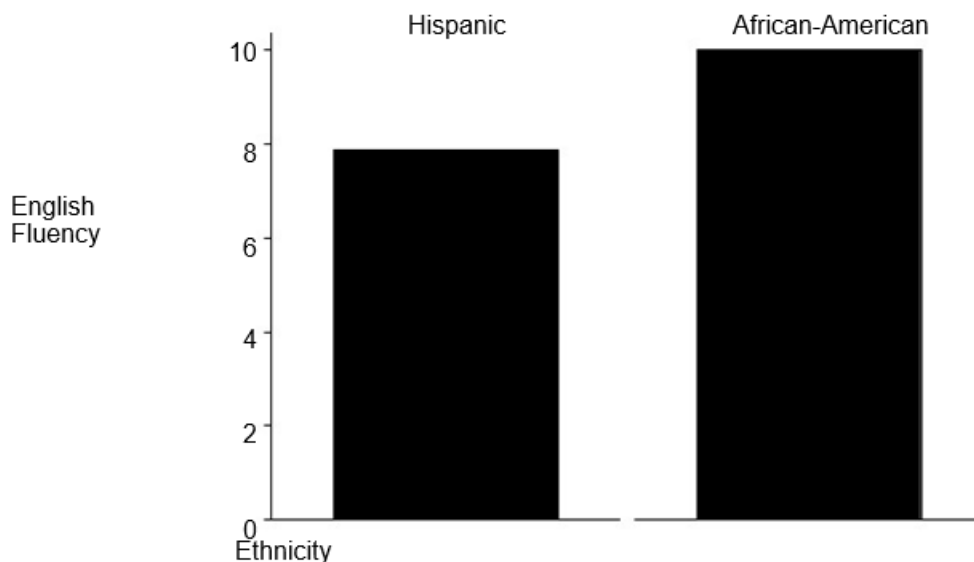


Figure 14. Mean English fluency of males and females in the study.

Finally, it was found that the English fluency of African Americans ($M = 10$, $SD = 0$) was not significantly ($p = .0736$, $t = -1.5591$) greater than the English fluency of the Hispanics ($M = 7.875$, $SD = 1.059$) in the study.

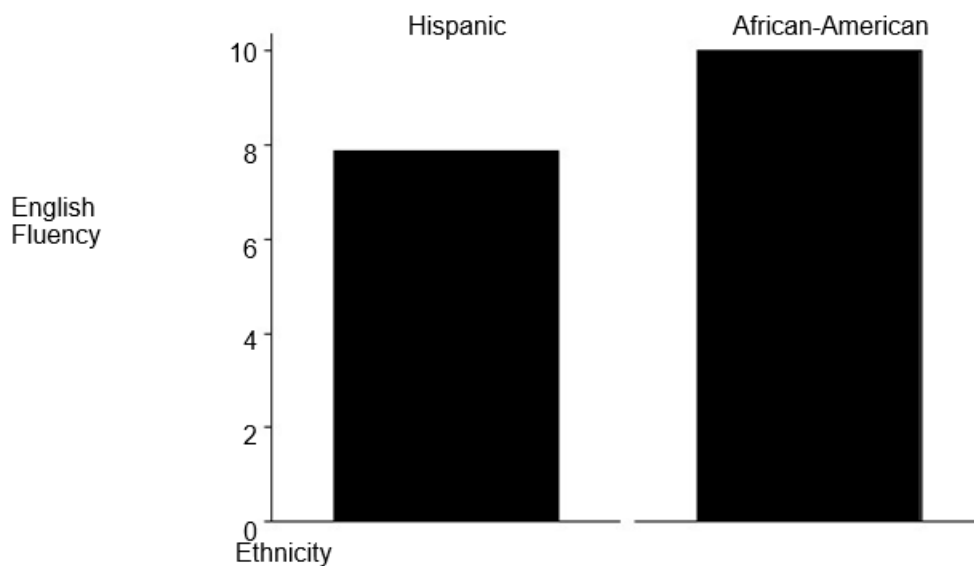


Figure 15. Mean English fluency by ethnicity.

Coding and Data Analysis

Coding and data analysis was conducted based on each of the three research questions in the study. The purpose of the coding and data analysis is to generate themes that will be examined in more detail. Although a line-by-line coding approach was adopted for all the data in the study, only relevant excerpts and summaries are presented in this section of the findings.

Coding and Data Analysis: RQ1

The first research question was as follows: What cultural barriers do African American and Hispanic clients in treatment perceive about the cultural competence of their clinicians (regardless of the clinician's race)? In order to answer this research question, the following steps were taken. First, key excerpts from participants' narratives were identified. Second, these excerpts were coded. Third, the codes were examined and cross-compared in order to provide a foundation for thematic identification.

Key excerpts from participants' narratives. The following excerpts represent crucial statements made by participants in terms of the first research question:

- This particular counselor thought that all African Americans think and have the same values and that the majority of our culture thinks the same way.
(Participant 1).
- When discussion came up about Africans and their culture, she was trying to be understanding but stereotyped ideas were still the same (Participant 1).

- It was very important for the counselors to know about my brother's morals, values, lifestyle, et cetera, because they didn't know about my brother enough to understand his wants, needs, and values...For example, he would go into other clients' rooms at night. They were assuming that there was a sexual reason for that, but he never expressed anything of a sexual nature. I had to tell them that. Also, being autistic, he would become belligerent when he was being mistreated or his needs were not met (Participant 2).
- There were several counselors, and some of them were African American, as well. The White counselors didn't seem to care too much about my brother as a human being. They just wanted him to do as he was told. They wouldn't really listen to me when I tried to explain that he was acting out because he was being mistreated when he was being given medication that was making him act worse instead of better (Participant 2).
- When trying to discuss my brother with this counselor, she thought I should do what they said, and there was no room for my own opinion or what I felt about the situation or about Black people on relatives when they don't act as others want him to act. She kept asking me, did I understand, as if I didn't have sense enough to understand (Participant 2).
- She never talked to me about my culture. As Black people we don't talk about our culture, we deal with how people treat us as African Americans, turning their nose up at us (Participant 3).

- I didn't care what they thought about my culture, I was there for treatment.

(Participant 5).

- Well, you don't need to know anything about my culture. If you're not going to be able to treat me you don't need to worry about my culture, my culture is me

(Participant 5).

- I prefer for a person to know who I am and what I'm about before you get into my business (Participant 6).

- I want them to understand where I'm coming from (Participant 7). She'd say everything that I tell her [inaudible] so I didn't trust her (Participant 8).

- The gap in between us, it'd be harder (Participant 10).

- And they don't really ask you where you come from or whether you are a true Spanish or are you Indian (Participant 4).

- But I do know my culture. I know where I come from. You know what I mean? And I do tell my therapist about my music and I value my Spanish, because that's my culture (Participant 9). Themes. The themes for Research Question 1 are shown in Table 1.

Table 1

Themes for RQ1

Theme	Support for theme
Understanding: Client cannot be understood without understanding or empathizing client's culture	Participants 3, 4, 6, 7, 9, 10 [Discrepant case: Participant 5]
Respect: Client's culturally influenced behavior can be ignored, misinterpreted, or not accorded proper therapeutic consideration	Participant 2
Categorization: Stereotyping can lessen therapist's fairness and professionalism in dealing with client	Participant 1
Confidentiality: Client and therapist can have different, culturally motivated understandings of confidentiality	Participant 8

Table 1 depicts the main themes that emerged from the coding and analysis of data related to the first research question. These themes will be examined in more detail later in the chapter.

Coding and Data Analysis: RQ2

The second research question was as follows: What cultural values or factors in identity are perceived to be important to African American and Hispanic clients in treatment? As with the first research question, data for the second research question were subjected to line-by-line coding, reduced to key excerpts, and finally used to generate themes.

Key excerpts from participants' narratives. The following excerpts represent crucial statements made by participants in terms of the second research question:

- My culture is very important to me. Morals and values are a very important part of who I am (Participant 1).
- When it comes to cultural values or factors, it's important that people know you and understand you without labeling you or judging you on gender and age and other situations (Participant 1).
- It was very important for the counselors to know about my brother's morals, values, lifestyle, et cetera . . . (Participant 2).
- Well, if people are different, they have different mentality, and some people have different type of feelings (Participant 4). Themes. Table 2 shows the themes that emerged for Research Question 2:

Table 2

<i>Themes for RQ2</i>	
Theme	Support for theme
Morals and values	Participants 1, 2, 6
Culturally specific feelings	Participants 4, 9

Only two themes emerged for Research Question 2, namely (a) morals and values and (b) culturally specific feelings. For reasons discussed more fully towards the end of this chapter, participants did not clearly articulate which aspects of culture were particularly important within the context of treatment.

Coding and Data Analysis: RQ3

The third research question was as follows: Which variables contribute to the dropout of African American clients and Hispanic clients? There was some overlap between the third and first research question; the distinction was that the first research

question was designed to identify all cultural barriers to treatment while the third research question was designed to identify only those barriers that contributed, or plausibly might have contributed, to dropping out of therapy. As such, only the narrative excerpts directly relevant to dropout (that is, directly related to dropout in the data) will be coded and analyzed in this section of the findings.

Key excerpts from participants' narratives. The following excerpts represent crucial statements made by participants in terms of the third research question:

- This particular counselor thought that all African Americans think and have the same values and that the majority of our culture thinks the same way (Participant 1)
- When discussion came up about Africans and their culture, she was trying to be understanding but stereotyped ideas were still the same (Participant 1).
- It was very important for the counselors to know about my brother's morals, values, lifestyle, et cetera, because they didn't know about my brother enough to understand his wants, needs, and values...For example, he would go into other clients' rooms at night. They were assuming that there was a sexual reason for that, but he never expressed anything of a sexual nature. I had to tell them that. Also, being autistic, he would become belligerent when he was being mistreated or his needs were not met (Participant 2).
- There were several counselors, and some of them were African American, as well. The white counselors didn't seem to care too much about my brother as a

human being. They just wanted him to do as he was told. They wouldn't really listen to me when I tried to explain that he was acting out because he was being mistreated when he was being given medication that was making him act worse instead of better (Participant 2).

- When trying to discuss my brother with this counselor, she thought I should do what they said, and there was no room for my own opinion or what I felt about the situation or about Black people on relatives when they don't act as others want him to act. She kept asking me, did I understand, as if I didn't have sense enough to understand (Participant 2).

- She'd say everything that I tell her [inaudible] so I didn't trust her (Participant 8).

Themes. Table 3 shows the themes that emerged for Research Question 3:

Table 3

Themes for RQ3

Theme	Support for theme
Respect: Client's culturally influenced behavior can be ignored, misinterpreted, or not accorded proper therapeutic consideration	Participant 2
Confidentiality: Client and therapist can have different, culturally motivated understandings of confidentiality	Participant 8

Discussion of Themes

A number of themes were identified in the study, with themes specific to each research question and other, more comprehensive themes pertaining to all of the research questions. The sub-themes were as follows:

1. Understanding: Client cannot be understood without understanding or empathizing client's culture.
2. Respect: Client's culturally influenced behavior can be ignored, misinterpreted, or not accorded proper therapeutic consideration.
3. Categorization: Stereotyping can lessen therapist's fairness and professionalism in dealing with client.
4. Confidentiality: Client and therapist can have different, culturally motivated understandings of confidentiality.
5. Morals and values.
6. Culturally specific feelings.
7. Confidentiality: Client and therapist can have different, culturally motivated understandings of confidentiality.

These sub-themes can be associated with two overarching themes in the study, namely professionalism and misalignment. The theme of professionalism related to several participants' stated belief that the therapeutic process had little to do with differences or similarities between their cultures and those of the therapists, but rather with the culture-independent ability of the therapist to serve a meaningful professional

function. The theme of misalignment related to other participants' stated belief that some sort of cultural alignment (whether reflected as cultural knowledge, awareness, sensitivity, or some related construct) between client and therapist was necessary for the therapeutic relationship to work.

While these two themes emerged from the coding and data analysis processes, there was little explanatory data underlying the themes. In other words, while participants did articulate their belief in either professionalism or misalignment, they did not, for the most part, attempt to explain how or why they had come by these beliefs, or what the justification for these beliefs was. I attempted to take advantage of the semistructured aspect of the interview protocol by asking numerous follow-up questions designed to delve more deeply into the participants' beliefs and obtain richer data, but, in the majority of cases, this strategy was not successful. Participants often refused to elaborate further, digressed to another topic, or repeated their initial responses. As such, while the two main themes emerging from the data are clear, the question of how to properly excavate these themes is somewhat difficult. Nonetheless, there are enough data to attempt an explication, albeit a limited one, of the two overarching themes.

Professionalism

The theme of professionalism can be understood as participants' determination to engage in therapy regardless of cultural dynamics between the participant and the therapist. This view was expressed most forcefully by Participant 5, but it was also mentioned by Participant 9 and alluded to by several other participants. The only two

participants who expressed a specific determination to cease therapy in case of a cultural misunderstanding were Participants 2 and 8, and, in both of these cases, the participants indicated that the misunderstanding would have to escalate into, or somehow lead to, outright unprofessionalism on the part of the therapist. No participant gave any indication that the mere existence of cultural difference or insensitivity, unaccompanied by unprofessionalism, could be grounds for the termination of therapy. Professionalism was an attitude of help seeking disconnected from cultural dynamics. Two kinds of disconnection emerged from the data. Participant 2 expressed the belief that culture didn't matter at all in the therapy room. Other participants (in particular, Participants 3, 6, 7, 10, 4, and 9) indicated that culture mattered, but they did not set the bar high for the therapist; these participants indicated that the therapist had to make an ordinary effort to understand the client's culture. No participant indicated that therapists were obliged to make an extraordinary effort to achieve cultural sensitivity in the context of the therapeutic relationship.

Misalignment

Misalignment was a theme raised explicitly by Participants 1, 2, 3, and 8, although only Participants 2 and 8 indicated their willingness to terminate therapy over it. Misalignment is a catchall phrase for any cultural misunderstanding, turbulence, or insensitivity that can occur in the context of a therapeutic relationship. There were only two kinds of misalignment mentioned in the data: (a) minor or benign misalignment, which took the form of therapists not understanding, or not demonstrating curiosity,

about the client's culture (Participants 3, 6, 7, 10, 4, 9); and (b) major or malign misalignment, which can take the form of racism (Participant 1) or malpractice (Participants 2, 8). In the narratives of Participants 1 and 2, it was fairly clear that the therapist's faulty treatment of the patient was rooted in a cultural discrepancy; it was more difficult to reach such a conclusion in the case of Participant 8, who ascribed cultural factors to a therapist's lack of confidentiality. While culture could certainly have been a factor in the case of Participant 8—the participant herself certainly believed that it was—the inference appeared to be weaker than in the cases of Participants 1 and 2.

In examining the narratives of Participants 1, 2 and 8, the connection between the overarching themes of misalignment and professionalism was clear; for each of these participants, misalignment was what brought about unprofessionalism in the therapist. In the narrative of Participant 1, misalignment expressed itself in the therapist's racial stereotyping of African American patients. In the narrative of Participants 2 and 8, misalignment expressed itself as the therapist's violation of professional guidelines about treatment and confidentiality, respectively. In each case, participants expressed their willingness to keep working with therapists of different cultural orientations until the point that the line of professionalism was crossed. Essentially, the theme of professionalism overlapped with the theme of benign misalignment; in other words, as long as the misalignment between the client and therapist was benign, participants indicated their willingness to continue in therapy without much concern for cultural awareness or difference. However, when clients perceived malign misalignment, they

were more inclined to see therapists as crossing lines of professionalism precisely because of a lack of cultural awareness or sensitivity.

Discrepant Themes and Cases

Participant 5 was the only participant who explicitly stated a belief that culture was not an important aspect of the therapeutic process. Every other participant in the study emphasized the importance of culture in one way or another. Thus, Participant 5 constituted the only discrepant case. However, Participant 5 did not necessarily articulate a discrepant theme; rather, Participant 5 appeared to be expressing an extreme view of misalignment; in other words, Participant 5 expressed a belief in the existence of cultural misalignment, but also stated that it was irrelevant to the therapeutic context, because professionalism could survive such misalignment. As such, Participant 5 did not contribute new themes to the study, but rather presented a unique perspective on both misalignment and professionalism.

Summary of Results

The main finding to emerge from the study was that participants had two main orientations towards cultural difference with therapists, namely professionalism and misalignment. These two themes can be considered reflections of each other. Participants were aware that, as African Americans or Hispanics, they had extensive cultural differences with their therapists; however, participants believed that misalignment was not a bar to engaging in a professional relationship with therapists until the misalignment escalated into malignity. Malign misalignment was a kind of misalignment that,

particularly according to Participants 2 and 8, was associated with the therapist's descent into malpractice. The other kinds of misalignment were considered manageable by the participants, even if and when therapists failed to inquire about the client's culture or to demonstrate cultural sensitivity in the therapy room.

Table 4
Sub-themes and Themes in the Study

Sub-themes	Themes
Understanding: Client cannot be understood without understanding or empathizing client's culture Respect: Client's culturally influenced behavior can be ignored, misinterpreted, or not accorded proper therapeutic consideration Categorization: Stereotyping can lessen therapist's fairness and professionalism in dealing with client Confidentiality: Client and therapist can have different, culturally motivated understandings of confidentiality Morals and values Culturally specific feelings Confidentiality: Client and therapist can have different, culturally motivated understandings of confidentiality	The theme of professionalism can be understood as participants' determination to engage in therapy regardless of cultural dynamics between the participant and the therapist; professionalism was an attitude of help seeking disconnected from cultural dynamics. There were two kinds of misalignment mentioned in the data: (a) minor or benign misalignment, which took the form of therapists not understanding, or not demonstrating curiosity, about the client's culture; and (b) major or malign misalignment, which can take the form of racism or malpractice.

Conclusion

As Moustakas (1994) suggested, phenomenology works on at least two distinct levels. The first level of phenomenology is the identification of a phenomenon; at this level, it is possible to establish that a phenomenon exists, to name this phenomenon, and to identify it with particular phenomenological characteristics. The second level of phenomenology is the explication of a phenomenon. After a phenomenon is identified,

further phenomenological analysis can help to establish how and why the phenomenon exists. This study was successful in identifying the phenomenon of cultural awareness in the therapeutic relationship and in associating this phenomenon with some basic characteristics, such as the propensity for clients to drop out if they felt cultural misalignment with their therapist or the propensity for clients to try to distinguish the importance of cultural awareness from the basic therapeutic contract. However, as discussed at length in the section on limitations, the study was less successful in explicating the phenomenon of cultural awareness in therapy. Despite being presented with relevant research questions and prompted with ad lib questions about cultural awareness, few participants were able to explicate the how and why attributes of the phenomenon of cultural awareness in therapy. More detailed suggestions for avoiding this limitation in future research will be presented in the fifth and concluding chapter on the study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of the conclusion is to summarize the findings of the study, discuss the limitations of the study, relate the findings to previous research, offer recommendations for future research, and provide a final, reflective conclusion. I have also incorporated some reflections into the discussion of limitations and to the generation of recommendations for future studies.

Summary of Findings

The main findings of the study were the identification of the main themes of professionalism and misalignment. As is discussed in the section on limitations of the study, the findings were more descriptive than analytical. The theme of professionalism touched on clients' willingness to press forward with therapy despite misgivings about cultural misunderstandings or lack of congruence. The theme of misalignment touched on either benign or malign cultural differences between the client and therapist, which, at their worst, were capable of disrupting therapy, and, at their best, were capable of allowing the clients to continue with therapy under the motivation of professionalism.

Limitations

The study had a number of limitations. One of the most important limitations of the study was lack of sufficient detail in responses. In some instances, participants did not respond to cues in the formal interview protocol. In other instances, despite being asked

open-ended questions designed to solicit rich responses, participants gave one-word responses (in particular, “yes” and “no” responses) that would have been more appropriate to closed questions. It was also observed that, despite being asked questions about cultural awareness, participants often digressed, inserting discussions about their medication, grievances, and treatment plans, all of which had little or nothing to do with cultural awareness.

To be sure, many clients assented to the claim that cultural awareness on the part of counselors was important, but did not go beyond this observation to explain how and why such awareness was important, and what the role of such cultural awareness in therapy was. In some cases, a language barrier might have been to blame for my inability to elicit rich responses from participants. However, I observed the same patterns of attenuated responses, digression, and lack of introspection even when interacting with participants whose English was flawless. Accordingly, something other than language must to be blame for the relatively lack of rich, relevant data in the study.

One possibility is that the participants in the study had not previously introspected about the role of cultural awareness in therapy, or else that they were not able or willing to convey that introspection in a research setting, perhaps because doing so was not relevant to their own needs as clients. Each of the participants in the study was, in at least one way, a cultural minority both in what remain a White-majority America and an overwhelmingly White-majority therapeutic culture. Cultural introspection is not necessarily a value that is encouraged by the majority culture, for which deeper cultural

awareness on the part of cultural minorities can be threatening. Oftentimes, cultural difference goes undiscussed or unexamined; consider, for example, that many of the participants in the study reported that their therapists never employed culturally sensitive approaches or exercised any form of cultural curiosity in the therapy room. This dynamic has been discussed at greater length in the discussion presented earlier in the chapter; the purpose of reiterating these points here is to indicate that the limitations of the study are fruitful in their own right. In other words, the relative lack of rich data reinforces some important points of how and why culture awareness is excluded, at least formally, from the therapeutic context. The limitation is thus reflective not only of a limitation of the study, but also of a limitation in the way culture is acknowledged, utilized, and managed in the therapeutic setting. Had therapists encountered by my subjects been more culturally aware, it is likely that the participants would have had more to say about the importance of cultural awareness within therapy. As it was, the patients and therapists appeared to be on the other side of a cultural gulf that the therapists were either unaware of or did not make a bona fide attempt to cross, which in turn prevented the patients from understanding (or even being aware of) the meaning of cultural awareness in a therapeutic setting. That said, some rich data and themes did emerge from the study and were subject to fruitful interpretation earlier in the chapter.

It is not clear whether the small size of the sample was a limitation. Typically, qualitative studies do not require the drawing of a large sample, because the need to generalize to a population through the utilization of a minimum sample size is a property

of quantitative studies, not qualitative studies. Theories of qualitative research suggest that a small number of participants is sufficient to reach data saturation. However, it is always possible that sampling a very limited number of participants from a single location can yield entirely different data than might have been obtained from engaging in a broader kind of sampling.

Relevance of Findings to Previous Research

As Snyder et al. (1977) argued, cultural difference, particularly in the form of conscious or unconscious stereotypes, is ever-present in therapy, probably because of the human need to employ stereotyping and similar cognitive shortcuts as a means of avoiding the burden of having to construct individual schemas for each person they meet (Dovidio et al., 2002). Cultural awareness can add richness to the therapeutic relationship; in particular, racer-concordant therapist visits appear to remove existing social and racial obstacles to the formation of a strong therapeutic relationship (Atkinson & Lowe, 1995; Hemant & Thornton, 2010; John, 2007; McLoyd & Dodge, 2004; Noguera, 2010).

Although the literature indicated that, in any instances, African Americans and other minorities seek a therapeutic experience that is easier for race-concordant therapists to provide, there has been little research on the question of whether minorities will continue therapeutic treatment even in the absence of racial concordance with the therapist, or even in the absence of cultural awareness displayed by the therapist.

However, theory suggests that African Americans and other minorities will be likely to

seek out race-concordant theorists or at least therapists who provide a high level of cultural awareness (Gloria & Peregoy, 1996; Jenkins, 1991; Kennedy, 2003; Rogoff, 2004; Stolzenberg, 2010). This finding was not confirmed by the findings presented in Chapter 4. Only three participants (1, 2, and 8) explicitly terminated therapy because of a cultural disagreement with the therapists; of the remaining 10 participants, none indicated that they wanted race-concordant therapists or that a high level of cultural awareness was necessary on the part of White therapists.

This finding can be interpreted in a number of ways. First, it could be the case that therapists have made strides in becoming more culturally aware and sensitive, and that previous scholars' findings about widespread cultural turbulence between clients and therapists (Atkinson & Lowe, 1995; Gloria & Peregoy, 1996; Hemant & Thornton, 2010; Jenkins, 1991; John, 2007; Kennedy, 2003; McLoyd & Dodge, 2004; Noguera, 2010; Rogoff, 2004; Stolzenberg, 2010) are not based on this recent change in professional dynamics. It is also possible that the sample drawn in this study did not adequately represent the experience of minorities in therapy; in other words, the relative lack of cultural turbulence between the participants and their therapists might not reflect what is actually the case in the population of minorities in therapy. Finally, it is possible that minorities, particularly African Americans and Hispanics, will be re-evaluating their approach to therapy. Participant 5 was particularly adamant about her insistence on receiving therapy for her problems apart from any considerations of cultural alignment or concordance with the therapist. Several of the other participants also indicated that their

primary goal was treatment (Participant 3, 6, 7, and 9). This attitude can be interpreted in two ways. One interpretation is that, with the passage of time, once therapy-averse or therapy-wary minorities are coming to accept therapy as a standard professional service, and that this change in attitude facilitates minorities' ability to engage in therapy without desiring a high level of customization. It is possible that the first generations of minorities to go to therapy were, because of higher levels of wariness and cultural taboos, required more hand-holding of a kind that could be better provided by race-concordant therapists. Similarly, it is possible that the spreading acceptance of therapy has lowered the bar in terms of what clients expect from their therapists in terms of cultural awareness; perhaps people who are more open to the idea of therapy are also capable and desirous of receiving therapy from people who are culturally different from them.

Another possibility is that the participants in the sample lacked a certain kind of critical consciousness about the role of cultural awareness in therapy. Clearly, cultural difference continues to matter in almost every social transaction in America, with therapy being no exception (Coleman, 2010; Kennedy, 2010; Ridley et al., 1994). However, it is possible that minorities are revising their expectations of cultural awareness downwards (as evidenced by Participant 3's statement that "as Black people we don't talk about our culture, we deal with how people treat us as African Americans, turning their nose up at us"), or perhaps failing to see the existence of cultural power dynamics in the therapy session. As Romero (2007) has argued, one of the end results of monoculturalism in therapeutic is that power issues related to cultural difference might be invisible to

minority clients, or minority clients might feel too disenfranchised to want to examine these issues directly (which appeared to be the case with Participant 3, whose comment suggested a certain weariness about the prospect of negotiating or even disclosing cultural difference with his therapist).

Of course, all of these interpretations might be correct, or they might also all be wrong. In the absence of more research on the topic, it is impossible to determine the relative contributions of changing standards of cultural competence among therapists, minorities' increasing acceptance of therapy, or minorities' static or declining critical consciousness to the observed finding, which is that minority clients do not appear to place a high premium on cultural awareness in the therapeutic setting.

Recommendations for Future Research

Based on the relative lack of rich data in the study, one recommendation for future qualitative researchers working with samples of therapeutic subjects is to pilot their interview protocols in order to be able to better calibrate the complexity and detail of questions. Cultural awareness is a complex construct, in that subjects are certainly likely to be aware of the meaning and basic implications of cultural awareness, but might not have given much thought to the more complex dynamics of culture as part of the therapist-client relationship. It is possible that the interview protocol I used was not fully appropriate for the sample, in that the language or concepts employed might have been too complex to facilitate data collection; pilot interviews could thus help future

researchers align the complexity and detail of their questionnaires with the narrative propensities and capabilities of their sample.

A related recommendation for future researchers is to employ a multi-interview or even longitudinal format with study participants, preferably couched in a methodology other than phenomenology. As Paolo Freire has argued, people who are or who feel disenfranchised by institutional power structures—of which therapy must be counted a part—often lack awareness of their role within the system and do not begin to articulate awareness until after extensive engagement with someone who can (a) give them a proper understanding of the proper relationships in the system and (b) encourage them to articulate their own point of view and, if necessary, challenge the existing power structure. Within the bounds of phenomenological research, researchers cannot and should not try to stimulate critical awareness in their subjects; the purpose of the researcher is to gather and analyze data pertaining to a phenomenon or subjects' interactions with a phenomenon, not to critically intervene in the subjects' perceptions. However, there are other qualitative research traditions that support more of a Freirean approach to engagement with subjects. In working with therapeutic clients who are marginalized (because of their ethnicity, employment status, place of birth, language spoken, and many other potential factors), it might be more appropriate for researchers to adopt a research tradition that supports not only passive data collection but also some form of critical intervention in the perceptions of the subject. In conducting my study, I often felt myself bounded by the limits of phenomenology, a structure within which I was

not able to do anything other than explore participants' existing perceptions and feelings. It appeared to me that several of the participants would likely have offered a more detailed and critical articulation of the power dynamics of culture that occur within the therapeutic relationship, if only I had been able to approach them with the mindset of developing a critical consciousness rather than as a phenomenological data collector. Accordingly, I would recommend to future qualitative researchers working with similar populations to they adopt a more interventionist research approach, and to remain engaged with subjects for several sessions, given that subjects will not immediately be able or willing to offer detailed, critical insight into the dynamics of cultural awareness in the therapy room.

In Chapter 4, it was established that minorities are not placing a high premium on cultural awareness in the therapeutic setting; those minorities who terminated therapy over questions of cultural difference did so only when confronted with overt malpractice, and overall the sample appeared willing to accept a minimal standard of cultural awareness (primarily limited to acknowledgement of difference and curiosity about the client's culture) rather than to insist on a more rigorous form of cultural sensitivity on the part of the therapist. This finding requires further explication. There appear to be three likely explanations of why minorities have fairly relaxed standards for cultural awareness in the therapeutic setting: changing standards of cultural competence among therapists, minorities' increasing acceptance of therapy, or minorities' static or declining critical consciousness. Future studies could examine these three themes as possible determinants

of minorities' increasing acceptance of basic, rather than rigorous, cultural awareness in the therapeutic setting. Such studies might also affirm the findings of previous studies that minorities are in fact more rather than less demanding of rigorous cultural awareness in therapeutic settings (Atkinson & Lowe, 1995; Gloria & Peregoy, 1996; Hemant & Thornton, 2010; Jenkins, 1991; John, 2007; Kennedy, 2003; McLoyd & Dodge, 2004; Noguera, 2010; Rogoff, 2004; Stolzenberg, 2010).

Reflection and Conclusion

As an African American female with an extensive background in therapy, I have seen many changes in minorities' approaches to therapy. I am personally in favor of a more rigorous form of cultural awareness or cultural sensitivity incorporated into therapy. I was surprised to find that so many of the participants I interviewed were at peace with what could be considered minimal standards of cultural awareness in therapy. To me, the most important aspect of the study was the relation of this finding to three possible theoretical underpinnings (namely changing standards of cultural competence among therapists, minorities' increasing acceptance of therapy, or minorities' static or declining critical consciousness). The primary significance of the study was its identification of these theoretical underpinnings, each of which has very different consequences for the issue of minority treatment in therapy. If given the chance to revisit this research topic as a scholar or in a professional research capacity, I would design a study capable of exploring these underpinnings further.

In terms of social change implications, I should note that this study provided compelling evidence that many therapists are failing to provide the kind of cultural sensitivity, much less culturally relevant treatment that are required or desired by African American or Hispanic clients, and therefore provided a call to action for therapists to better address culture in the therapy room. The main social change implication of a more culturally relevant and sensitive therapy for African Americans and Hispanics is that these populations will receive improved mental health outcomes; successful therapy for minorities means increased happiness, function, and productivity for otherwise vulnerable people. For such outcomes to be obtained, therapists need to find a way to be more culturally sensitive and aware, using the kinds of guidance provided in this study and other reviews of the special therapeutic needs of African American and Hispanic clients.

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Appendix A: Client Perception of Mental Health Counselor's Culture Awareness Interview

1. Tell me how important was it for your counselor to know about your morals, values and lifestyle. Was it important that your counselor asked about your morals, values and lifestyle? What cultural values or factors do you perceive to be important in treatment?
2. What do you believe your counselor thought about your race, customs, values, and lifestyle?
3. Have you discussed your customs and values with your counselor, and how did the counselor communicate with you about these issues?
4. How likely are you to stay in treatment if you believed that your counselor cared about your customs and values, did this affect whether you stayed in treatment?
5. What were your thoughts and feelings if you believed your counselor did not understand or discuss your life customs and values?

Demographic Questionnaire

Data collected from this survey will be used for dissertation research purposes only, and your name will not be associated with your responses in any manner.

Please provide the following demographic information:

1. Your gender: Male _____ Female _____
2. Your age _____
3. Your race or ethnicity _____
4. Your city of birth _____

5. Your education level (year) _____
6. Your occupation (if any) _____
7. What do you consider to be your first language?
8. What other languages do you speak?
9. What language do your parents speak at home?
10. On a scale of 1 to 10, where 10 is complete fluency, how fluent do you think you are in English?

Appendix B: Transcripts of Interviews

[Begin Part 1 Participant 1]

RESEARCHER: Before we begin the interview itself, I'd like to confirm that you have read and signed the informed consent form, that you understand your participation in this study is entirely voluntary, that you may refuse to answer any questions, and that you may withdraw from the study at any time.

PARTICIPANT: I agree.

RESEARCHER: Have you ever dropped out of treatment?

PARTICIPANT: My student dropped out of treatment. He is African American.

RESEARCHER: Tell me how important it is for your counselor to know about your self-morals and values.

PARTICIPANT: My culture is very important to me. Morals and values are a very important part of who I am. When it comes to cultural values or factors, it's important that people know you and understand you without labeling you or judging you on gender and age and other situations.

RESEARCHER: What do you think you believe the counselor thought about your student's race customs or values and lifestyles?

PARTICIPANT: This particular counselor thought that all African Americans think and have the same values and that the majority of our culture think the same way.

COUNSELOR: Have you discussed your customs and values as an African American with the counselor?

PARTICIPANT: When discussion came up about Africans and their culture, she was trying to be understanding but stereotyped ideas were still the same.

RESEARCHER: How likely are you to stay in treatment if you believed your counselor did not understand or discuss your life, customs, or values?

PARTICIPANT: She cannot help me or with my values so that I can trust her, believe in her.

NEXT TAPE

[Begin Participant 2]

RESEARCHER: Before we begin the interview itself, I'd like to confirm that you have read and signed the informed consent form, that you understand your participation in this study is entirely voluntary, that you may refuse to answer any questions, and that you may withdraw from the study at any time.

PARTICIPANT: I agree.

RESEARCHER: Have you ever dropped out of treatment?

PARTICIPANT: Well, I had to pull my brother out of therapy treatment.

RESEARCHER: Tell me how important was it for the counselor to know about your brother's morals, values, and lifestyle. What cultural values or factors did you perceive to be important in treatment?

PARTICIPANT: It was very important for the counselors to know about my brother's morals, values, lifestyle, et cetera, because they didn't know about my brother enough to

understand his wants, needs, and values since he was in a GROUP home. For example, he would go into other clients' rooms at night. They were assuming that there was a sexual reason for that, but he never expressed anything of a sexual nature. I had to tell them that. Also, being autistic, he would become belligerent when he was being mistreated or his needs were not met. I believe religious values are important as well as parental interactions and how well one respects elders, parents, siblings, et cetera are all part of cultural values, and all cultures are slightly different.

RESEARCHER: What do you believe your brother's counselor thought about you, your race customs, values, and lifestyle?

PARTICIPANT: There were several counselors, and some of them were African American, as well. The White counselors didn't seem to care too much about my brother as a human being. They just wanted him to do as he was told. They wouldn't really listen to me when I tried to explain that he was acting out because he was being mistreated when he was being given medication that was making him act worse instead of better. They would not advocate for him to be taken off the medication or for it to be changed. One counselor used to call me at work and demand that I come to the hospital when my brother was in the hospital to discuss ending his treatments and just let him die. I felt that he had no compassion for him as a Black man and just wanted to be done with him.

RESEARCHER: Have you discussed your customs and values with your counselor, and how did the counselor communicate with you about these issues?

PARTICIPANT: When trying to discuss my brother with this counselor, she thought I should do what they said, and there was no room for my own opinion or what I felt about the situation or about Black people on relatives when they don't act as others want him to act. She kept asking me, did I understand, as if I didn't have sense enough to understand. We finally found another place where the people were more receptive and more professional and showed more understanding.

RESEARCHER: How likely are you to stay in treatment if you believed your counselor did not understand or discuss your life, customs, or values?

PARTICIPANT: My feelings were first anger and frustration and then a determination to fight until we got my brother into a situation that was easier for him, which we did. His mood and everything got better once we moved him to a new situation. The new counselor was a Black woman.

[Begin Participant 3]

RESEARCHER: Okay, before we begin the interview itself, I'd like to confirm that you have read and signed the informed consent form, that you understand your participation in this study is entirely voluntary, that you may refuse to answer any questions, and that you may withdraw from the study at any time.

PARTICIPANT: I agree.

RESEARCHER: Tell me how important it is for your counselor to know your morals, values, and lifestyle. Was it important that your counselor asked about your morals, values, and lifestyle? What cultural values or factors did you perceive to be important in treatment?

PARTICIPANT: They are supposed to. They got to understand my culture and everything.

RESEARCHER: Have you discussed your customs and values with your counselor? What did your counselor think about your race customs, values and lifestyle?

PARTICIPANT: I don't. She never talked to me about my culture. As Black people we don't talk about our culture, we deal with how people treat us as African Americans, turning their nose up at us.

RESEARCHER: How likely are you to stay in treatment if you believed your counselor cared about your customs and values; did this affect whether you stayed in treatment?

PARTICIPANT: Yes, I'd go all the time if I thought they understood my culture.

RESEARCHER: What were your thoughts and feelings if you believed your counselor did not understand or discuss your life customs and values?

PARTICIPANT: You have to tell the counselor about your culture.

[BEGIN PART 1]

[Begin Participant 4]

RESEARCHER: Is it important for you for the counselor to understand something about you as your culture? How important do you think it is for the counselor to understand something about your culture? About your Hispanic culture? Is it very important?

PARTICIPANT: Mucho.

RESEARCHER: Mucho? Okay.

[Participant speaking inaudibly in Spanish – too far from mic]

RESEARCHER: The counselor that she talks to, do you think that the counselor is taught enough about your culture, understands enough about your culture?

PARTICIPANT [Through Translator]: Yes, they understand.

RESEARCHER: But they understand her as a Hispanic coming to America, does the counselor understand enough about the lives of Hispanics?

PARTICIPANT: Sí.

RESEARCHER: How likely are you – will you stay in treatment if you think that they understand you enough?

PARTICIPANT: Sí.

RESEARCHER: Have you ever been anywhere else besides this clinic for treatment?

PARTICIPANT: Sí.

RESEARCHER: Okay, and you feel like you're understood here?

PARTICIPANT: Sí

RESEARCHER: Now, what if they don't understand anything about your culture? Would you still keep talking to them or look for somebody who understands more about Spanish people?

PARTICIPANT [Through Translator]: It really don't matter as far as that goes, if they understand as long as they can take care of their kids.

RESEARCHER: If they don't understand anything about –

PARTICIPANT [Through Translator]: She don't care as long as – she's here for her kids.

RESEARCHER: Okay, so what about if they understand something about their kids' culture, about their kids being Hispanic? You know, everybody as their own identity. And I'm trying to find out how important it is to understand something about the kids' identity, but they've got to first understand something about their culture. Does that mean anything to her? What does she feel? They probably have a lot of Spanish counselors here. I want to make sure – do you understand what I'm saying? Do they understand you? What does she look for?

[The session was interrupted when the participant and translator were called to their appointment]

[Part 1 Participant 5]

RESEARCHER: Have you ever been in treatment before?

PARTICIPANT: No.

RESEARCHER: Okay, before we begin the interview itself, I'd like to confirm that you have read and signed the informed consent form, that you understand your participation in this study is entirely voluntary, that you may refuse to answer any questions, and that you may withdraw from the study at any time.

[Participant signed document]

RESEARCHER: How old are you?

PARTICIPANT: 35.

RESEARCHER: African American or Hispanic?

PARTICIPANT: African American.

[Asks documentation questions about language preference, etc.]

RESEARCHER: Always ask first, because – you know. Were you born in Philadelphia?

PARTICIPANT: Yeah.

RESEARCHER: How far did you go in school?

PARTICIPANT: I graduated.

RESEARCHER: 12th?

PARTICIPANT: Yeah.

RESEARCHER: Are you working?

PARTICIPANT: Not right now.

RESEARCHER: Do you consider your first language to be English?

PARTICIPANT: Yeah.

RESEARCHER: Do you speak any other languages?

PARTICIPANT: No.

RESEARCHER: Have you ever dropped out of therapy anywhere? Maybe you didn't drop out of therapy here, but have you ever been to any other clinics before and maybe you didn't like it so good, and you just stopped coming?

PARTICIPANT: I transferred.

RESEARCHER: You transferred. Did you transfer because of –

PARTICIPANT: I moved.

RESEARCHER: Oh, because you moved.

PARTICIPANT: Yeah.

RESEARCHER: Okay. I'll put 'transferred.' You transferred to here?

PARTICIPANT: Yes.

RESEARCHER: How important is it to you the counselor, or whoever you talk to, whether it's a counselor, psychiatrist, psychologist or anybody, that they understand something about you as an African American? That they know something about your culture. Is that important to you?

PARTICIPANT: No.

RESEARCHER: What do you believe your counselor thought about that you talked to before you got here – what do you think they thought about your culture as an African American?

PARTICIPANT: I have no idea. I didn't care what they thought about my culture, I was there for treatment.

RESEARCHER: You know how sometimes some people say it's really important that a person really understands something about who I am as a person if they're going to be the person that's treating me. How much do they understand me as an African American or as a Hispanic or as a White American. They know something about you.

PARTICIPANT: Well, you don't need to know anything about my culture. If you're not going to be able to treat me you don't need to worry about my culture, my culture is me. [Inaudible comment]

RESEARCHER: Okay, so that's not important to you. So you know if you're talking to somebody and you haven't thought about how this person might be. For example, you might look at me and think, does she really understand where I am today? You know you might be talking to someone but in the back of their mind they might be saying, that person doesn't really understand; they can't really identify with me. You know what I'm trying to say? Have you ever had any of those kind of thoughts?

PARTICIPANT: No.

RESEARCHER: So, let's say they did seem like they understood a lot about you, how likely are you to stay in treatment if they feel like they can really identify with you?

PARTICIPANT: That's fine. I guess I'd be more likely – I mean, that's not really the issue, what my issue is.

RESEARCHER: As far as whether they know anything about my history as an African American or know anything as far as my history, what's going on as far as issues I'm here for in my treatment.

PARTICIPANT: [No response heard.]

RESEARCHER: Okay, so if they didn't understand nothing about you as an African American, that wouldn't mean nothing to you, you wouldn't care about that? Am I correct?

PARTICIPANT: Yes.

RESEARCHER: Okay. That's basically it. I appreciate you taking the time. Thank you very much.

[End of Part 1]

[Begin Part 2 Participant 6]

RESEARCHER: Before we begin the interview itself, I'd like to confirm that you have read and signed the informed consent form, that you understand your participation in this study is entirely voluntary, that you may refuse to answer any questions, and that you may withdraw from the study at any time. I can't do nothing without your consent to participate.

[Discussion about her schooling, her profession, pursuing her PhD with an emphasis on cultural diversity and how important it is to people who come to treatment]

PARTICIPANT: [Documentation signed and dated 8/14]

RESEARCHER: Do you identify yourself as African American?

PARTICIPANT: Yes.

RESEARCHER: How old are you?

PARTICIPANT: 48.

RESEARCHER: Have you ever been to therapy anywhere and stopped going?

PARTICIPANT: Yes.

RESEARCHER: Were you born in Philadelphia?

PARTICIPANT: Yeah.

RESEARCHER: How far did you go in school?

PARTICIPANT: I have a PhD.

RESEARCHER: Okay, college. What did you get your PhD in?

PARTICIPANT: Commercial.

RESEARCHER: Right on. Are you working now?

PARTICIPANT: No.

RESEARCHER: What do you consider your first language?

PARTICIPANT: English.

RESEARCHER: Do you speak any other languages?

PARTICIPANT: No.

RESEARCHER: What about in your house, in your home when you were coming up, did everybody speak English?

PARTICIPANT: Yes.

RESEARCHER: Completely fluent in English, right?

PARTICIPANT: Yes.

RESEARCHER: How important was it for you and your counselor to know about – in the places that you've been in counseling – how important was it for your moral values and your lifestyle – that the counselor knows something about it?

PARTICIPANT: Very important.

RESEARCHER: Can you tell me why?

PARTICIPANT: Because I prefer for a person to know who I am and what I'm about before you get into my business. [Laughs]

RESEARCHER: Okay. What do you believe your counselor thought about your customs and your lifestyle? As you look over the counselors that you've seen in a lifetime --

PARTICIPANT: Equal.

RESEARCHER: Equal.

PARTICIPANT: Yes.

RESEARCHER: Have you ever actually sat down and discussed your customs and values with your counselor?

PARTICIPANT: No, I haven't.

RESEARCHER: And how do you feel that they communicated to you? Do you feel that they were able to understand where you were coming from?

PARTICIPANT: They understood it.

RESEARCHER: You were pleased with it?

PARTICIPANT: Yeah.

RESEARCHER: How likely are you to stay in treatment if you think that they understand your customs and your culture?

PARTICIPANT: As long as needed. As long as needed.

RESEARCHER: What were your thoughts and feelings if you believe your counselor did not understand your customs and values and you didn't even talk about them? How do you feel about having somebody like that?

PARTICIPANT: I won't say nothing. I don't let people into my business [inaudible]. I like the details [inaudible].

RESEARCHER: So in other words, are you saying that unless – that's important for them to understand you or to know something about you.

PARTICIPANT: Yes.

RESEARCHER: In order for you to stay in treatment?

PARTICIPANT: Right.

RESEARCHER: Have you ever been in a case where they didn't understand you?

PARTICIPANT: No.

RESEARCHER: Okay, thank you very much.

[Begin Participant 7]

[Participation introduction discussion and paperwork explanation]

RESEARCHER: Before we begin the interview itself, I'd like to confirm that you have read and signed the informed consent form, that you understand your participation in this study is entirely voluntary, that you may refuse to answer any questions, and that you may withdraw from the study at any time.

RESEARCHER: One minute . . . 48 . . . Hispanic . . . Were you born in Philadelphia?

PARTICIPANT: No, in Puerto Rico.

RESEARCHER: How far did you go in school?

PARTICIPANT: Tenth.

RESEARCHER: Tenth grade?

PARTICIPANT: Yeah.

RESEARCHER: Do you work?

PARTICIPANT: No.

RESEARCHER: Is English or Spanish your first language?

PARTICIPANT: Really both. Spanglish.

RESEARCHER: English and?

PARTICIPANT: Spanglish.
RESEARCHER: Spanglish? Okay.
PARTICIPANT: Yeah.
RESEARCHER: Do you speak any other languages?
PARTICIPANT: No.
RESEARCHER: How about your parents? What do they speak at home?
PARTICIPANT: Both. Both.
RESEARCHER: English and Spanish.
PARTICIPANT: Yeah.
RESEARCHER: In the house. You're very fluent, right? In English?
PARTICIPANT: Yeah.
RESEARCHER: All right. How important is it to you that your counselor understands something about your culture? When you come for treatment here or anywhere else, is that important to you?
PARTICIPANT: 'excuse me?
RESEARCHER: How important is it for your counselor to understand something about your culture?
PARTICIPANT: Very important.
RESEARCHER: It's very important?
PARTICIPANT: Yes.
RESEARCHER: Why?
PARTICIPANT: I want them to understand where I'm coming from.
RESEARCHER: Because some people – I've had some people say to me, I don't feel that comfortable if they don't understand me as well –
PARTICIPANT: I'll tell you --
RESEARCHER: -- as a Hispanic man coming to America. That's why I'm doing this. What do you believe your counselor even thought about your race or your customs or your values? Not just counselors; you can include psychiatrists, psychologists, you could be talking about anybody. It don't have to be just the therapist.
PARTICIPANT: What?
RESEARCHER: What do you think they thought about you as a Hispanic? You know how people talk to somebody and you walk away and you hear some kind of feeling about what they thought about you?
PARTICIPANT: Yeah. Well, when I leave the office they be asking me if I'm happy [inaudible].
RESEARCHER: You. I'm talking about you.
PARTICIPANT: Yeah.
RESEARCHER: Oh, so you think that your counselor was happy?
PARTICIPANT: Yeah. Yeah.
RESEARCHER: Have you ever been anywhere where you didn't think they were happy when you left?
PARTICIPANT: No.

RESEARCHER: How about the psychiatrist?

PARTICIPANT: The same.

RESEARCHER: They were happy about you? About your [inaudible – sounds like ‘rage’], that everything would be all right?

PARTICIPANT: Yeah, we talked, and everything’d be all right.

RESEARCHER: Have you ever actually sat down and discussed your customs and values with the doctor or with the therapist?

PARTICIPANT: Customs and values?

RESEARCHER: Your customs. Like your beliefs. Like --

PARTICIPANT: I know what you’re saying. No. I don’t talk to them about that.

RESEARCHER: How likely are you to stay in treatment if you have a counselor that understands everything about you being a Hispanic? Take for example, if you had a counselor of a different nationality, how important – would you stay in treatment if he didn’t understand your culture or would you not leave? Or you could have a Hispanic counselor and have them not understand.

PARTICIPANT: I believe I would leave. Yeah. I would leave if they don’t understand me.

RESEARCHER: Some people think that’s important, and that’s why I’m doing this study, because I want to get what people really feel about their – because when you first start talking to somebody, the first thing you’re looking at is their culture. It’s not just a body in a chair. This is who I am [inaudible] or whatever part you came from. Who are you looking at? Who is she in your mind? First of all, wait a minute, do you understand who you have sitting in this chair? You follow what I’m saying?

PARTICIPANT: That’s true.

RESEARCHER: Okay, so – have you ever – what were your thoughts and feelings if you believed they did not understand or discuss your customs or values?

PARTICIPANT: [inaudible question]

RESEARCHER: If you thought they didn’t understand you.

PARTICIPANT: I’d think they didn’t do their job right. I’d think they’re not working right.

RESEARCHER: And would you still continue to talk to them?

PARTICIPANT: No.

RESEARCHER: If you believed?

PARTICIPANT: Nope, I’m real sure.

RESEARCHER: Okay, thank you very much.

PARTICIPANT: You bet.

[Part 2 Participant 8]

[Introduction, explanation]

RESEARCHER: This says basically that you agree to participate. I can’t do nothing without you signing this first.

[Participant agrees. Chat about documentation]

RESEARCHER: This has nothing to do with your treatment here. This is separate from them. This is like a little survey so I can get a better feel for what's important to you when you come to see your counselor.

[Brief discussion of study and documentation]

RESEARCHER: Do you consider yourself to be a Latina, a Hispanic, or African American? Which one?

PARTICIPANT: Hispanic.

RESEARCHER: How old are you?

PARTICIPANT: 46.

RESEARCHER: You look young! Have you ever been anywhere and stopped going to treatment or decided you didn't want to go to treatment before?

PARTICIPANT: No.

RESEARCHER: Is this the only place you've ever --

PARTICIPANT: I came here and then I went to AVM.

RESEARCHER: How'd you like it?

PARTICIPANT: I didn't like my therapy, so I changed it.

RESEARCHER: You changed it. Okay. So you did drop out. You stopped going to AVM.

PARTICIPANT: Yeah.

RESEARCHER: Okay, that's fine.

PARTICIPANT: [Inaudible] -- she'd say things back -- I don't know -- I didn't trust her.

RESEARCHER: You didn't trust her. That's an important thing to be able to do. Before you start talking to somebody, you gotta trust them first. So that's why I try to be careful. You're female, right?

PARTICIPANT: Yeah.

RESEARCHER: And did you say you were 47?

PARTICIPANT: Yeah.

RESEARCHER: Hispanic. And what's the city you were born in?

PARTICIPANT: Puerto Rico.

RESEARCHER: How far did you go in school?

PARTICIPANT: Twelfth grade.

RESEARCHER: Did you graduate?

PARTICIPANT: Yes.

RESEARCHER: And what's your occupation?

PARTICIPANT: Housewife.

RESEARCHER: What do you consider to be your first language?

PARTICIPANT: Spanish.

RESEARCHER: Do you speak any other languages?

PARTICIPANT: No. English and Spanish only.

RESEARCHER: What about in your home? Your parents, what language do they speak in the house?

PARTICIPANT: Spanish.

RESEARCHER: Some people I've talked to say no, my parents don't speak Spanish in the house. So would you say you're very fluent in English?

PARTICIPANT: Yeah, more now. You know, when you marry and your kids come, you speak English.

RESEARCHER: Okay. How important was it for your counselor to understand something about your customs and your lifestyle as a Hispanic – what is important that your counselor know something about your values and understand you as a Puerto Rican?

PARTICIPANT: Yes.

RESEARCHER: Would you say that it was very important?

PARTICIPANT: Yes.

RESEARCHER: And what about if they didn't?

PARTICIPANT: I don't know. I don't know that.

RESEARCHER: Okay. That's what I want to know.

PARTICIPANT: [inaudible] probably more English than Spanish [inaudible] probably more Spanish.

RESEARCHER: Okay. What do you believe your counselor thought about your race, your values and your lifestyle?

PARTICIPANT: [Inaudible response- sounds like I don't think she thought nothing, because she was Spanish.]

RESEARCHER: What about anything else?

PARTICIPANT: She was Spanish but – I don't know. I didn't trust her.

RESEARCHER: You didn't trust her.

PARTICIPANT: No. I don't know, there was something about her that – I don't know. She'd say everything that I tell her [inaudible] so I didn't trust her.

RESEARCHER: Okay, so you think she lacked confidentiality.

PARTICIPANT: Yeah, that.

RESEARCHER: Because she told all your business.

PARTICIPANT: Yeah.

RESEARCHER: So you don't think that she really communicated enough about your heritage –

PARTICIPANT: She was Spanish. What I would tell her, she would say something to [inaudible]

RESEARCHER: But as far as your race, values, and your lifestyle, do you think she understood that, or didn't she?

PARTICIPANT: She was Spanish, too. I don't think she had a problem with it.

RESEARCHER: Because sometimes you can talk to another Spanish person and think they can't identify with your problems even though they claim to, right? But you didn't feel that way about her?

PARTICIPANT: No.

RESEARCHER: Okay, did you ever sit down and talk to your counselor about your customs and your values?

PARTICIPANT: Yes, I have.

RESEARCHER: What about at APM?

PARTICIPANT: [Inaudible response – sounds like I didn't have that trouble.]

RESEARCHER: Even though she was Spanish.

PARTICIPANT: Yeah.

RESEARCHER: How likely are you to stay in treatment? So would you stay in treatment if you thought she didn't understand you?

PARTICIPANT: That's why I came here.

RESEARCHER: So you didn't think she even cared about that.

PARTICIPANT: Yeah.

RESEARCHER: Okay. What were your thoughts, if you believed that your counselor didn't understand – that's why you left, right?

PARTICIPANT: Yes.

RESEARCHER: Okay, we're done. Thank you very much.

[Part 2 Participant 9]

[Explanation of study] – A substantial part of this participant was inaudible; he was too far from the mic, he tended to mumble, and there was a great deal of background noise, i.e., people, music, and sirens]

RESEARCHER: It's okay if this is your first time here. I'd like to confirm that you have read and signed the informed consent form, that you understand your participation in this study is entirely voluntary, that you may refuse to answer any questions, and that you may withdraw from the study at any time. It's just a few minutes. I only have five questions. It's not therapy, ma'am, it's nothing to do with therapy.

RESEARCHER: I'm doing a little study on cultural diversity. I chose the population of African American and Hispanic cultures. I wanted to see what kinds of things are important to you when you come to see a therapist. How important is it for the therapist to understand you culturally as an African American man? Do you identify yourself as African American or Hispanic?

PARTICIPANT: I'm African American.

RESEARCHER: African American? How old are you?

PARTICIPANT: I don't speak Spanish.

RESEARCHER: It's all right.

PARTICIPANT: Sixty-two?

RESEARCHER: Sixty-two. Have you ever been to counseling before and stopped going?

RESEARCHER: What?

PARTICIPANT: Have you ever been to counseling before and stopped going?

PARTICIPANT: Yeah. [Inaudible mumbling]

RESEARCHER: Okay, okay. That's what I want to know, that's what I want to know.

PARTICIPANT: [Inaudible]

RESEARCHER: That's fine, that's fine. But you will talk to me for just a few minutes?

PARTICIPANT: Go ahead.

RESEARCHER: Okay, cool. What I need you to do – I can't use this unless you say I can. I need you to put your name right here and sign your name right here. That says that you don't mind talking to me. That's all this is.

PARTICIPANT: I'll sign it. I mean, I'll talk to you, but I'd rather not sign it. You understand.

RESEARCHER: Well, basically it's a study just to find out – for example, I talk to people – I'm a therapist. I'm a family therapist. I'm working on my doctorate in clinical psychology to become a clinical psychologist. I'm basing the study on patients that I've worked with for over twenty-five years – I've been in the field a long time. And I need to talk to them, and I would say, how come you didn't come to therapy no more? How come you stopped your therapy? And they would say, well, I don't feel like you understand me as a Black man, what it's like to be Black in America. I don't think that person will understand me. What if I were a Hispanic coming to America? Stuff like that. That's what this is about. So are you comfortable with that?

PARTICIPANT: Uh –

RESEARCHER: It's only five questions. It's not long. It's not that deep. I just want to get your opinion. It has nothing to do with therapy or medicine.

PARTICIPANT: [Inaudible response]

RESEARCHER: Okay. But is it important to you? I just want to know if it's important to you.

PARTICIPANT: [Inaudible response]

RESEARCHER: Okay, this is what I want to know, this is what I want to know. But before I keep talking, I need you to sign here to say it's okay for us to keep on talking. I can't do nothing without your permission.

PARTICIPANT: I got to do this right now, I can't keep talking.

RESEARCHER: Yes, you can. That's why I said, 'hey, Dusty.'

PARTICIPANT: [Inaudible response]

RESEARCHER: But you do want to participate in this? I just want to get feedback from you.

PARTICIPANT: [Inaudible response as he resists participation]

RESEARCHER: It's just that I can't do it without your signature. They could say I made it up. You see what I'm saying? This goes to prove it all. We have to turn it in. And if your signature's not on here, how are they going to know I didn't make it up, that I didn't put words in your mouth? If you don't put your name on this paper, they could say I made it up. That's why I need you to write your name on here. Print it on the first line . . .

PARTICIPANT: [acquiesces and signs]

RESEARCHER: Put today's date, which I believe is the 14th. I thank you very much. So you identify yourself as African American, right?

PARTICIPANT: Yeah.

RESEARCHER: Okay, okay. And how old did you tell me you were – did you say sixty?

PARTICIPANT: Sixty-two.

RESEARCHER: Sixty-two?

PARTICIPANT: Yeah.
RESEARCHER: Did you tell me that you went somewhere before and stopped going?
PARTICIPANT: [Inaudible response – sounds like I went to Columbia]
RESEARCHER: Okay. [Inaudible] – whatever.
PARTICIPANT: [Inaudible]
RESEARCHER: And that's important.
PARTICIPANT: [Inaudible] – I didn't like it, you know.
RESEARCHER: Okay. What city were you born in, was it Philadelphia?
PARTICIPANT: No.
RESEARCHER: What city?
PARTICIPANT: I was born in Louisville, Georgia.
RESEARCHER: How far did you go in school?
PARTICIPANT: Eighth grade.
RESEARCHER: Eighth grade.
PARTICIPANT: [inaudible] – to understand some things. I'm trying to understand some things. I learned to do with what I had. I usually do well, but you know how it goes.
RESEARCHER: That's right. Some people are self-taught anyway. Some people just can't do certain things.
PARTICIPANT: [Inaudible] A lot of times I can't make them understand what I mean.
RESEARCHER: Uh-huh.
PARTICIPANT: I don't talk that loud. That's just the way I am. I can't talk that loud.
RESEARCHER: Okay. And what's your occupation?
PARTICIPANT: I'm not working right now, I don't work.
RESEARCHER: Okay.
PARTICIPANT: I used to take up tailoring in school, stuff like that.
RESEARCHER: Did you ever work in that field?
PARTICIPANT: No. I worked in the kitchen of the hospital.
RESEARCHER: In the kitchen?
PARTICIPANT: Yeah.
RESEARCHER: Like a dishwasher?
PARTICIPANT: Yeah. Dishwasher.
RESEARCHER: Okay. What do you consider your first language? English?
PARTICIPANT: Yeah, English. That's all I know. English.
RESEARCHER: Okay, just English. And what about your parents at home, did they speak English at home?
PARTICIPANT: Yeah.
RESEARCHER: So you're very fluent in English.
PARTICIPANT: What?
RESEARCHER: You understand English real good.
PARTICIPANT: Yeah.

RESEARCHER: Okay. So tell me, how important is it – I think you did say that it's very important for your counselor to know something about your culture and your values, right?

PARTICIPANT: Hm?

RESEARCHER: Didn't you tell me it's very important for your counselor to understand something about you as a Black American?

PARTICIPANT: [Inaudible] – I mean, if I'm going to [Inaudible] – you know what I'm saying? [Inaudible]

RESEARCHER: You're saying you talk about your culture and everything, right?

PARTICIPANT: Well, I never said [inaudible]

RESEARCHER: And if they don't understand you --

PARTICIPANT: [Inaudible] – already went through all this [Inaudible]

RESEARCHER: And I'll tell you why I asked you that question, because whenever you go to see somebody, you go see the doctor or counselor or psychiatrist – I don't care who you see. When they first look at you they're looking at African American male. They need to be able – that's before anything else, before they start talking about your problems, what it is – When you're sitting in the chair in front of them. And so basically that's what I'm asking you, how important is that to you?

PARTICIPANT: [Inaudible]

RESEARCHER: 'Scuse me? My name? Patricia.

PARTICIPANT: Yeah. Patricia, right?

RESEARCHER: [Spells her name] So, have you ever run into a counselor that you think really didn't understand your culture and really didn't you?

PARTICIPANT: I went to therapy one time – [Inaudible] – I only went there one time. [Inaudible] -- when I was there. I really couldn't answer that well, because I didn't – [Inaudible]

RESEARCHER: So how was it for you talking to her, do you think she understood you? At the time?

PARTICIPANT: [Inaudible] – but she never told me she didn't understand me. You see what's going on, you know, you deal with it. She might've said, you know, whatever [Inaudible]

RESEARCHER: Did you ever talk about your culture?

PARTICIPANT: Naw, we never even talked about that.

RESEARCHER: But is that important to you?

PARTICIPANT: My culture?

RESEARCHER: Mm-hm.

PARTICIPANT: [Inaudible – sounds like that's not something we discussed]. We never talked about our culture. [Inaudible]. We see what's going on and stuff like that. You know, you deal with it. [Inaudible]

RESEARCHER: When you say, 'it's how people treat us,' what do you mean?

PARTICIPANT: Everybody, you know, somebody might look at us like [Inaudible] – Stuff like that. I don't know, you know?

RESEARCHER: Mm-hm.

PARTICIPANT: 'Cuz I'm not around [Inaudible – sounds like that subculture stuff], you know?

RESEARCHER: How likely – in other words, if you really thought that the counselor really understood you as an African American male and understood your culture, would you be willing to stay in treatment? Would you keep coming?

PARTICIPANT: Well, [Inaudible] with what's going on, and they're trying to help me, if I understand them they understand me. I mean, I was a long time [Inaudible]

RESEARCHER: Okay. Especially if you thought they understood you and your culture, right?

PARTICIPANT: Mm-hm.

RESEARCHER: [Spells Joseph] And what were your thoughts and feelings if you believed your counselor? In other words, suppose you had a counselor, and in your mind – or it could be a psychologist or a medical doctor – and you, in your mind, when you left that place you thought, hey, wait a minute, I don't even think they understood anything about what Black people go through in this country.

PARTICIPANT: Well, you don't judge people.

RESEARCHER: You don't think it's a requirement for them to already know –

PARTICIPANT: They devoted time [Inaudible]

RESEARCHER: And what they've gotta do. They've gotta read your history. They've gotta know something about you.

PARTICIPANT: Right. You've gotta tell them stuff yourself. What's going through your mind. [Inaudible]

RESEARCHER: So in other words, you automatically think that they don't understand you and you're going to have to tell them?

PARTICIPANT: [Inaudible] – information, you've got to tell them. Tell me something about my problems [Inaudible for quite a while due to background noise and distance from mic]

RESEARCHER: Okay, okay, thank you.

[Away from mic – recruiting another participant]

[Part 3 – Participant 10 – Great deal of background noise]

RESEARCHER: Alright, so basically this is a study on cultural diversity. First I have to have you sign that this is completely volunteered, [Explanation of document and procedure]

RESEARCHER: Okay, do you consider yourself Hispanic or African American, Latino?

PARTICIPANT: Hispanic.

RESEARCHER: Hispanic?

PARTICIPANT: Mm-hm.

RESEARCHER: How old are you?

PARTICIPANT: Twenty-three.

RESEARCHER: Have you been going to therapy and stopped going? Maybe not here but maybe somewhere else? Have you ever been anywhere else before here?

PARTICIPANT: No.
RESEARCHER: Is this the only place you ever came to?
PARTICIPANT: Yes.
RESEARCHER: So you never stopped going to treatment?
PARTICIPANT: No.
RESEARCHER: And you say you're twenty-three?
PARTICIPANT: Yes.
RESEARCHER: And where were you born? Were you born in Philadelphia or Puerto Rico?
PARTICIPANT: No, Philadelphia.
RESEARCHER: How far did you go in school?
PARTICIPANT: I went to college at Norman Gabriel. I have an associate's degree.
RESEARCHER: An associate's degree?
PARTICIPANT: Mm-hm.
RESEARCHER: And occupation? Are you working?
PARTICIPANT: No.
RESEARCHER: You consider your first language to be . . .
PARTICIPANT: Spanish.
RESEARCHER: Do you speak any other languages?
PARTICIPANT: English. [Inaudible]
RESEARCHER: How important is it for you for your counselor to understand something about you being a Hispanic male or something about your culture or what your values are? Because you know, everybody has their own culture, and how important is it for like the doctors and the therapists that are talking to you that they understand something about your culture?
PARTICIPANT: Vaguely, but, yes.
RESEARCHER: Why?
PARTICIPANT: The gap in between us, it'd be harder [Inaudible. A friend translates to him. His response and the exchange are inaudible, other than "No, Bro" – "Yeah, Bro".]
RESEARCHER: You say it's really important to you because . . .
PARTICIPANT: [Inaudible but sounds like] It's for the clarity, the fear, for the pride.
RESEARCHER: That's an important point. Have you ever been somewhere where they didn't see who you are, where you didn't think they did see who you are?
PARTICIPANT: Many places.
RESEARCHER: You have.
PARTICIPANT: Not here.
RESEARCHER: Not here. But some other place. Did you stop going?
PARTICIPANT: I've never been or come to a place like this.
RESEARCHER: Okay, so once you found out that they didn't understand who you are, so you did – so you wouldn't even – so basically you didn't really give them the time of the day.
PARTICIPANT: No.

RESEARCHER: Okay. All right. What do you believe – when you walked away from some of these places where you got therapy at, when you walked away, what do you think they were thinking about you as a Hispanic male?

PARTICIPANT: [Inaudible] – trying to compare myself to anybody.

RESEARCHER: And not really seeing what the problem is.

PARTICIPANT: Yes. It's more a [Inaudible, sounds like 'iconography'].

RESEARCHER: Okay, okay, that's what I want to know. And how did that make you feel?

PARTICIPANT: [Inaudible response]

RESEARCHER: Have you ever discussed your culture or values with your counselor? Talked with them about, you know, the Hispanic culture?

PARTICIPANT: If they don't know it they wouldn't be here.

RESEARCHER: Okay. And how do you think they respond? How do they communicate to you about the things that you talk to them about?

PARTICIPANT: [Inaudible response]

RESEARCHER: When you're in treatment, do you think that they care about your culture?

PARTICIPANT: No.

RESEARCHER: Because it's important, you know? Let's say they didn't understand you, what would you think about them after that? [Inaudible] about your culture, what are your thoughts about that?

PARTICIPANT: [Inaudible] I don't know why they're even saying that. I could be wrong or maybe there's a reason why, I don't know.

RESEARCHER: You'd try to find out why they were [Inaudible]

PARTICIPANT: Yeah.

RESEARCHER: Thank you very much.

[Remainder of Part 3 is seeking other participants]

[Part 4, Participant 11 – Background noise and papers obscure dialog]

[Documentation discussion – Permission obtained]

RESEARCHER: How do you identify yourself? Are you Hispanic or do you say Latino or African American, which one?

PARTICIPANT: Both.

RESEARCHER: How old are you?

PARTICIPANT: Thirty-nine.

RESEARCHER: You look very young for thirty-nine.

PARTICIPANT: Thanks.

RESEARCHER: Have you ever been to any other place for treatment before coming here and you didn't like it and you stopped going?

PARTICIPANT: [Inaudible response]

RESEARCHER: You stopped going. Okay. [Inaudible remarks] Male, 39, Hispanic right? What city were you born in?

PARTICIPANT: Where I was born?

RESEARCHER: Mm-hm. Puerto Rico or Philadelphia?
PARTICIPANT: [Inaudible response, but heard 'PR or DR or whatever you want to call it.' In context: } Dominican Republic.
RESEARCHER: Republic. Okay. How far did you go in school?
PARTICIPANT: Tenth.
RESEARCHER: And what's your occupation?
PARTICIPANT: Pretty simple [inaudible] – and the retarded – maternity pool.
RESEARCHER: Maternity pool?
PARTICIPANT: Uh-huh.
RESEARCHER: You said material or maternity?
PARTICIPANT: Maternity.
RESEARCHER: For pregnant people?
PARTICIPANT: Yes.
RESEARCHER: What do you consider to be your first language? Spanish or English?
PARTICIPANT: Well, I prefer English; I study in English.
RESEARCHER: Are you fluent in Spanish?
PARTICIPANT: Yes.
RESEARCHER: Okay. So your first language, is it English?
PARTICIPANT: Spanish.
RESEARCHER: Spanish. Okay. How many languages do you speak?
PARTICIPANT: Just Spanish and a little bit of Papillon. Papillon is English, but not American. It's like a little bit English. People there, they lack their own tongue. They take it from another country. I speak a little Papillon. But Papillon, they knew half-English mixed.
RESEARCHER: Okay. So you would say three languages?
PARTICIPANT: Two.
RESEARCHER: Two? English, Spanish . . . Do your parents speak – at home do they speak English or do they speak Spanish?
PARTICIPANT: No, Spanish.
RESEARCHER: Some people I talk to, they say, at home my parents don't speak Spanish in the house.
PARTICIPANT: They only speak Spanish.
RESEARCHER: But you're pretty – what would you say on a scale of one to 10 being very fluent, how fluent would you say you are in English?
PARTICIPANT: About five of ten. Five, about halfway.
RESEARCHER: Five.
PARTICIPANT: Yeah. I know English, but I understand Spanish better. [Inaudible additional comment]
RESEARCHER: So they get what you need to do, right?
PARTICIPANT: Yeah, if they don't speak Spanish.
RESEARCHER: So, tell me, what's important in the counselors – what about the places you left, how important was it for you for the counselor to understand you as a Puerto

Rican male?

PARTICIPANT: Uh . . .

RESEARCHER: Or any time. Did you feel that they understood you?

PARTICIPANT: In the last clinic they didn't really do that much to help me. Because with everything, doesn't move. [Inaudible]. But for no reason over there was supposed to be a help. So that was the reason that I left to come here. It wasn't because they wouldn't take care of me; it was because it was far away.

RESEARCHER: It was because it was what?

PARTICIPANT: It was far away. From my house.

RESEARCHER: Okay.

PARTICIPANT: They took me here for pregroup. I think it's because it's way close to me.

RESEARCHER: Mm-hm.

PARTICIPANT: I like here.

RESEARCHER: But the other place, you didn't think they really put in the time with you –

PARTICIPANT: No.

RESEARCHER: Okay.

PARTICIPANT: They even – I had medication [Inaudible portion] the doctors prescribed for me for two, over three years I'm on medication. So what they did, they tried to cut it. They told me, do not give it to me. [Inaudible, but sounds like 'so far, it's total addiction already']. They don't really help me at all. Now they're going to cut my meds, but I already have [Inaudible]. They have a pharmacy in here, and they just want to cut my meds, because they think I don't need it. I really need it, because they're, they give me a condition. They really ask me why I need it for and why I'm here. They don't really know why I'm here for.

RESEARCHER: Mm-hm.

PARTICIPANT: Over here, [inaudible – sounds like it ends with 'to be in that class, to be at that level.'] They think the medication will affect me. It doesn't affect me, because I'm still here, and I've been here for three years.

RESEARCHER: What do you think, at the other place, what do you think that they thought about your race?

PARTICIPANT: Uh . . . they don't have no different about that. They [Inaudible]. And they don't really ask you where you come from or whether you are a true Spanish or are you Indian.

RESEARCHER: You say they didn't ask you, right?

PARTICIPANT: They didn't really ask me where I was from, no.

RESEARCHER: So they didn't even identify with you then.

PARTICIPANT: No.

RESEARCHER: That's what I want to know. And that's important.

PARTICIPANT: Yeah, because sometimes you've got to get information. And if I know where you come from, I would like to hear you tell me about your country. To see how you're going to treat me.

RESEARCHER: Yes. Absolutely. That's what this is all about.

PARTICIPANT: I'm very patient. I don't have an attitude like that. And some of my – a couple of people who come here from my country, they either had one of the doctors – what do you call – the therapists – They know come from our country. And here and in [sounds like] Cambria and Roman Daulphin – they have one over there, too. They really have like from twenty therapists, they have like fifteen Dominicans. I don't know why. I guess they dedicated their lives to being maternity.

RESEARCHER: So you identify was Dominican Republic or Hispanic?

PARTICIPANT: Dominican Republic.

RESEARCHER: Okay.

PARTICIPANT: [Inaudible – sounds like 'I'm going to ask you a favor – it's not like all the nurses are Dominican]. It's not just that. It's the way they talk. They talk to you, they talk to you, they don't have no [Inaudible], they don't have to call or nothing, They just come and they get what you need.

RESEARCHER: Okay. How likely are you to stay in treatment if you think that they cared about your culture? If you think your counselor cares about your culture, do you think you'd stay in treatment?

PARTICIPANT: Yes. Because of they care –

RESEARCHER: About your culture?

PARTICIPANT: Yes. They really want to have total say, like extra, you know, like problem of how [Inaudible – sounds like 'on the street'] – they really told me where, what, how to react. [Inaudible]. I'm going to tell him what's going on with me; they really told me how to prevent it. How to be – how to do it yourself. Because before I was uncomfortable with that. They really got me on [inaudible – sounds like 'one of these']. Then they take me off of that. [Inaudible.] But they would have seen me here –

RESEARCHER: They made you feel at home?

PARTICIPANT: Yeah.

RESEARCHER: But at the other clinic they didn't. They make you want to go back to your country.

PARTICIPANT: Yeah.

[Lengthy pause]

RESEARCHER: Thank you very much. I'm glad you like it here. I think it's very nice here, too.

PARTICIPANT: Sometimes people here are a little angry, not in the way they treat me . . .

[Participant continues to talk about the clinic and his medication issues for several minutes]

RESEARCHER: Yes, yes. Because those things are very, very important when we come, you know? Because I always say, before anything else, first of all the person's gotta feel

comfortable and feel like they understand the person. When you sit down and talk to them, before you even tell a person about your problems, you are a Hispanic or a Dominican Republic male, and they've got to first acknowledge that. You're sitting in front of them. Do they know you? Do they understand?

PARTICIPANT: [Inaudible – sounds like 'they got to be responsible, too' then more inaudible]. – They don't have no passion, they don't want to wait. The majority of people, they don't have a passion. They get angry fast. They don't want to wait.

RESEARCHER: Where was this at, at the other clinic?

PARTICIPANT: Everywhere you go. Here, too. Over there [Inaudible].

RESEARCHER: Oh, my goodness.

PARTICIPANT: [Inaudible] – And I see them arguing. But I thought it was too close to me. No, it was the doctor – uh – and it was passion. The passion says I don't want to wait. I thought he was going to smack me and say, what? He didn't want to prescribe the medicines that I need that are supposed to help me.

RESEARCHER: Mm-hm.

PARTICIPANT: They want a thing right away. They don't want to wait.

RESEARCHER: They don't want to be patient.

PARTICIPANT: No.

RESEARCHER: Have you ever ran into any kind of people or any doctors that didn't want to be patient with you?

PARTICIPANT: No. Everywhere that I go out this happens. That's what I mean. Everywhere, every year [inaudible] – they don't like anybody.

RESEARCHER: Right.

PARTICIPANT: That's what happens when people, you know, they come from another direction. Me, I don't see that much fighting. They come in a little bit angry, but they don't curse [inaudible as he continues his rant] – or whatever.

RESEARCHER: Mm-hm. But the other thing that you don't like. You felt like they didn't really take the time to understand your culture, understand you as a person, but when you came here, you felt like you was at home.

PARTICIPANT: Yes.

RESEARCHER: You know, like everybody – you know – and that's important. That's how people – when I first start talking to folks, I say, first of all, please feel comfortable. Have you ever been to treatment before? Some people say yes, some people say no. And I say, well, did you feel about it? Did you like it? You know how you be thinking, who is you, what's your culture, what are your parents? Are you African American or Caucasian? They don't understand who you are. First they gotta see who they looking at. Do you agree?

PARTICIPANT: Yeah, well, yeah.

RESEARCHER: That's horrible.

PARTICIPANT: Well, if people are different, they have different mentality, and some people have different type of feelings.

RESEARCHER: Right.

PARTICIPANT: When you have – it's difficult for you to have the right person all the time. You're not always going to have somebody who doesn't hate you.

RESEARCHER: Right.

PARTICIPANT: And I understand that. But if you [inaudible] you understand you're not supposed to give respect to nobody if – it's better if they respect you.

RESEARCHER: Mm-hm.

PARTICIPANT: But I think you can respect another even if they don't respect you. That mean you really don't care about nothing.

RESEARCHER: Mm-hm.

PARTICIPANT: Even when you gave them what they need, they not happy.

RESEARCHER: Right.

PARTICIPANT: They really say have something angry. Maybe when they were kids, they were in trouble. It might be they violated, they might be molested, and that's what got them so angry.

RESEARCHER: They don't want to talk.

PARTICIPANT: They don't want to say what they was offended about. These kids here, they really don't develop right until they give them medicine.

RESEARCHER: Mm-hm.

PARTICIPANT: Because they don't have the support they need.

RESEARCHER: Mm-hm.

PARTICIPANT: All the problems you hear grown people have, it's because the way their culture – the way they raise them.

RESEARCHER: That's right. That's what this is all about.

PARTICIPANT: Even – if you hit your kid, if you them when they're little, they always going to see you as the – [imitates a child whining] as a jerk. A jerk always needs attention, I'm going to give you some time, like that, you know.

RESEARCHER: Mm-hm.

PARTICIPANT: Now, the kid – [inaudible, but sounds like 'I have to hit him. I have to hit him. I have to hit them.']

RESEARCHER: All those things are important. Very important.

PARTICIPANT: You want to treat your kids the way you want to see them as an adult. And that's that. [Inaudible phrase]. No matter what happened to you in the past. Majority of people, they're like that. When you say kids – they use them.

RESEARCHER: That's right. That's why I –

[TAPE ENDS]

[Part 5 Participant 12]

[Sounds of paperwork being processed and instructions on filling out documents]

RESEARCHER: [Chats with participant to establish comfort]

PARTICIPANT: I was born and raised in Puerto Rico.

RESEARCHER: Okay

PARTICIPANT: In 1982.

RESEARCHER: And how old are you?

PARTICIPANT: Thirty-one.
RESEARCHER: Have you ever been in treatment before?
PARTICIPANT: This is actually my first time ever.
RESEARCHER: Okay. Being in treatment?
PARTICIPANT: Yes.
RESEARCHER: Okay. How long have you been coming here?
PARTICIPANT: This is my second time.
RESEARCHER: Okay. So at one point you stopped and then came back? You said this is your second time.
PARTICIPANT: Yeah, second visit.
RESEARCHER: Oh, your second visit. I get it. And how do you like it?
PARTICIPANT: Fine. That's why I came back.
RESEARCHER: Okay, all right. What'd I want to ask . . . how old did you say you are?
PARTICIPANT: Thirty-one.
RESEARCHER: And what was your date of birth again?
PARTICIPANT: 9/04/1982.
RESEARCHER: How far did you go in school?
PARTICIPANT: Tenth grade. But right now I'm actually working to get my GED. I'm actually taking the tests. I've got two more left. Writing an essay and math.
RESEARCHER: Good going! That's fantastic.
PARTICIPANT: I'm actually going to Congress.
RESEARCHER: Yeah, they've been around for a long time. They've got a nice program. And right now are you working?
PARTICIPANT: Actually, I'm disabled.
RESEARCHER: Okay.
PARTICIPANT: I just had two major reconstruction surgeries on my [sounds like] prostate. That's why I'm here.
RESEARCHER: Okay. What do you consider to be your first language?
PARTICIPANT: Spanish.
RESEARCHER: What other languages do you speak?
PARTICIPANT: English.
RESEARCHER: And what language do your parents speak at home?
PARTICIPANT: Spanish, because my mother doesn't –
RESEARCHER: Oh. [Interruption, followed by movement away from the mic]
RESEARCHER: When you were talking to your counselor, how important is it to you that they understand about your values and your morals and understand them; in other words, is it important to you that when you're talking to a therapist that they understand something about [Inaudible] your culture? Do you think they need to know something about that when they're working with you?
PARTICIPANT: No.
RESEARCHER: No? Okay, it's not important.
PARTICIPANT: I don't know why I would talk to my counselor about me being Puerto

Rican.

RESEARCHER: I can answer that question, actually. Whenever you're working with [Inaudible] you work with a lot of different people. And it's important for the person that's treating you to know something, a little bit about who you are, because everybody's not the same. Everybody's got their own identity. You know, their own culture, their own – you know. And they should – because you can't culture-fy everybody the same way. And different people have different views on enlightenment. You know, just in general. And it's just important to know something about them. And based on my experience – like I said, I've been in this field 25 years [becomes inaudible] – you know what I'm saying? And I've had some people come, which is why [Inaudible] counselor, because I don't think they [Inaudible] – you know, Puerto Rican here in America and making that journey here. [Inaudible] They don't understand what it's like to be Black in America [Inaudible] They're talking to you about your life. Whatever it is that you're dealing with. So when they're talking to you, they should know something about your history, a little bit about the life of a Hispanic, about the life of a African American, or even a Caucasian. About the life of a [Inaudible], about the life of a Irish person when they start talking to you. But that's why they gotta have a education. It's going to be part of their education. So I'm talking to people hanging around here to see what you want. It's just like you working on a car. You have to know something about cars. You can't just go start working on a car. You have to know what you're doing. That's all I'm saying.

PARTICIPANT: I'm going to make this real short. I am –

RESEARCHER: I could see you understand.

PARTICIPANT: No. I am – how to put this – I am a composer writer, a [inaudible – sounds like 'a reggae tone'] artist from Orlando, Florida.

RESEARCHER: That's fantastic.

PARTICIPANT: I lived in Orlando, Florida for sixteen years. But I do originate, when I say I was born in Puerto Rico, I only lived there five years. I've been in the States more than in Puerto Rico.

RESEARCHER: Okay.

PARTICIPANT: You know what I mean? But I do know my culture. I know where I come from. You know what I mean? And I do culture my therapist about my music and I value my Spanish, because that's my culture. I'm Puerto Rican. A lot of people ask me why I don't write in English [Inaudible] – It just comes from being Latin, I guess.

RESEARCHER: And it's part of your culture, uh-huh. That's fantastic.

PARTICIPANT: Sure, I mean [Inaudible] – I'm proud to be born anywhere I come from. And why I left it Puerto Rico. 'Cuz I was only there five years.

RESEARCHER: Uh-huh. So in other words, I think what I hear you saying is that when you talk to your counselor it's not important for him to know anything about Puerto Rican culture. He doesn't have to know.

PARTICIPANT: No, it is important. It is. But I didn't come for that to see her.

RESEARCHER: You don't have to. You don't have to.

PARTICIPANT: I'm coming for what I'm coming for.

RESEARCHER: Oh, yeah.

[Mic moved; largely inaudible remarks about coming to a doctor? For over a minute all that can be heard are scattered words behind ambient talking – this continues throughout]

RESEARCHER: I'm just trying to get to what you want me to say. Are you saying that's not important to you or that is important to you?

PARTICIPANT: Um, it is.

RESEARCHER: Okay. All right. That's all I'm saying. And I understand. I think you [Inaudible for about thirty seconds – something about if I want to pray in church] – everyone has a certain thing that they do. [Inaudible] – and that's why I'm trying to bring this to light so you can get a better understanding why I'm doing it and where I'm coming from. But you're [Inaudible]

PARTICIPANT: [Inaudible short response]

RESEARCHER: Oh, absolutely. I got the point. What you're saying to me is, [Inaudible] my whole history and everything, that you stayed there for five years [Inaudible] – But what I was trying to find out, is it important for you when you're seeing somebody that they understand, you know – because they can be talking to you – what works for one person may not work for another person [Inaudible] – and that comes from your culture, something that you learned [Inaudible]. Okay, the next question: What do you believe they thought about your race, your culture, your values – like, she was okay with it? Or he was okay with it? Or did you walk away feeling like – I asked you – no, wait –

PARTICIPANT: She actually [Inaudible]

RESEARCHER: Okay. So you felt like she was [sounds like 'intense']. So you didn't feel any [Inaudible]. Okay. Um . . . did you ever discuss your culture or values with your counselor, and how she you communicate – like when you explain something to me, did you ever just sit down and to her about [Inaudible] and the fact of what you're going through.

PARTICIPANT: Yeah. I told her about it.

RESEARCHER: And you were okay with that.

PARTICIPANT: Yeah. I actually like talking to her.

RESEARCHER: Okay. Now, what were your thoughts [Inaudible – somethinga bout 'do you think they understand'].

PARTICIPANT: [Response inaudible.]

RESEARCHER: Well, even the doctors. If they don't really understand your problems or who you are, how are they – you know what I mean?

PARTICIPANT: [Inaudible]. I mean, nowadays people know what is what. You know, if you are Black or African American or if you are Indian or he's Italian and I'm Puerto Rican, you know who is who. So, why the person is not [Inaudible] – I don't understand that kind of thinking.

RESEARCHER: Because some of them are not able to [Inaudible]. They're not educated [Inaudible]. Oh they can try. You'd be surprised. That's why I'm going to school, because [Inaudible 'cultural differences . . . ethnic . . . type of medication . . . sometimes

what happens is . . . misdiagnosis . . .] – they really didn't do the research on different people and how you approach different people, because you gotta approach people according to their culture sometimes. But you know, everybody's got their own personality. That's what I'm trying to say. I suppose a little something about people [Inaudible] and who they are when you're talking to them, but you just can't talk to them like you talk to everybody. You know what I mean? And that's real. And I have some statistics where, you know, some different groups even got misdiagnosed by some of the psychiatrists. They diagnosed them, because they think they have some kind of a – some type of problem, some type of mental illness, and there may not even be no mental illness. Culturally, that just might be who that person is. May not be nothing wrong with him. You know what I'm saying? Like he got [inaudible].

PARTICIPANT: So –

RESEARCHER: But um, I thank you for your time, and I see that you do understand. I hope I was able to give you a little bit of insight. So now, the next time – every day when you're talking to somebody – and I'm not talking about necessarily [Inaudible] but when you go to the doctor that they gotta know about you, too. The differences and the different kinds of things that occur or are common in different [Inaudible] and have a little bit, you know, [Inaudible] You gotta know something about a person's history [Inaudible] in a relationship when you're getting to know somebody, you gotta get to know them. You gotta ask them about their history [Inaudible] How about your mom? How about your dad? [Inaudible] You gotta find out about the person's history. If you don't talk to them, you don't know nothing about their history, you don't know who your getting involved with. You know what I mean?

PARTICIPANT: Okay.

RESEARCHER: [Gives an inaudible example] Then that way you can kind of know what to expect.

PARTICIPANT: I understand.

RESEARCHER: Okay, cool. Thank you very much.

PARTICIPANT: You're welcome.

RESEARCHER: Keep up the good work [exiting goodbyes]

[Part 5, Participant 13]

[Introduction and explanation of the study to a new participant; Sirens, traffic, children, others obscuring exchange. Another potential participant is selected.]

RESEARCHER: I'm doing a study here at the clinic, and basically it's a study in cultural diversity. Different cultures and how you feel like when you're talking to doctors, whether here or someplace else –

PARTICIPANT: Yeah, I'm on TDY.

RESEARCHER: Okay. And how important it is for them to understand something about your culture when they treat you.

PARTICIPANT: What do you mean?

RESEARCHER: It's very important, because everybody is not the same.

PARTICIPANT: I don't know what you mean – what do you mean everybody's not the same?

RESEARCHER: There you go.

PARTICIPANT: I used to come here years ago.

RESEARCHER: Oh, really. Okay.

PARTICIPANT: [Participant is difficult to understand.] I went to [?] clinic for a couple months. So I took a picture [Inaudible] I told them, I have a headache. Because I went to the hospital emergency, and they found a tumor in my brain.

RESEARCHER: Mm-hm, mm-hm . . .

PARTICIPANT: Okay? I explain to her, my mission is simple. [Inaudible] You have cancer. I'm filled with cancer. I was in the hospital for six months. So, I'm just trying to [Inaudible couple of words].

RESEARCHER: Okay.

PARTICIPANT: So they told me, you need therapy. You need a lot of help.

RESEARCHER: Okay.

PARTICIPANT: I said yeah. I tried to kill myself and everything. And she said, 'I want to help you.' Every time she said I will help you. So I go there, TDY.

RESEARCHER: Did you like it?

PARTICIPANT: Yeah. They give me my pills and help, and my psychologist is Dr. [?] . Yeah. He give me some – aw, man.

RESEARCHER: Okay, so would you be willing to participate in my little study? It'll only take about three minutes.

PARTICIPANT: Yeah.

RESEARCHER: It's not long. So what I need you to do, this says that you don't mind doing it, because I can't do it unless you say you don't mind. Unless you want it. So all I need you to do is print your name here and sign your name here. Because otherwise they could say I made it up.

PARTICIPANT: [Laughs] I'll sign it.

Exchange as documents are filled out]

RESEARCHER: This seems like a very nice place here. It looks like everybody likes to come.

PARTICIPANT: Yeah. They help me here. [Inaudible exchange about giving her a sleeping pill, 'my nerve pills,' etc.]

RESEARCHER: So how do you identify, as Hispanic, Latina, or should I say Dominican?

PARTICIPANT: Naw, Spanish.

RESEARCHER: Spanish?

PARTICIPANT: Yes.

RESEARCHER: Okay. And how old are you?

PARTICIPANT: Forty-seven. I just turned forty-seven August the eighth.

RESEARCHER: Okay. Have you ever been somewhere – have you ever dropped out of therapy? Have you ever went to therapy and stopped going, because maybe you didn't like it or something?

PARTICIPANT: No I never – I always go. I always go to my therapy. I started going a long time ago [Inaudible]

RESEARCHER: Okay, so you're saying that you never dropped out?

PARTICIPANT: Never. Never. I've been going there for three years.

[Inconsequential, inaudible exchange]

RESEARCHER: So let me ask you this part then. When you talk to your counselor, do you think it's important for her to understand your culture?

PARTICIPANT: Yes, she understands that.

RESEARCHER: Do you think it's important?

PARTICIPANT: Yeah, she should

RESEARCHER: How come you think it's important? Why do you think it's important?

PARTICIPANT: [Inaudible lowered voice.] I could tell that. They're looking for it.

RESEARCHER: Okay. So you think it's important for her to understand your –

PARTICIPANT: Very. Yeah.

RESEARCHER: Something about family people that know something about [Inaudible]

PARTICIPANT: [Inaudible response]

RESEARCHER: I can understand. I can understand that. What do you believe your counselor – when you left your counselor's office, what do you think she thought about your race? Or what do you think she thought about your culture?

PARTICIPANT: She be fine. She be all right. Calm.

RESEARCHER: Do you think she cares about you?

PARTICIPANT: Yeah. She cares about me.

RESEARCHER: Is she Hispanic?

PARTICIPANT: Yeah. She always calls me – how you doing, [Inaudible] She give me token and everything.

RESEARCHER: So you're really okay with her.

PARTICIPANT: Yeah. She's nice.

RESEARCHER: Okay. Have you ever sat down and talked to her about your customs and your values? When I say customs, I mean – you know how everybody has their own, like, way that they live, their lifestyle, like that?

PARTICIPANT: Yeah.

RESEARCHER: Like, White people have their own culture, African Americans are another culture, Dominican is another culture –

PARTICIPANT: Yeah.

RESEARCHER: And Hispanic is another culture. Do you think that your counselor – what do you think she thought about it? Do you think that – did you discuss anything about your culture to her?

PARTICIPANT: Yeah.

RESEARCHER: What did you tell her about your –

PARTICIPANT: I tell her everything.
RESEARCHER: Have you ever talked to her about your Spanish culture?
PARTICIPANT: Yeah.
RESEARCHER: Like all Spanish people have different cultures, too.
PARTICIPANT: Yeah.
RESEARCHER: Not everybody's the same.
PARTICIPANT: Yeah.
RESEARCHER: But you do talk to her?
PARTICIPANT: Yeah. Everything.
RESEARCHER: Okay. You talk about your culture.
PARTICIPANT: Everything. Everything.
RESEARCHER: Now, how likely are you to – if you think that your counselor believes – I mean understands something about your culture, would that make you want to stay in treatment and keep coming?
PARTICIPANT: Yeah.
RESEARCHER: Okay. So that is important to you.
PARTICIPANT: Yeah. That's very important to the job. [Inaudible]. You know.
RESEARCHER: Okay.
PARTICIPANT: And my medicine. You know.
RESEARCHER: Okay.
PARTICIPANT: You go to a counselor, you're gonna see [Inaudible – sounds like 'that a medicine doctor']
RESEARCHER: Okay.
PARTICIPANT: A whole bunch.
RESEARCHER: Okay. Suppose you went to see your counselor didn't understand anything about your family's history, what would you do about that?
PARTICIPANT: I'd change.
RESEARCHER: Okay. Why do you think that's important?
PARTICIPANT: Hm?
RESEARCHER: Why do you think that's important for her to know something about you?
PARTICIPANT: Well, she looks to know about nearly everything. Everything. If she don't understand me, I'd be after her, like, 'well, you don't understand me, I'll get somebody else.
RESEARCHER: There you go.
PARTICIPANT: You know. She really, really understands me.
RESEARCHER: Have you ever been to anybody that you felt didn't understand you?
PARTICIPANT: One here. She just – I don't know.
RESEARCHER: You feel like she don't understand you?
PARTICIPANT: No. It hurt in here. And when I was in the hospital the doctor told me, you need some [inaudible word] or some therapy. And I said 'yeah.' Then she came. She came to see me. And she told me, 'Listen. I'm a therapist' [inaudible – something about

Social Security] . And she took me. And I've been going there, it's going to be three years. I like her, 'cause she's very nice.

RESEARCHER: Oh, okay.

PARTICIPANT: And she's Dominican, too.

RESEARCHER: Okay.

PARTICIPANT: She be calling me, too.

RESEARCHER: And you like her.

PARTICIPANT: I was in the hospital she was [inaudible] and she come and visit me in the hospital, too.

RESEARCHER: Oh, good! Well, that was good. Well, it sounds like you're sure happy about that.

PARTICIPANT: Yeah.

RESEARCHER: And she still likes you.

[END OF TAPE]

[Part 6, Participant Fourteen]

[Opening chat]

RESEARCHER: Now, how do you identify yourself? African American, Hispanic?

PARTICIPANT: African American.

RESEARCHER: I always ask, because you know . . . How old are you?

PARTICIPANT: Twenty.

RESEARCHER: Okay. Have you ever visited other places for therapy before here?

PARTICIPANT: [Sounds like] The Wedge.

RESEARCHER: Okay. And have you ever dropped out of a place that you went to for treatment? Stopped going, because, you know –

PARTICIPANT: No.

RESEARCHER: Okay. Did you keep going or did you stop?

PARTICIPANT: I didn't stop, I went to an outpatient program. Because was in [Inaudible] already. Because was trying to [Inaudible – sounds like 'I was trying to start a tokery,' then more inaudible] – and locked us all up. And they offered me a [Inaudible] – They offered me a deal just to pay a fine and leave me alone, and I said, 'I'm not taking no deal. To add to my grief, [Inaudible, something about downtown and pills] and now I'm on probation and I'm just basically just tired of being an outpatient over here. But the pills, they've got me on these drugs.

RESEARCHER: Have you ever gone to therapy [Inaudible] before the Wedge?

PARTICIPANT: Naw [Inaudible – sounds like] the first time was there.

RESEARCHER: Did you like it? Or did you not like it?

PARTICIPANT: It's all right, it's all right.

RESEARCHER: Have you ever been anywhere that you not liked it?

PARTICIPANT: It's all right.

RESEARCHER: Have you ever been anywhere where you didn't like it [Inaudible]?

PARTICIPANT: Either way, you're just gonna have to continue me in the Wedge, because my insurance couldn't cover that and an outpatient program. The outpatient program wasn't something I really even needed, because I wasn't using drugs. [Inaudible] – false arrest. And I'm still – [Inaudible] – so I was kind of upset about that. I couldn't continue my treatment, and I had therapy that was going for over two years, and I would never stop that but the drug program. So then I came – I started coming here.

RESEARCHER: Mm-hm.

PARTICIPANT: Sometimes I need to talk to somebody.

RESEARCHER: Okay. It is, oh, absolutely.

PARTICIPANT: [Inaudible but might've said, 'I've been going to therapy for a long time'] – some good advice.

RESEARCHER: And what city were you born in? Where you born in Philadelphia?

PARTICIPANT: Philadelphia.

RESEARCHER: How far did you go in school?

PARTICIPANT: [Inaudible].

RESEARCHER: And what's your occupation?

PARTICIPANT: [Inaudible, but sounds like 'A window washer, but I'm unemployed right now.']

RESEARCHER: Okay. What do you consider to be your first language?

PARTICIPANT: English.

RESEARCHER: What other languages do you speak?

PARTICIPANT: None.

RESEARCHER: What about your parents? What language do they speak at home?

PARTICIPANT: English.

RESEARCHER: How important is it for your counselor to know something about your values and your morals?

PARTICIPANT: Real important.

RESEARCHER: How come?

PARTICIPANT: Because I want to feel like I get something out of counseling.

RESEARCHER: Okay, so you can't get informed that they understand if they're not saying something back at you about our culture and values – you understand what I'm saying? Don't you think it's important? What do you believe your counselor thought about your race and your culture and values?

PARTICIPANT: I think she understands.

RESEARCHER: Any of them. It doesn't have to be somebody here, it can be somebody at the Wedge, or it could be somebody here.

PARTICIPANT: I think they understand.

RESEARCHER: The ones – the counselors that you've seen.

PARTICIPANT: Well –

RESEARCHER: Not just here, now.

PARTICIPANT: No, see, [Inaudible – sounds like 'I know Dominican people like that; I'm a nice person'].

RESEARCHER: And those are the ones that you always had, or –

PARTICIPANT: No, I was with Dominican people. Because the Dominicans are special. The Dominicans [Inaudible].

RESEARCHER: Oh, absolutely. I've seen it all.

[Inaudible exchange]

RESEARCHER: Have you discussed your customs and your values – did you communicate with her about your customs and your values? [Inaudible] – counselors, wherever you go, understand something about your culture and values, how likely are you to stay in treatment?

PARTICIPANT: [Inaudible]

RESEARCHER: And what are your thoughts and feelings [Inaudible] – but what I'm hearing you saying so far the Dominican behavior you liked overall. [Inaudible] and connected with you as an African American and understood about your culture.

[Inaudible]. How did you feel about that?

PARTICIPANT: You mean their technique? [Inaudible sentence ending with 'culture'.]

RESEARCHER: Okay. [Inaudible]. Get that book published.

[END OF LAST TAPE]

Curriculum Vitae

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ASSOCIATIONS: American Psychological Association
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Who's Who

RESEARCH EXPERIENCE: Qualitative Research/ Phenomenological Study
Neuva Vida Mental Health Clinic 2013

CLINICAL SKILLS: Personality testing
Rorschach
MMPI II
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Family Assessment
Marriage Counseling
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Sexual Counseling

PROFESSIONAL EXPERIENCE:**TEACHING AND LEADERSHIP EXPERIENCE**

Delaware County Community College, Adjunct Faculty, Psychology, 2010-2011

University of Phoenix, Instructor, Abnormal Psychology

Watterson Skills Center, Teacher, Career Assessment and Evaluation

CLINICAL EXPERIENCE

FMA Professional Resources, Marriage and Family Counselor, 2014-Present

FMA Professional Resources, Clinical Supervisor / Consultant, 2013-2014

FMA Professional Resources, Marriage and Family Counselor / School Counselor, 2011-2013

John F. Kennedy Behavioral Health Center, Behavioral Health Center, 2007-2010

Women's Christian Alliance, Family Therapist, 2000-2006

Multicultural Counseling Services, Family Therapist, 2004-2005

Eagleview Hospital, Addictions Counselor, 2004-2005

Thomas Jefferson Hospital, Methadone Maintenance Counselor, 2001-2003

Horizon House, Counselor, 1998-2000

Delta School, Counselor, 1995-1998

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SPECIALIZATIONS:

Psychological Testing

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