

2-11-2026

Invisible Man: Mental Health Providers and How Implicit Bias Manifests When Treating African American Men

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Walden University

College of Health Sciences and Public Policy

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Jamila K. Robinson

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2026

Abstract

Invisible Man: Mental Health Providers and How Implicit Bias Manifests When Treating

African American Men

by

Jamila K. Robinson

MA, Trinity Washington University, 2007

BS, University of Maryland University College, 2002

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

February 2026

Abstract

African American men continue to face disproportionate barriers to engagement, accurate diagnosis, and equitable nonbiased treatment in mental health settings. The purpose of the qualitative narrative inquiry was to explore how implicit bias and sociocultural assumptions manifest among mental health providers who diagnose and treat African American men. Bronfenbrenner's ecological systems theory, which considers the influences of all the systems that shape an individual's lived experiences, was the study's theoretical framework. Semi-structured interviews were conducted with five licensed mental health providers who worked in large hospital systems, private practice, or community-based clinics. The interview data were analyzed using Braun and Clarke's six-phase thematic analysis to identify patterns, meaning, and contextual influences in participant narratives. Three major themes emerged: implicit bias and ethical dilemmas, medical mistrust, and stigma and masculinity and seven sub-themes, two include African American men lack trust due to fear and lack of knowledge leads to bias. The ecological systems framework helped reveal how these influences operate across multiple levels—from individual provider awareness to institutional policies and macrosystem. The findings suggest that implicit bias remains a contributing factor to mental health disparities among African American men. The study highlights the need for culturally relevant modalities, bias training, reflective supervision, and cultural competency training. Implications for positive social change include elevating provider voices and demonstrating how implicit bias can be recognized and mitigated through grounded ecological approaches to care.

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Dedication

This dissertation is dedicated to my husband, son, brothers, and every African American man who has ever carried pain in silence. For those who felt unseen, unheard, or misunderstood. May this work contribute to a future where you are met with compassion rather than assumption, and equity rather than bias. Your lived experiences ignited my passion for research. This dissertation is for you.

Acknowledgments

To the mental health providers who courageously shared their lived experiences- thank you for your honesty and commitment to transform the way care is delivered. To my children, thank you for believing in me when I struggled to believe in myself. Your love carried me through every chapter of this journey. To my husband, thank you for supporting me and holding it down for me so I could carve out time to think, research, and write. I appreciate everything you have done to support my dream. To my mom, thank you for reminding me I could do all things through Jesus Christ. You continued to push me, listen, and let me vent when I was at my wits end. Thank you for believing I could get to the finish line. Thank you to my committee who continued to work with me to ensure I reached the finish line.

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Chapter 1: Introduction to the Study

The most significant health disparity among ethnic groups in the United States is observed in the African American community. More specifically, African American men face a disproportionately higher rate of adverse health outcomes involving chronic diseases such as diabetes, hypertension, substance use, as well as the lowest life expectancy compared to any other group (Smith-Woods & Diggs, 2024). The mental health landscape in American society suggests a gross disparity in mental health status among minorities, notably African Americans in compared to European Americans (Sanders et al., 2024). African Americans experienced poorer health outcomes than their European American counterparts in terms of various health measures, including infant mortality, substance use, mental health, diabetes, and cancer (Kaiser Family Foundation, 2024). The findings have the potential to produce positive social change in the field of social work, and a better understanding of this phenomenon may improve the overall health outcomes of African American men by improving mental health practices and increasing the number of African American men who seek treatment.

One barrier to African American men seeking mental health services, implicit bias among mental health providers, refers to prejudices that occur outside individual's conscious awareness; this unconscious prejudice may sometimes conflict with values or beliefs, and manifests in mental health care for African American men as a significant factor in terms of disparities (Metzger, 2023). Implicit bias among clinicians correlates with poorer communication between patients and physicians and lower patient satisfaction ratings regarding quality of medical encounters (Metzger, 2023). Biased

providers also have the potential to misdiagnose depression in African American men and underestimate their cognitive capacity and stigma associated with seeking treatment (Smith-Woods & Diggs, 2024).

This study explored how mental health providers' sociocultural assumptions and biases manifest when diagnosing and treating African American men. Current researchers have explored lived experiences of African American men and their health disparities; however, limited literature exists on how these experiences may impact appropriate mental health care to African American men. Chapter 1 includes the background, problem statement, purpose of the study, research question, theoretical framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance of the study.

Background

African American men faced several challenges that affect their physical and emotional health. Their depressive occurrences are more disabling, persistent, and resistant to treatment than those experienced by European Americans (National Institute on Minority Health and Health Disparities, 2023). African Americans experienced mental health episodes differently than their European American counterparts due to social and economic disadvantages, systemic racism, lack of health insurance, poverty, social determinants, medical mistrust, bias, and lack of culturally appropriate medical and mental health care (Johnson et al., 2021). Hippel (2022) stated African American men experienced depression and other mental health symptoms differently than European

Americans because they often present with somatic symptoms or physical complaints instead of sadness or hopelessness.

Somatic systems, often overlooked by mental health providers, lead to undiagnosed and untreated symptoms. In addition, African Americans significantly underuse mental health services (Smith-Woods & Diggs, 2024). Neglecting mental health needs of African American men can result in devastating experiences to individuals as well as their families. This situation leads to increased vulnerability and increased chances of self-medicating with drugs and alcohol, homelessness, incarceration, homicide, and suicide (Office of Minority Health, 2023).

Mental health challenges of African American men impact and have major implications for social work practice. Mental health providers often function as frontline workers for mental health services and often advocate for marginalized communities. The mental health field miss opportunities to improve health outcomes of African American men when they do not address this situation as a public health crisis. Mental health providers must develop a nuanced understanding of these dynamics to improve health outcomes of African American men. Recent literature explored from the lens of the African American patient; however, a lack of literature exists that focuses on socio-cultural assumptions and biases among mental health therapists. One in five U.S. adults experience a mental health condition; however, only 40% receive treatment (Sanders, et al., 2024). Only one in three African Americans seek mental health treatment (Sanders et al., 2024). Several barriers prevent African American men from seeking treatment, such as African American men often receive differential mental health treatment when it

comes to mental health therapeutic services (Johnson, et al., 2024). According to Pederson (2023), African American patients receive care at least 20% lower in quality compared to their non-Black counterparts largely because of consequence of systemic bias and stigma.

Despite growing efforts to improve health disparities among African American men, there are still disproportionate biases among mental health providers. A mental health providers' positive and negative lived experiences can influence how they deliver quality mental health care to this population. Research stated that providers' with elevated implicit bias demonstrated negative patient-provider communications (Pederson, 2023). This practice often leads to treatment disparities characterized by delayed diagnosis, limited access to evidence-based interventions, and reduced adherence to follow up care among African American patients (Pederson, 2023). In addition, African American men are 20% more likely to experience severe psychosocial distress than their European American counterparts (National Alliance on Mental Health, 2024). Despite a lower prevalence of depression, African Americans are less likely to use mental health services as they are more likely to report severe and chronic illnesses (Pederson, 2023). Understanding these factors is critical for developing effective programs, policies, and practices to improve health outcomes.

Problem Statement

The problem is conscious and unconscious negative bias influences how mental health therapists deliver services to African American men. Licensed clinical social workers, psychologists, and therapists serve diverse populations with various

backgrounds, and it is important for them to be culturally competent when servicing them. The use of culturally competent practices serves to support diverse populations' mental health, including that of African American men. Cultural competence includes having insights regarding these populations and ensured mental health providers understand their own cultures, worldviews, implicit bias, and discrimination. On the other hand, lack of cultural competence further perpetuates inequities such as implicit bias, discrimination, and racism.

Negative bias against marginalized groups of people impacted patient-provider communications regarding clinical decisions providers make and their practices, which result from systemic biases (Vela et al., 2022). Of particular importance, both systemic and individual provider biases contribute to misdiagnoses and underdiagnoses of African American men (Miola et al., 2025; Sanders et al., 2024). According to (Teplin et al. 2023), clinicians' unconscious bias influences diagnostic decision making by shaping the clinicians' assumptions about symptoms severity, patient credibility, and compliance likelihood toward their patients, and this influences diagnostic decisions that may lead to misdiagnosis for example, clinicians' are less likely to prescribe appropriate medication to patients of color; making assumptions about their health literacy or factoring in the patients' socioeconomic status. In summary, although research has identified clinician bias as a contributor to inconsistent and unequal treatment, limited research exists regarding how such bias experiences clinician client interactions. This study addressed this gap by exploring the real-world impact of bias and social assumptions, trust, and treatment equity.

Purpose of the Study

The purpose of this qualitative narrative inquiry included how mental health providers' sociocultural assumptions and biases manifest when diagnosing and treating African American men. Clinical providers' life experiences often shape their perceptions of patients, affecting their triage and treatment decisions. Understanding how these lived experiences influenced mental health care delivery is crucial for potentially mitigating negative mental health outcomes among African American male patients. To address the research gap, this study explored mental health providers lived experiences using narrative inquiry with mental health clinicians as the participants, i.e., licensed clinical social workers.

Research Question

The following research question underpinned this narrative inquiry: How do mental health providers' sociocultural assumptions and biases manifest when diagnosing and treating African American men?

Theoretical Framework

The framework selected for this study is ecological theory. Bronfenbrenner (1994) developed a theory of human development that would consider the influences of all the systems that play a role in impacting an individual's lived experiences (Crawford, 2020). The ecological framework identified influences on an individual's attitudes and behaviors resulting from friends, family, personal and social environments (Bronfenbrenner, 1995). This theory explored individual and external factors which influenced an individual's or provider's lived experiences and is often utilized in both the

public health and behavioral health settings to improve health outcomes. Bronfenbrenner (1995, 1979) argued that the development of an individual's behavior and thinking process can be influenced by their interactions with four systems:

1. Microsystem focuses on individuals' cognitive abilities, biological characteristics (the mental health providers' environment).
2. Mesosystem focuses on connections between family and school environment (mental health providers' social system and support).
3. Ecosystem is the social setting (mental health providers' social structure).
4. Macrosystem focuses on the cultural environment (mental health providers' own culture and value system).

Using Bronfenbrenner's ecological framework related to the study because it furthered understanding of how mental health providers' lived experiences may impact their provision of mental health services to African American men. Exploring how a provider's lived experiences (negative and positive) may influence delivering mental health care to this population is critical. Examining the behavior and experiences of mental health providers may increase opportunities to engage African American men in culturally appropriate ways. This framework is useful for exploring the macro–micro level of mental health providers by examining their individual and environmental experiences and whether that plays a role in how they deliver mental health services to African American men. Chapter 2 includes more details on the ecological theory as applied to this study.

Nature of the Study

I used a narrative inquiry approach to explore how mental health providers' sociocultural assumptions and biases manifested when treating and diagnosing African American men. I selected an interpretive narrative inquiry for this study to understand participants' experiences and stories regarding how biases (implicit or explicit) among mental health providers manifest in the diagnosis and treatment of African American men. Narrative inquiry focuses on how individuals' experiences are influenced by culture and society (Clandinin, 2021). By exploring provider motivations and actions, I aimed to understand more about the clinical treatment provided to African American, which often receives subpar care.

The study had five participants, at which point, I obtained saturation. The participants resided in the Mid-Atlantic area of the United States and consisted of licensed clinical social workers to align with purposive sampling (Alhassan, et al., 2022; Stratton, 2024). In alignment with narrative research, I conducted individual, open-ended, semi-structured interviews that were conducted with the mental health provider participants. Using thematic analysis, I generated themes based on clinician responses to the interview questions. To maximize confirmability, I used the Zoom platform for the audio-recordings and transcriptions.

Definitions

Adverse childhood experiences: Traumatic events that happen during childhood, which include violence, abuse, or growing up with a family member with substance use or mental health problems (Centers for Disease Control and Prevention, 2025.).

Black or African American: A person having origins in any of the Black racial groups of Africa. It includes people who indicate their race as Black or African American (Census.gov, n.d.).

Bias: The evaluation of something or someone that can be positive or negative, and implicit or unconscious bias is when the person is unaware of their evaluation (Gopal et al., 2021).

Lived experiences: Individuals' acquisition of knowledge through direct, firsthand experience in everyday events rather than through assumptions and constructs from other people (World Health Organization, 2011).

Mental health: Diagnosable mental disorders, which are health conditions characterized by changes in mood, behavior, and thinking associated with distress or impairments (U.S. Department of Health and Human Services, 1999).

Mental health provider: A clinician who is qualified to identify and treat mental health conditions. Most have at least a master's degree. Some may have a higher level of education, training, and credentials (Mayo Clinic, n.d.).

Assumptions

The first assumption refers to the participants' honesty regarding their job classification of licensed clinical social worker and the minimum requirement of 3 years of experience and relevant experience to provide meaningful and in-depth data. A second assumption included that the participants answered questions openly and honestly.

Scope and Delimitations

The scope of the study included five mental health providers' lived experiences who fit the inclusion criteria of licensed clinical social workers and 3 years of professional service, within a mental health facility located in the Mid-Atlantic area of the United States. Recent peer-reviewed literature explored the perceptions among African Americans from a patient perspective; however, the research did not explore sociocultural assumptions and biases among mental health therapists who diagnose and treat African American men. Therefore, I explored mental health provider's lived experiences and how they manifest when diagnosing and treating African American men.

To align with purposive sampling common in qualitative research, I excluded mental healthcare providers who did not provide mental health therapy to African American men. Through this research, I did not seek generalizability in quantitative terms compared to the larger population or regarding other settings, participants, or topics outside of the scope of this research.

Limitations

The narrative approach lacks generalizability due to targeting a specific group, such as African American male patients and mental health providers. This study focused on providers and how they serve African American men. To reduce challenges with recruiting providers willing to participate, I conducted interviews via Zoom to allow flexibility for the participants. I made every effort to conduct the study with at least 4 to 7

providers; therefore, I requested and received approval from the IRB to provide gift cards that could help mitigate challenges with recruitment.

Significance

According to Smith-Woods and Diggs (2024), African American men who are diagnosed with a mental health illness can be described as having a double burden. Through this research, I sought to provide an understanding of how mental health providers' lived experiences can potentially influence mental health care delivery to African American male patients. Prior researchers indicate that an implicit racial and ethnic bias exists among health care professionals in favor of European American patients over African American, Hispanic, or dark-skinned patients (Metzger, 2023). This study, then, has positive social implications because of the importance for mental health providers to gain a better understanding of the complexities involved with serving African American male patients. Most importantly, exploring African American men's complex nature, cultural cues, medical mistrust, and social implications to health outcomes has the potential to improve the life expectancy of African American men.

In this study, I explored how mental health providers' sociocultural assumptions and biases manifest when diagnosing and treating African American men. The results of the study identified barriers and how it impacted African American men. This study provided an understanding of the mental health providers through the lens of ecological theory which may improve programs, policies, and practices. The inclusion of culturally appropriate practices, interventions, and policies for providers may increase the number of male African American patients seeking mental health treatment.

Summary

African American men have a long history of neglect and abuse, and it has influenced how generations of African American men feel about accessing health services (Hippel, 2022). Mental health challenges continue to rise in this community, yet some African American men still do not seek the care they need. Despite the known mental health issues African American men are often reluctant to seek treatment (Hippel, 2022). In this chapter, I presented the background, problem statement, purpose of the study, research question, key terms, assumptions, scope and limitations and delimitations of the study. The problem consisted of how mental health therapists' conscious and unconscious negative bias influences the services provided to African American men (Meidert et.al, 2023; Pederson, 2023; Smith-Woods & Diggs, 2024). The purpose of the study explored how mental health providers' sociocultural assumptions and biases manifest when diagnosing and treating African American men.

It is essential to the mental health field to improve health outcomes for African American men. Social workers should be trained to recognize and dismantle systemic barriers contributing to their marginalization (Higgins and Finchum, 2024). By offering culturally sensitive therapy and interventions, social workers can help them navigate barriers (Higgins and Finchum, 2024). One strategy to address this is to understand how mental health providers who treat African American men experience life both personally and professionally by examining their individual and environmental experiences. Understanding the providers' lived experiences may help improve the mental health field by enhancing policies in medical and social work institutions to increase coursework on

culturally relevant and appropriate techniques for minority populations (Higgins and Finchum, 2024). Culturally competent care mandates that health care providers possess the capability to comprehend their clients' cultural backgrounds (Sanders et al., 2024).

This qualitative study addressed the research question: How do mental health providers' sociocultural assumptions and biases manifest when diagnosing and treating African American men? In Chapter 1, I introduced the problem with biases among mental health providers who diagnosed and treated African American men using narrative inquiry. Chapter 2 includes a comprehensive literature review that encompasses previous research on sociocultural assumptions and biases and discusses the narrative inquiry as the framework. The literature review provided the framework for the current study.

Chapter 2: Literature Review

Introduction

In this qualitative narrative inquiry study, I explored how mental health care providers' life experiences and understanding manifested in their mental health services to African American men. The findings from this study have the potential to improve health outcomes for African American men by developing programs, policies, and practices that support African American men's mental health and improving mental health therapists' efforts to diagnose and treat them.

The problem is that conscious or unconscious negative bias influences how mental health therapists deliver services to African American men. A limited body of examined how mental health provider attitudes, perceptions, and biases may negatively affect mental health care services. Recent peer-reviewed literature included explorations of the perceptions among African Americans; however, these studies did not include sociocultural assumptions and biases among mental health therapists who diagnose and treat African American men. Research exploring mental health therapists using phenomenology lacks in the current research (Ma et al., 2022; Mullen et al., 2021).

Limited research exists that seeks to understand how provider bias, perception and beliefs impact mental health care to African American men diagnosed with depression (Vela et al., 2022). Researchers indicated negative bias against marginalized groups of people, such as minority populations impacts patient-provider communications, clinical decision-making, and institutionalized practices (Vela et al., 2022). Vela et al. (2022) published a systematic literature review of 15 studies which explored the evidence of

implicit racial bias and health outcomes. Cadaret et al., (2025) demonstrated African American men prefer therapists who share the same racial and gender identify and Kalbaugh et al., (2025) suggested that implicit bias among clinicians contributed poorer treatment outcomes for African American patients.

In this literature review, I explore topics such as mental health providers, African American, health equity, health disparities, medical mistrust, and bias. I chose the ecological systems theory to explore mental health providers' lived experiences. I used the four levels systems theory to explore the personal and environmental systems. The chapter ends with a summary of the literature review.

Literature Search Strategy

I conducted an online literature search strategy to research topics that included health disparities, lived experiences, bias, mental health providers, social workers, adverse childhood experiences, and African American men. I used the following databases to conduct my search for literature: CINAHL Plus, Thoreau, and Pub Med databases from Walden University's online library and Google Scholar. I used the following terms in the search: *bias, implicit bias, mental health providers, adverse childhood experiences, mental health, health disparities, African American men, lived experiences, social determinants of health, health equity, community health, medical mistrust, health care utilization, racism in healthcare, stigma, well-being, historical trauma, and perceptions and beliefs*. Any peer-reviewed articles that could not be identified within the 5-year period required additional research using federal government sources such as websites. These federal agencies included the Centers for Disease

Control and Prevention, Substance Abuse and Mental Health Services Administration, and The Department of Health and Human Services. I restricted the search to peer-reviewed articles published from 2021 to 2025 to address the current status in the field.

Theoretical Foundation

I used the ecological systems theory for this study. Bronfenbrenner (1994) developed a theory of human development that would consider the influences of all the systems that impact an individual's lived experiences (van Manen, 2021). Through this theory, Bronfenbrenner suggested human development does not occur in isolation but in the individual's environment. The comprehensive ecological framework identified influences on an individual's attitudes and behaviors resulting from friends, family, personal and social environments (Bronfenbrenner, 1995). In using this theory, I explored individual and external factors that influence an individual or provider's lived experiences and are often used in public health and behavioral health settings to improve health outcomes.

The different levels of the ecological system include the microsystem, mesosystem, exosystem, macrosystem, and the chronosystem. The microsystem encompasses the family and peer influence. The mesosystem addresses interactions between environments. The exosystem refers to the impact of the external environment. The macrosystem includes both cultural and societal influences. The chronosystem consists of time and life transitions and historical transitions.

Ecological systems theory and its environmental layers have been adopted by several fields, such as social work, education, and psychology. I chose the ecological

systems theory for this study because the participants' lived experiences are situated and influenced by the various contexts represented in the theory. The theory aligned with the ways people such as social workers or mental health providers, navigate their environments and, as a result, may impact how they deliver mental health care to African American men. I selected this theory because of the multiple layers of the environment and how the layers can influence an individual such as a mental health provider. By examining the lived experiences of providers, possibility exists to establish a connection between providers, patients, and their environment.

Two researchers used the ecological systems theory focused on African American men's mental health and clinical decision making among providers. Rovito et al., (2022) used the social ecological model to examine individual, interpersonal, community and policy factors affecting isolation in young men. The key findings determined that social connectedness includes the individual, the individual's infrastructure, and community who shaped it like the individual. This study reflects a relevant example of how the ecological theory frames mental health behaviors and the social well-being of men.

Watkins et al. (2022) examined trauma exposure in young African American men, and their findings identified influences across multiple levels, including individual, interpersonal, organizational, community, and policy levels. The participants highlighted the need to incorporate multilevel, culturally tailored interventions to improve mental health care. Rogehr et al. (2021) used the ecological framework for clinician decision making in high-risk mental health contexts, focusing on the systems level stresses, and

noted human behavior is a consequence of the interaction between the individual and the systems.

Literature Review Related to Key Concepts

African American Men and Medical Mistrust

African American men have mistrust of the health care systems and health care professionals (Pederson, 2023). African American men have a long history of medical mistrust when it comes to their medical providers and mental health. Medical mistrust presents a barrier to treatment among African American men; therefore, mental health providers should seek to understand this population to reduce barriers to treatment. In addition, similar studies have noted historical and modern racism, abuse of government, and cultural values which contribute to medical mistrust (Metzger, 2024).

African American men lack trust in their health providers for many reasons, one of which includes the Tuskegee experiment. In 1932, the United States Public Health Service conducted a study of untreated syphilis in African American men also known as the Tuskegee experiment (Centers for Disease Control and Prevention, 2024). The stated purpose of the study explored how syphilis changed if untreated, examining its natural progression; however, the U.S. Public Health Service not only observed the patients but experimented on them without their knowledge or permission. Researchers did not collect informed consent; therefore, poor African American men were unaware of the study's implications.

At the time of the implementation of the study in 1932, no known cure for syphilis existed. In 1947, the discovery of penicillin offered hope. However, the

Tuskegee leaders withheld treatment for 40 years (Centers for Disease Control and Prevention, 2024). Because of the Tuskegee Experiment and other systemic disenfranchisement of non-White populations, generations of African American families lack trust in their medical providers.

Systemic racism deters African American men from seeking mental health services due to the mistrust in the health care system and fear of racial discrimination (Higgins, 2024). In addition, mental health providers often do not understand the dynamics of African American men. The lack of understanding can result in inadequate treatment and exacerbation of mental health problems (Hippel, 2022). For example, African American men's expressions of distress may be misinterpreted as behavior problems instead of being recognized as a mental health issue (Hippel, 2022). African American men are skeptical of seeking mental health treatment, despite experiencing higher rates of mental health disorders compared to other groups and African American men are less likely to seek treatment, due to medical mistrust (Pederson, 2025).

According to Smith-Woods and Diggs (2024), African American men experience historical trauma, social determinants of health, and societal views which deter them from seeking treatment. Smith-Woods and Diggs (2024) conducted a study to examine how African American men seek mental health services, the importance of the black church and their role within the black church as a protective factor in promoting mental health, wellness, and resilience. Researchers emphasized the church's role as a trusted setting for families in addressing social determinants of health. Smith-Woods and Diggs (2024)

determined that through engagement, healing, and faith-based strategies the church fostered an inclusive environment and psychological healing to the black community.

Bonacci (2021) conducted a qualitative study and examined how medical mistrust impacted African Americans and Hispanics with preexposure prophylaxis an HIV medication. Although treatment was effective, the study found participants expressed concern about the treatment, intentions behind the new therapeutic intervention, its side effects, and the lack of cultural sensitivity. Bonacci (2021) determined there are significant barriers to accessing preexposure prophylaxis medication due to stigma, mistrust, and racism in the health care system. The goal of the researchers was to improve equity by including provider training, strengthening partnerships, and improving programs, policy, and practices.

Bias Among Health Care Professionals

Taking care of personal mental health is an important yet overlooked necessity for African American men. It is essential to improving the health outcomes for African American men. African American men have compounded challenges that impact how they perceive mental health treatment such as racism and historical mistreatment with the health care system, and biases. The disparity among African American men can be attributed to bias in the mental health field, both conscious and unconscious bias by mental health providers. For the purposes of this study, mental health providers are considered health care professionals. Recent studies identified and examined whether health professionals or mental health providers were biased towards their patients (Hippel, 2023; Smith-Woods & Diggs, 2024; and Pederson, 2025). The studies provided

an understanding of how systemic bias, stigma, and trauma from the perspective of African American men.

Research indicated bias can manifest in several ways for African American men, such as stereotyping, misinterpretation of symptoms, and lack of cultural competence across treatment modalities (Slatton, et al., 2025). Provider bias influenced their perceptions and beliefs and the treatment of African American men, Slatton et al., (2025). Vela et al. (2022) conducted a literature review examining studies to identify if health care providers were biased toward their African American male patients. The review examined both implicit and explicit bias among providers and identified 15 studies designed to explore evidence of the provider implicit bias and health outcomes. Vela et al. (2022) determined biases exist among health care professionals and can impact patient and clinician communication. Teplin (2023) revealed racial and ethnic biases often resulted in psychiatric misdiagnosis, marginalizing African American patients exacerbating disparities in access and treatment modalities.

The medical Cognitive Habits and Growth Evaluation Study (CHANGES), a longitudinal study, sampled 49 U.S. medical schools to measure associations between intervention and levels of bias among medical students. The study surveyed 4500 students, and the results showed 74% exhibited implicit bias and 67% explicit (Vela et al., 2022). This study was one of the largest studies conducted among medical students and demonstrated that even medical students were biased, therefore they had the potential to provide care based on stereotypes and misinformation which impacted their patient health outcomes.

Meidert et al. (2023) conducted a scoping review analyzing 5,186 records of the eighty-one studies of health care professionals across North America and Europe which determined to indicate some level of bias. The researchers identified unconscious bias among health care professionals and investigated whether provider biases were different across the world. For the purposes of this study, health care professionals included physicians, nurses, midwives, occupational therapists, and physiotherapists. Meidert et al. (2023) determined there was prevalence of implicit bias among health care providers such as racial, weight and mental health biases. Much of the study focused on physicians and nurses, not mental health providers exclusively.

Crapanzano et al. (2023) examined the impact of explicit and implicit bias against mental health illnesses by health care providers, to include primary health, medical students, and nurses. The authors reviewed 18 studies from 1996 to 2020 and identified two categories to explore, vignettes and qualitative studies. Regarding vignettes, Crapanzano et al. (2023) found at least 80% of clinical decisions were negative towards patients with mental health disorders, while only 21% favored clinical decisions. In contrast, the qualitative studies reported bias behaviors against the patient with mental illness. The overall findings concluded providers are biased against their patients with mental illness and their bias does negatively impact their clinical decisions.

Sanders et al. (2024) examined implications of misdiagnosing African American men's trauma response, systemic biases, and negative narratives. Sanders et al. (2024) used a conceptual framework which explored historical trauma, discrimination, and traumatic responses to stress. The key findings of the study suggested African American

men are often misdiagnosed due to provider biases, lack of humility and cultural competence (Sanders et al., 2024).

Stigma and Historical Trauma Among African American Men

African American men suffered from sustained historical trauma and how they manage the trauma can affect how they are perceived in society. Historical trauma and stigma are barriers that affect African American men and their ability to seek and receive mental health services, Bauer, et al. (2023). Historical trauma is often because of sustained violence in the African American community, and over time symptoms can manifest into posttraumatic stress disorder (PTSD) or adverse childhood experiences. Ugwuode et al. (2023) indicated there is a link between prolonged exposure to violence and the development of PTSD symptoms in African American men. Ugwuode et al. suggested that African American youth who live in low-income urban areas are susceptible to risk factors that increase their susceptibility to trauma. Because of the sustained trauma, African American men have learned to mask their emotions and trauma symptoms. As a result, providers may not recognize their symptoms as trauma or PTSD, therefore leading to misdiagnosis. In addition, the study revealed a lack of longitudinal studies that examined the physiological and psychological signs of PTSD and how it affects African American men and their relationship with mental health services.

Jones et al. (2023) examined PTSD among African American adults between 18 to 34, 35 to 49 and 50 and up. The severity of PTSD was based on the age group, associations of PTSD, chronic stress, and racial discrimination. Jones et al. concluded that PTSD was higher in African American middle-aged men and women ages (18 to 34)

at 14% because of life circumstances. The findings underscored the importance of addressing unique challenges of African American men and how they experienced PTSD which affects how they engage with mental health professionals.

Bauer et al. (2023) conducted a qualitative study using the theory of planned behavior to explore the factors that influence mental health care among young African American men ages 18 to 30 who experienced trauma. Bauer et al. (2023) explored the link between trauma, attitudes and behavioral control related to mental health screening using 55 focus groups from an urban community setting in Kansas City, Missouri. Findings showed both positive and negative attitudes about mental health treatment; for example, positive beliefs where mental health could be helpful and build coping skills, negative attitudes were based on effectiveness and concerned services may be a waste of money overall, attitudinal support for care was moderate, however, many of the negative attitudes persisted. In addition, the study showed there is a need to include culturally relevant interventions to address barriers faced by African American men.

Shannon (2022) used a humanistic approach, focused on logistic regression, and investigated factors influencing African American men's decision to seek mental health treatment focusing on stigma and help-seeking behaviors. The study determined stigma and help-seeking behaviors are a predictor in determining if 119 African American men seek help from a mental health counselor. The research examined the patients' experiences with treatment, and the study underscored the importance of reducing stigma among African American men.

Mental Health Practice and Cultural Competency

Cultural competency emerged as a foundation of social work and should be a guiding principle in how therapists deliver quality, effective, and equitable care to diverse populations. Attipoe (2024) developed a practical guide Gathering, Assessing, Creating, Implementing and Evaluating (the GACIE model) that underscored the importance of including cultural competency in training for social work and human services. The purpose of the framework was to improve the practitioner's ability to triage and treat clients and understand their background and to apply cultural relevancy when delivering services to African Americans. Although there is an effort to incorporate cultural competency there are challenges with translation of the core principles for therapists to put into practice.

Williams et al. (2024) focused on two methods to teach cultural competence at the bachelor and master social worker programs. The researchers focused on cultural competence among social worker students and promoting racial equity in the social work programs. The challenges and opportunities identified in this study incorporate strategies to improve racial equity and social justice among social worker students. Williams et al. (2024) recommended integrating cultural humility into policies and mental health provider self-reflection to reduce implicit bias.

Summary and Conclusions

The gaps identified in the literature particularly the limited attention to mental health providers' sociocultural assumptions and biases and how the perspectives shape clinical decision making with African American men underscore the need for an in-depth

qualitative approach. As a result, qualitative methods described in Chapter 3 were intentionally selected to elicit providers lived experiences through in-depth interviews allowing participants to articulate nuanced perspectives that were absent from research. The methods selected were essential to exploring complex phenomena and provided a framework for interpreting how provider lived experiences manifest in clinical practice. Chapter 3 outlined the methodological framework used to explore these experiences systematically.

Building on the methodology above the following section connects the study to a broader scholarly context by synthesizing recent research (2021 to 2025) that documents how systemic bias, trauma, stigma, and medical mistrust uniquely affect African American men and their ability to function in a positive and safe way. Ugwuode et al. (2023) demonstrated how community sustained violence takes a toll on African American men and how trauma may show up. Bauer and Shannon explored personal barriers to mental health treatment specifically stigma, mistrust, lack of access and help-seeking behaviors. Both Crapanzano (2023) and Teplin (2023) describe how racial and mental health biases led to misdiagnosing and subpar clinical decisions. What is known is how African American men perceive mental health services and their overwhelming distrust of the medical field in general. Previous researchers explored the experiences of African American man as patients. However, it is unknown how the mental health therapist's negative bias affects their diagnosis and treatment of African American men. In addition, there are limited explorations of the mental health providers' lived experiences using an ecological framework.

Improving mental health care for African American men required culturally relevant training and practices for the mental health providers and other clinicians who support them. Addressing disparities among this population will improve health outcomes for African American men. Understanding mental health therapists lived experiences, may be useful in the development of programs and practices to improve their care, diagnosis, and treatment of African American men.

Chapter 3: Research Method

Introduction

In this qualitative narrative inquiry, I explored how mental health providers' sociocultural assumptions and biases manifest when treating and diagnosing African American men. Recent peer-reviewed literature explored the perceptions among African American from a patient perspective; however, it did not explore sociocultural assumptions and biases among mental health therapists with a focus on African American men; therefore, a gap was identified in the research. Historical studies explored African American men from a patient perspective; however, this study examined the mental health providers' lived experiences. The research informed the mental health field by identifying best practices in training and policies to address mental health provider biases toward African American men. The findings have the potential to produce positive social change in the field of social work, as better understanding this phenomenon may improve the overall health outcomes of African American men by improving mental health practices and increasing the number of African American men who seek treatment.

In this chapter, I provide an overview of the research plan using a qualitative narrative inquiry approach. Bronfenbrenner's (1974) ecological systems framework was used in conjunction with the interaction dimension of narrative research to guide this research. This chapter begins with a presentation and rationale of the chosen research design, qualitative narrative research. Next, I detail my role in the research. The methodological processes follow this section and include the decisions and rationales

regarding the participants, instrumentation, data collection, and data analysis sections.

Then, I describe the data analysis plan and trustworthiness related to the study.

Research Design and Rationale

The research question guided this study and focused on how mental health providers' socio-cultural assumptions and biases manifest when diagnosing and treating African American men. The main constructs include social and cultural assumptions, which encompassed the beliefs and expectations about values, behaviors, and societal norms (Sue & Sue, 2022). Biases refer to conscious or unconscious stereotypes or prejudices (Ogunleye, 2022; Vela et al., 2022). According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), mental health treatment serves as the framework that guides therapy such as treatment planning, service eligibility, and patient/provider communication (APA, 2022). Mental health diagnosis refers to the criteria that identify certain patterns such as thoughts, feelings, or behaviors that may cause significant distress. (APA, 2022)

A qualitative narrative research design explored these constructs in terms of how mental health providers' sociocultural assumptions and biases manifested in how they diagnose and treat African American men. I chose the qualitative research tradition given the importance of participants' voices and aspects of situated practice (Creswell & Poth, 2023). Narrative inquiry serves as meaningful way to inform future practices for issues of great social importance (Clandinin & Cave, 2023; Gavidia et al., 2022). In using narrative inquiry, researchers addressed participants' stories and works to co-construct the story (i.e., restorying; Clandinin, 2022; Connelly, 2022) through reflexivity, quality criteria,

and member checking processes (Gavidia et al., 2022). In utilizing narrative research, I became closer to understanding the phenomena through deep interpretive and critical analysis (Gavidia et al., 2022). For these reasons, I used the narrative inquiry approach to develop a nuanced understanding of mental health providers' situated experiences diagnosing and treating African American men.

Role of the Researcher

In this research, I functioned in the roles of research designer, recruiter, interviewer, and data analyst. My role in interviewing consisted of being a listener, an observer with an r outsider or etic perspective (Creswell & Poth, 2023) in that I did not participate in any professional activities while conducting research. My academic education in public and community health provided the background in understanding the connection between bias among mental health providers and improving health outcomes. I do not have any personal or professional relationships with mental health therapists who participated in this study. I conducted the interviews virtually, and I used a partner organization to disseminate the recruitment participant flyer. In this process, I sought to avoid researcher bias in participant selection.

While I foresaw no professional power dynamics, an inherent power dynamic exists within the researcher-participant differential. As an interviewer, the researcher holds a sense of power within the relationship (Lahman, 2025). However, I do not have a direct background in mental health, therapy, or cultural assumptions that could shape the interview questions. To manage my biases, I used a reflexive journal throughout to document personal assumptions. To ensure power relationships did not emerge, I

highlighted that participation in the study required voluntary and informed consent. I sent the transcripts to the participants for review and requested they return them within 5 business days. To reduce ethical issues with confidentiality, I de-identified participants and reminded them not to use their real names. To honor the participants' time and knowledge, I provided a \$25 gift card to all participants who completed the interview process.

Methodology

Participant Selection Logic

In this qualitative narrative inquiry research, the target population consisted of clinicians such as social workers who are licensed therapists (i.e., LCSW, LPC, LMSW) who diagnosed and treated African American men for mental health services. The sample included 5 clinicians who met the criteria for participation. While this is a small sample size, participants were added until data saturation occurred. Narrative researchers invest in the time-intensive re-storying process of representing the participants' journeys and understandings that leads to providing robust data (Lahman, 2025). Hossain et al. (2024) advocated for smaller sample sizes for comprehending difficult, complex, and differences in participant stories. For the purposes of this study, I relied on a smaller sample due to its rich and deep nature of participant stories that include context, emotion, temporality, and personal meaning (Hennink et al., 2022; Nowell et al., 2023; Vasileiou et al., 2022).

Sampling Strategy

I used purposive sampling. The use of this sampling technique in qualitative research as the process ensures that the participants have direct knowledge and

experiences of the phenomenon so they can contribute directly to the study (Alhassan, et al., 2022; Stratton, 2024). The specific purposive strategy used, criterion sampling, refers to identifying participants based on predetermined eligibility criteria. According to Clandinin and Connelly (2002), criterion sampling aligns with narrative research because participants need to have a deep understanding of the topic to provide rich data through telling their story.

Inclusion and Exclusion Criteria

First, participants needed to be employed as clinicians at a mental health clinic or hospital system in the Mid-Atlantic region of the United States. Second, they had to be social workers who hold a therapist license (i.e., LCSW, LMSW, LPC) who diagnosed and treated African American men for mental health services. Third, participants must have had at least 3 years of experience providing mental health services to African American men. I designed the interview questions to focus on the perceived bias, social, and cultural assumptions of mental health providers.

Instrumentation

I developed a sampling questionnaire (Appendix A), semi-structured interview guide (Appendix B), and recruitment flyer (Appendix C). The participant recruitment flyer included the study purpose, inclusion criteria and contact information for interested participants. The sampling questionnaire ensured the participants met the sampling criteria and provided basic information about the volunteer clinical background. The sampling criteria included the specific participant requirements, the participants' number of professional years, demographics they served, and licensing in the state of Maryland.

I used a semi-structured interview to allow flexibility and in-depth exploration of participants (Adams, 2023). The interview protocol included open-ended questions for three main sections: introduction, main topical section, and a conclusion. I implemented the open-ended interview guide to facilitate deep discussion with the therapists about their professional and firsthand experiences. The introduction section included three general and broad items, surrounding the topic of personal and professional background to establish and build rapport between the participant and me. The main topical section included items focusing on biases, social assumptions, and experiences focused on African American men, cultural competency, diagnosis, and institutional and systemic reflections all supported by the ecological framework. I sought to ensure these items would elicit narratives from the participants about African American men, potential biases, and sociocultural assumptions. The concluding sections focused on future implications and positive social change.

Procedures for Recruitment, Participation, and Data Collection

Recruitment and Participation

After the Institutional Review Board (IRB) approved my application which included reviewing recruitment materials, recruitment flyers, screening questionnaires, and informed consent, I began the recruitment process. A representative from a partner organization assisted in gaining access to mental health providers. I first contacted the partner organization via email to introduce myself and provide an overview of the study. I sent the recruitment email to clinicians by the partner organization that included the participant flyer with general research introduction and an overview of the research and

what was required to participate. Interested clinicians were directed to click on Google Forms questionnaire link provided on the flyer. After clicking the link, participants completed the sampling questionnaire (Appendix A).

The participants answered the questions and self-identified whether they met the criteria. The sampling questionnaire also restated the participation requirements of one, voluntary, 45–60-min virtual audio recorded interview. After the participant completed the sampling questionnaire, I reviewed their responses to determine if they met the inclusion criteria. After I determined the participants' eligibility, I ensured each participant read and acknowledged the informed consent. I then selected a time to meet via Zoom, audio only, to begin the 45–60-min, open-ended, semi-structured interview.

Data Collection

I collected data for the study using two methods. First, a sampling questionnaire was used to screen participants. Second, using the interview guide individual interviews were conducted to gather each participants' narrative about biases, experiences focused on African American men, sociocultural assumptions, stigma, and institutional and systemic reflections. I conducted, recorded, and transcribed the interviews via Zoom platform. The recording included audio only. I generated Microsoft Word documents for each transcript. Over a 2-week period, I scheduled one-on-one, 45–60-min interviews with five participants to ensure all questions were answered. After the interview, I ended with a summation of the interview, identified any issues that may have arisen, and closed out with the next steps. I included guidance to the participants if follow-up was needed

after the initial interview. I provided a copy of the transcript to the participants for review and requested it be returned within 5 business days.

Data Analysis Plan

To analyze the rich narratives, I used Braun and Clarke's (2021) six-step thematic analysis framework. The framework along with narrative inquiry was to identify patterns of meaning within and across individual narratives. This strategy aligned with the ecological framework, which looks at individual beliefs, interpersonal relationships, practices, and broader sociocultural systems. The following phases guided the thematic analysis:

1. Manually reviewed all participant narratives and became familiar with ensuring clarity and understanding of the text.
2. Generated initial codes collating relevant data to each code.
3. Gathered all relevant data and code into potential themes.
4. Reviewed the themes checking to ensure they are coded appropriately and compared them to entire data set.
5. Conducted ongoing analysis to ensure each theme was accurate and told the story, ensuring the definitions and names for each theme.
6. Provided relevant and compelling examples to extract and add to the findings relating to the research question and literature.

To ensure triangulation, I manually reviewed the transcribed data for clarity, organizing the qualitative narrative into codes and then themes. I used reflective

journaling as part of interpretive analysis and tracked participants' perspectives. No discrepancies occurred such as conflicting responses or unexpected narratives.

Issues of Trustworthiness

To ensure the trustworthiness of the study, I addressed established criteria of credibility, transferability, and dependability and including these strategies in qualitative research enhances the rigor of the study. (Braun & Clark, 2023; Lincoln & Guba, 1985) Trustworthiness in qualitative research involves analysis of the data provided by participants to establish credibility and integrity (Adler, 2022). To strengthen the study and ensure rich and in-depth narrative, I sought to ensure trustworthiness.

Credibility

To preserve the richness of the study, I engaged in prolonged engagement through interviewing to ensure participants' stories and themes were captured accurately, and the interviews were scheduled within a 2-week period. Through thematic analysis, coding and audio recording were used to ensure accuracy of participants' lived experiences (Drisko, 2024). Through in-depth, semi-structured interviews, I provided detailed descriptions of participants' stories, their therapeutic encounters with African American men, and their professional and personal backgrounds. Through the interview guide, I employed a step-by-step protocol facilitating the interview process. The interview guide included interview questions and follow-up probing questions, which helped to capture in-depth storytelling. I selected participants from a Mid-Atlantic area in the United States to allow for diversity among the providers' backgrounds, professional experience, and

demographics. Transferability supports thick description of the narrative, which allowed other researchers to replicate the findings.

Dependability

Triangulation involves using more than one data collection method to confirm findings across multiple settings or approaches (Morgan, 2024; Vivek et al., 2023).

Triangulation boosts credibility reduces bias and improves complexity, (Morgan, 2024). I used data from several sources to produce an audit trail: semi-structured interviews, multiple participants, different time points, transcripts, screening questionnaires, and themes.

Confirmability

Researchers examine their own role in the research by using a reflexive journal to document the thoughts, any biases, assumptions, and feelings during the study (Olmos-Vega, 2022). Confirmability ensures the findings represent the participants' voices and not the researcher (Braund et al. 2024; Olmos-Vega, 2022). I used a reflexive journal to help identify potential biases and increase transparency throughout the research process. To support confirmability, I kept an audit trail, documented coding and the thematic development to ensure the study reflected participants' perspectives. (Peddle et al., 2025). I implemented these methods to reduce biases of the participants and their narrative responses.

Ethical Procedures

In conducting this study, I adhered to the established ethical guidelines for human subjects, participants' rights, privacy, and their overall well-being. I gained IRB approval

was complete prior to data collection to ensure ethical standards for human participants and was followed (U.S. Department of Health and Human Services, 2022). Informed The *Belmont Report* (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979) is based on principles of respect for persons, beneficence, and justice. I sent informed consent forms via email to the participants prior to the study commencing. I ensured participants had time to review the informed consent, had the opportunity to ask questions, and understand the requirements for participating. Informed consent forms were sent via email to the participants prior to the study commencing. I also reminded participants before, during and after the interviews that participation was voluntary, and they could end their participation at any time. In addition, I ensured privacy and confidentiality, making sure notes and raw data were securely stored and that direct quotations did not reveal participants' personal identification. Data is retained until 5 years of post-publication, after which I will permanently destroy the files. To ensure I did not violate trust or power relationships, I aimed to minimize undue influence with potential participants, ensured equity and representation with diversity among the participants; limiting, and minimizing conflicts of interest with the participants (Hammersley, 2023; Resnik, 2022).

Summary

I used one research question to guide this study. How do mental health providers' socio-cultural assumptions and biases manifest when diagnosing and treating African American men. Using narrative research design and methodological framework, I explored lived experiences of mental health providers through narrative inquiry. I

employed a narrative inquiry grounded in three-dimensional space of interaction, continuity, and situation (Clandinin & Connelly, 2000). I implemented a purposive criterion sampling strategy, semi-structured interviews, and a thematic analysis process. The analysis process aligned with Braun and Clarke's (2006) six step thematic analysis. To reinforce alignment and quality, I followed trustworthiness strategies of credibility, transferability, dependability, and confirmability.

My role as the researcher included observer-participant, recruiter, interviewer, and data collector and analyst. I reviewed the stories provided by the participants and used thematic analysis to analyze the data manually. To ensure ethical considerations, I followed the IRB process as it relates to human subjects and ensured all participants had a clear understanding of the study, informed consent, and their rights. In Chapter 4, I provide details regarding demographics, data collection, setting, data analysis, and evidence of trustworthiness. After discussing my changes in instrumentation, techniques, or data analysis strategies, I present the results and summarize the answers to the research question.

Chapter 4: Results

Introduction

The purpose of this qualitative narrative inquiry was to explore how mental health providers' sociocultural assumptions and biases manifest when diagnosing and treating African American men. I used the following research question to guide this narrative inquiry: How do mental health providers' sociocultural assumptions and biases manifest when diagnosing and treating African American men? In this chapter, I present the research setting, demographics, data collection, data analysis, evidence of trustworthiness and the results followed by chapter summary.

Setting

I collected data from participants in the Mid-Atlantic area of the United States. The participants in the study were providers who work in the following settings: community-based outpatient clinic, private practice, and a large hospital system. The interviews were conducted virtually from my home office without distractions, and the participants were in their own private settings. All participants provided mental health treatment to African American men.

The data collection consisted of individual, semi-structured interviews conducted via Zoom. Before the interview started, I reminded each participant of the informed consent and asked if they (a) had any questions concerning participation and (b) still wanted to participate. I started each interview with the purpose of the study and transitioned to lived experiences and their backgrounds to learn more about their individual and firsthand experiences.

Demographics

The eligible participants for this study included mental health providers who (a) are licensed in the state of Maryland, (b) have at least 3 years' professional experience, and (c) have diagnosed and treated African American men. The participants selected for the study consisted of three women and two men. The participants' experience ranged between 3 and 27 years of professional experience as therapists. Their backgrounds also varied; for example, some attended an HBCU, and some a predominately White institution. Both offered quite different educational experiences, exposure, and professional background. In Table 1, I provide specific details for each participant.

Table 1

Participant Demographics

Participant	Gender	License type	Years of experience in counseling
Therapist 1	Female	LGSW	18
Therapist 2	Female	LCPC	27
Therapist 3	Female	LMSW	20
Therapist 4	Male	LMSW	15
Therapist 5	Male	LMSW	3

Note. LGSW = licensed graduate social worker; LCPC = licensed clinical professional counselor; LMSW = licensed master social worker.

Data Collection

The Walden University Institutional Review Board (IRB) approved this study on September 9, 2025 (approval no. 09-10-25-0634280). I elicited the assistance of partner organizations in distributing the participant recruitment flyer. Interested clinical mental health providers completed a sampling questionnaire via Google Forms followed by the

receipt of the informed consent form document via email they provided. Participants contacted me within a week after recruitment flyers were distributed to schedule interviews. I scheduled interviews during the week of October 6, 2025, and interviews were conducted from my home office where it was quiet and private. All interviews were scheduled and recorded as planned without any unusual circumstances.

The study included a total of five mental health therapists who practice in the Mid-Atlantic area in the United States, a community outpatient clinic, private practice, and large hospital system. All participants completed the questionnaire and self-identified inclusion criteria of being licensed in Maryland, over 3 years professional experience and diagnose and treat African American men. To ensure confidentiality, participants were identified as Therapists 1, 2, 3, 4 and 5. The interview guide included 17 semi-structured questions, and I conducted the interviews via zoom from my home office, a quiet and private location to avoid interruptions. The interviews lasted up to 60 min. During the interviews I used active listening and followed up with probing questions where needed. All participants provided candid and open responses to the interview questions, including professional backgrounds. After the interviews, I saved all transcripts to review manually in Microsoft Word. All interviews were scheduled and recorded as planned without any unusual circumstances.

Data Analysis

The data analysis process involved a systematic and iterative examination of the interview transcripts from five mental health therapists to identify emerging themes and meanings related to their work with African American men. After data collection, I

immersed myself in ensuring accuracy by reviewing the transcribed data and listening to the audio recordings again. I followed Braun and Clarke's six-step thematic analysis (2006, 2021) to analyze the data and develop codes and themes. This strategy is aligned with the ecological framework which looks at individual beliefs, interpersonal relationships, practices, and broader sociocultural systems. I looked for similarities and phrases from the transcripts during the coding process to ensure I captured the data accurately. I manually reviewed the data in Microsoft Word and followed the six steps outlined by Braun and Clarke, as follows:

1. Familiarization with the data: To ensure clarity and understanding of the text my analysis began with an in-depth process to familiarize myself with the data which I manually reviewed and annotated all interview transcripts multiple times to gain an understanding of the participant narratives. I annotated directly within Microsoft Word to note my initial observations, reflections, and nuanced experience. This allowed me to identify any recurring ideas, patterns, or themes across the data.
2. Initial code generation: After reviewing the narratives, I highlighted the general data to identify relevancy looking for narrative to collate by similar and recurring codes. I conducted a manual, line by line coding process using Microsoft Word. I generated codes inductively by highlighting the appropriate segments of text and inserting my comments within the document. Using the manual approach allowed me to remain connected to participant stories while

systematically capturing relevant and meaningful data capturing participant's lived experiences.

3. Search for themes: I reviewed the manually generated code across the entire Word document to identify broader meaning. I grouped related codes and organized the groups into preliminary themes and subthemes using a coding table. This iterative process allowed me to compare codes across participants to explore similarities or differences and to develop initial thematic schemes.
4. Review of themes: I reviewed each potential theme and evaluated it against the coded data to ensure accuracy. I reviewed the original transcripts in Word to confirm that the themes were well supported by the participant narratives. Any themes that lacked sufficient data were refined, merged, or discarded to strengthen alignment with the research question.
5. Definition and naming of themes: I continued to immerse myself in the data and audio recordings to ensure I captured the data accurately. I reread the data, codes, categories and then identified themes based on commonality among the participants. I engaged in an interpretive process to define the scope and meaning of each theme and subtheme. I then refined each theme by cross-checking the coded references within Microsoft Word, to ensure naming conventions accurately reflected the essence of the participants' narratives. I did not include any data that did not align to my literature review or research question.

6. Production of the report: The final phase involved synthesizing the themes into a cohesive narrative presented in Chapter 4. I selected a representative participant quote directly from Microsoft Word transcripts and integrated the findings to support each theme. Throughout the process, I emphasized analytic interpretation, transparency, and reflexivity to ensure the findings presented were credible and an accurate reflection of the stories captured.

Themes

I established themes by reviewing and evaluating codes, categories, and subcategories from the data. I derived the themes from the research interview data that aligned with the research question. Overall, the themes addressed the underlying meanings of the participants' storied experiences. In the data analysis process, my role as the researcher included identifying and interpret the data to generate larger patterns i.e., themes. As a result, I generated three themes from the IRB approved data set.

The themes that emerged were as follows:

1. Implicit bias and ethical dilemmas was Theme 1. Some of the participants described implicit bias and ethical dilemmas as one of the main reasons African American men do not engage in therapy. Participants explained that sometimes their implicit bias may be a barrier for African American men to seek help. Participants also acknowledge their implicit bias can impact how they diagnose and treat African American men, and they realize having self-awareness is one way to mitigate these barriers.

2. Medical mistrust emerged as a central theme that reflected the participants' perceptions on African American men's guarded nature with mental health providers. Participants described mistrust rooted in both historical as well as contemporary experiences such as discrimination, misdiagnosis, and inequitable treatment. Mistrust was also seen as a protective factor to protect themselves from repeated exposure to systems perceived as unsafe. Medical mistrust can influence clients' willingness to disclose personal information and how they accept clinical recommendations and remain engaged in treatment. Fear of judgement and misinterpretation, and harm were identified as underlying factors that caused the medical mistrust.
3. Stigma and masculinity emerged as a theme highlighting how the mental health providers perceived the African American men's cultural expectations and social norms on mental health. Participants described how their ideals of masculinity can impede how they engage in therapy. Participants noted African American men feel ashamed and emasculated when showing vulnerability in therapeutic setting. This turns into internalized stigma, because emotional distress can be viewed as a weakness rather than a legitimate health concern.

Evidence of Trustworthiness

Throughout the research process, I sought to ensure trustworthiness to enhance the quality of the study. Lincoln and Guba (1985) suggested that credibility,

transferability, dependability, and confirmability guide the process to ensure rigor. In qualitative studies trustworthiness focuses on data, interpretation, and procedures to ensure the quality of the study (Polit & Beck, 2021). The study's purpose and methodology were derived from the research problem, research question, and the gap. I developed interview questions to address the research question, and I stopped after interview number 5 once saturation was reached (i.e., no new information was generated through the analysis). These strategies together help to reinforce the trustworthiness of the findings and ensure the accuracy of the data reflects the lived experiences of the mental health provider.

Credibility

To preserve the richness of the study, I committed to prolonged engagement through interviewing to ensure participant's stories and themes were captured accurately. Through thematic analysis, coding and recording was the process used to ensure accuracy of the participants lived experiences (Drisko, 2024). Based on the data from in-depth, semi-structured interviews I provided detailed descriptions of the participants' stories, their therapeutic encounters with African American men and their professional and personal backgrounds. Through the interview guide, I employed a step-by-step protocol facilitating the interview process. The interview guide included interview questions and follow-up probing questions which helped to capture in-depth storytelling. I selected participants from the Mid-Atlantic area in the United States to allow for diversity among the providers background, professional experience, and demographics. Transferability

supports thick description of the narrative which allows other researchers to replicate the findings.

Transferability

Transferability refers to researcher's process of providing enough details about the research context (i.e., research focus, setting, participants) that readers can determine if the findings resonate given the readers contexts (Creswell and Poth, 2018). To meet this quality assurance step, I provided thick, descriptive accounts and contexts of the participants' stories to allow readers to determine applicability to other settings. While this study did not aim for generalizability, the detailed methodology including population, recruitment strategies, sampling methods, data collection, and data collection techniques can be used by other practitioners to draw meaningful connections between this study and other settings.

Dependability

Dependability was supported through a transparent methodological approach that clearly defined data collection procedures, manual coding in Microsoft Word, and the use of six-step thematic analysis. Dependability is confirmed demonstrating the study's procedures are logical, systematic, and well documented. Triangulation involves using more than one data collection method to confirm findings across multiple settings or approaches (Morgan, 2024; Vivek et al., 2023). Triangulation boosts credibility, reduces bias, and improves complexity (Morgan, 2024). I used data from several sources (i.e., participant triangulation) and kept an audit trail of my processes throughout the study and kept detailed notes regarding the plan put forth in Chapter 3.

Confirmability

Researchers must examine their own role in the research by using a reflexive journal to document the thoughts, any biases, assumptions, and feelings during the study (Olmos-Vega, 2022). Confirmability ensures the participants' voices are represented accurately (Braund et al., 2024; Olmos-Vega, 2022). As such, I used a reflexive journal to help identify potential bias and increase transparency throughout the research process. To support confirmability, I kept an audit trail and used document coding and thematic development to ensure the study was based on participant perspectives and not my biases (see Peddle et al., 2025). I employed these methods to reduce biases of the participants and their narrative responses.

Results

In this section, I present the findings that emerged from the data analysis of the interviews with five mental health therapists, highlighting key themes and subthemes that reflect their experiences, perceptions and interactions when working with African American men. In line with qualitative research and thematic analysis, I organized the results according to themes and subthemes, no discrepant cases to report arose during the analysis to report. The participants were from a community-based outpatient clinic, private practice, and a large hospital system. All therapists interviewed provided mental health services to African American male clients.

After the interviews, I re-read each transcript and began the manual coding. Following the 6 steps of thematic analysis (Braun * Clarke, 2022), I generated the following themes: (a) implicit bias and ethical dilemmas, (b) medical mistrust, and (c)

stigma and masculinity. These themes mirrored and extended insights identified in the literature review. Although this study included only five participants, I achieved thematic saturation when no new subthemes emerged after the fifth interview. Multiple participant data segments (i.e., interview quotes) were supported by codes and patterns, with frequencies ranging from one to five participants, indicating both common and nuanced experiences. Table 2, I illustrate the progression from participants raw data, direct quotes, code names, and frequency. Table 3 illustrates the analytic progression from participants subthemes and major themes through thematic analysis.

Table 2*Codes, Example Quotations, and Participant Frequency*

Code Name	Direct Quote	Participant	Frequency Count	Interview Question
Implicit Bias	I have to constantly check myself to make sure I am acting ethically and minimize bias.	3	4	7
Triggers and Bias	Many therapists have some sort of implicit bias. They can often be triggered if not self-aware.	1-5	3	8
Lack of trust	During treatment, there's a level of mistrust that shows up right away.	1-4	3	9
Masculinity	We have to be careful how we talk to our black men, how we treat them because they feel emasculated when seeking help.	1-5	4	13-14
Fearful of seeking help	African American men fear if they open up they are labeled weak.	1-3	3	14

Table 3*Themes and Subthemes*

Theme	Subtheme
Implicit bias and ethical dilemmas	Lack of knowledge leads to implicit bias. Self-awareness to avoid implicit bias. Self-awareness of own implicit bias to provide appropriate care.
Medical mistrust	African American men lack trust due to fear. Trust takes time to build.
Stigma and masculinity	Perceptions that seeking help affect masculinity. Trauma and masculinity.

Theme 1: Implicit Bias and Ethical Dilemmas

Implicit bias among mental health providers emerged as a common theme among the participating therapists. This theme emerged as a central element across participant narratives highlighting subtle ways that implicit bias can shape clinical decision judgments and ethical decision making when working with African American men. “Participants 1 and 3 explained, sometimes I catch myself making assumptions about a client’s behavior before really listening. I have to constantly check myself to make sure I am acting ethically and not letting stereotypes guide treatment.”

Participants described how implicit bias is often unintentional and unrecognized, intersect with clinical uncertainty. “Participant 1 explained, ethnically, I knew I had a responsibility to pause and question my own personal assumptions because acting on them would be unethical”. The theme highlights internal conflicts providers face as they try to balance their professional commitment to equitable care. The narratives shared by participants illuminated how implicit bias not only affected individual encounters, but it also raised questions about fairness and responsibility in the mental health field. The

participants were very candid with their reflections about personal and professional experiences, describing in detail their own biases and stereotypes, “Participant 1 explained, I became aware my initial clinical impressions were influenced by my biases and stereotypes”. Some reflected on times when they may have been triggered or recalled a similar situation that resonates with their background. Some described efforts to self-reflect and others admitted difficulty recognizing bias in practice.

Subtheme 1: Lack of Knowledge Leads to Implicit Bias

The subtheme “lack of knowledge refers to implicit bias due to the participants limited knowledge, particularly in the mental health setting. During the interviews, participants mentioned lack of adequate cultural knowledge, historical awareness and contextual understanding of African American men lived experiences. “Participant 3 explained, “a lot of what I know comes from general training, were not trained on the cultural cues or historical trauma of Africa American men.” They also stated that they can unknowingly rely on stereotypes or sociocultural assumptions. Some participants noted that therapists who lack this knowledge are apt to interpret symptoms. For example, the therapists may assume African American men are angry, unable to handle therapy. Some participant therapists conveyed how therapists might formulate negative treatment recommendations often without conscious intent. “Participant 3 explained, “I’ve seen scenarios where an African American man was labeled angry when in fact, he was just expressing his frustration or mistrust.”

The less practitioners knew about the nuances and cultural cues of African American men, the more likely their decision-making was influenced by subconscious

biases rather than evidence-based assessment, interventions, or culturally responsive care. Thompson et al. (2023) reported that clinicians often interpret African American men's symptoms of distress through the lens of aggression, leading to disproportionate diagnosis and/or psychotic or behavior disorders. During my five interviews participants mentioned the requirement to participate in ongoing professional training to maintain their educational and licensure requirements. "Participants 1 as well as four other participants explained, "We're required to complete a certain number of CEUs [continuing education units] every year, and there are plenty of courses to take but none of them address the experiences or clinical needs of African American men." The trainings offered covered a variety of topics to ensure providers are current on their licensure; however, many do not focus on African American men. As implicit bias manifests in clinical engagement, who can often create ethical dilemmas that challenge the integrity of therapeutic relationships. Providers may unintentionally misdiagnose, over pathologize, or minimize the concerns of African American men, resulting in inequitable treatment outcomes. Insufficient knowledge can lead to individual bias as well as moral conflicts which question fairness and justice within clinical practice. Some of the mental health providers' experiences are highlighted below.

Participant 1 explained,

Although we may be educated providers, we don't always educate ourselves about different subcultures (e.g. LGBTQ [lesbian, gay, bisexual, transgender, and queer/questioning], foster care, criminal justice system, etc.), which can cause our

personal biases to be in the way of how we practice, which can cause us to be maladaptive.

Participant 4 recalled a time where their client experienced a death in the family and the mothers' social services benefits were transferred to him. The participant thought the family was not providing the client with the social and financial support needed. In the African American community there is a stereotype that we spend the check on other things. In this case the participant did not believe his family was spending his benefits appropriately or timely. "Participant 4 explained,

My initial thoughts were that his family was stealing his money, but I never shared them with my client, ultimately his family came through. But my bias and stereotype did have me thinking about whether they were going to help this young man."

Participant 5 explained,

From the time that I was a child or born into the context in which I was born in, bias was embedded in me intentionally and unintentionally. That is the reason I bring up my religious background. Because I do think it has shaped me in a way... it shaped a huge part in the way that I saw the world, in the way that I interacted with people, until I began to get reeducated. By what I... what I call or identify as a new paradigm. That [reeducation] began to happen through my own experiences.

Subtheme 2: Self-Awareness to Avoid Implicit Bias

Great value exists in cultivating sustained practitioner self-awareness. Self-awareness consists of is an internal process providers must engage in to interrupt their automatic assumptions and prevent biased interactions during clinical encounters. When providers examine their own belief systems and emotional reactions, they create space for more intentional and equitable decision making. “Participant 1 explained, it’s our ethical responsibility as providers who remain aware of their own biases are at risk for contributing to miscommunication, misdiagnosis, or inequitable treatment”. I discovered during my interviews many of the participants were self-aware to avoid implicit bias and were dedicated to ensuring they did not let it impact how they administered therapy. Participants recalled being reflective during the process and seeking support from their supervisors to ensure they remained neutral. Some of the mental health providers’ experiences are highlighted below.

Participant 1 recalled a time when a client’s background mirrored the therapist’s background, same family structure, and story. The therapist felt triggered right away with grief as this story was like hers. Participant 1 explained,

I had to remove myself because you know this is exactly what I went through. I initially thought I could not serve him. I talked to my clinical director to make her aware of the dynamic and she felt I could manage the client because I was self-aware. You do not want any ethical dilemmas.

Participant 4 explained,

I think another way that I continue to, uh, confront that is asking myself hard questions, and one of those hard questions would be? Are all biases bad? If I have a bias, it isn't necessarily a bad thing to have a bias. Does that bias impact or affect the way that I practice? And if it does, does it affect it in a negative way?

Yeah, and that's the reason why I say, are all biases bad?

Subtheme 3: Self-Awareness of Own Implicit Bias to Provide Appropriate Care

During the interviews several of the providers were mentioned reflecting on their work with African American men. They seemed to demonstrate reflective work to ensure their judgments and interventions remain ethical and culturally responsive. Providers described self-awareness as ongoing conscious process of monitoring their thoughts, emotional reactions, and interpretations during sessions with African American men. This reflective process allowed the provider to recognize when bias-driven assumptions might influence their clinical assessments, prompting them to slow down, reassess, and seek additional context before making clinical decisions. By doing so, the provider can demonstrate stronger commitment to ethical care, acknowledging that appropriate treatment cannot occur when unexamined biases shape therapeutic encounters. When providers engage in self-reflective practices, they gain awareness to safeguard against misdiagnosis, or dismissing client's concerns, ultimately promoting care that is respectful and attuned. Some of the mental health providers' experiences are highlighted below.

Participant 2 explained,

Therapists have some sort of implicit bias when working with African American men. It is possible that therapist can become triggered if not self-aware. I often

have conversations/reflection with myself to make sure I am self-aware so I can handle the client with care and the appropriate treatment plan. Therapist 3 explained, A client and their spouse were discussing a situation relating to verbal conflict which hit close to home, it was a sting for me to listen to this couple because I have experienced that, too, with my spouse. I must become self-aware and make sure I am providing service based on their experiences and not my own triggers.

Participant 3 recalled a time in working with a client whose family structure was fragmented, the father was not present, and when he was, the presence was inconsistent. The therapist's experience was the opposite.

Participant 3 explained,

My father was always present and available for anything my brother and I needed. So, it's upsetting to see how others deal with this issue. I have always had my father, but I can see how this could break a family.

All the participants seemed aware of their own implicit biases and sociocultural assumptions. They recognized that this bias exists and the mechanisms in place to mitigate that bias to ensure it does not manifest in the diagnoses and treatment of African American men.

These findings illuminate how the overall theme of implicit bias and ethical dilemmas manifested across participants' narratives, revealing gaps, internal reflections, and ethical practice. The subtheme lack of knowledge leads to implicit bias demonstrated how limited understanding often can create conditions in which biased assumptions form

and influence clinical decision making. Conversely, the subtheme of self-awareness of ones owns implicit bias underscores the importance of self-reflection as a mechanism to reduce harm with African American men. Together, these subthemes show implicit bias functions in several ways rather than a single point of failure shaped by what providers know, don't know and how they examine themselves within the therapeutic encounter.

Theme 2: Medical Mistrust

As participants reflected on their clinical experiences, participants identified medical mistrust as one of the main barriers for access to treatment as well as the reason African American men do not open fully during sessions. In Chapter 2, this theme captured the impact of historical trauma, cultural humility, and prior encounters with discriminatory and dismissive care by mental health providers all which shape how African American men perceive care. Participants described medical mistrust as a barrier along every step of the clinical process, influencing African American men's willingness to disclose information, accept treatment recommendations or remain in treatment. "Participant 3 explained that there's a level of mistrust that shows up right away and follows the client through every stage of treatment and it's the reason many of them disengage before therapy can really begin". Four participants identified mistrust regarding mental health remains a barrier to treatment for African American men which are linked to community attitudes and legacy of historical exploitation. During the analysis, I noted four therapists indicated trust as a barrier to treatment and argued that building trust takes time.

Subtheme 1: Trust Takes Time to Build with African American Men

African American men tend to take their time during the mental health journey to gain trust with their providers. Participants reported that trust could not be achieved through the standard rapport-building strategies; instead, it required sustained consistency, transparency and authenticity over time before they felt their clients trusted them. Participants noted African American men needed therapist who demonstrated their reliable and trustworthiness over time. With this awareness, the participant therapists shared strategies they used to establish trust, such as active listening without judgment and acknowledging their clients' lived experiences without bias and discrimination. "Participant 5 explained, "When trust is built slowly, I've seen African American men begin to challenge their own assumptions about mental health, they begin to feel seen and understood rather than evaluated." Participants noted that when trust was carefully cultivated over time, African American men were more likely to open up and participate in treatment and begin to challenge their own internalized experiences of mistrust within mental health settings. As participant 1 explained "on average it takes at least 6 months for African American men to trust their therapist enough to share their intimate thoughts and struggles". Some of the mental health providers' experiences are highlighted below.

One participant explained that: in her experience, African American LGBTQ men were more open than heterosexual African American men. African American men often connect better with someone they know such as their barbers. It takes time to build their trust, and they must be willing to open up; you cannot help them if they aren't truthful. "Participant 2 described how: "trust is essential to building a rapport with African

American men so they can feel safe and relaxed when sharing their inner most thoughts”.
“Participant 4 explained “Unless you tell me you have a plan to hurt yourself; you can tell me anything you want. I must build trust with them; I am here to listen.”

Subtheme 2: African American Men Lack Trust Due to Fear

Building on the previous subtheme trust with African American men takes time. When compounded with fear, a deeply rooted in historical landscape, distrust takes even longer to dismantle. The previous theme focused on time and intentionality with African American men; however, the data in subtheme address the slow process and the guarded and complex nature of building trust. Overall, the participant therapists described their perceptions of African American men’s mistrust due to fears of being judged, misdiagnosed, or dismissed. This fear then contributes to these men’s heightened vigilance and hesitancy to engage in mental health treatment. Participant 4 explained, “a lot of men come in already guarded because they are afraid of being misunderstood, they show up to therapy with hesitation or short answers.” During some of the interviews, I sensed that the participants felt their clients’ fear impeded the therapists’ ability to connect with their clients. Based on the analysis, I noted a connection between time, fear and trust in the participants’ storied experiences and it with this connection, I gained a sense that medical mistrust is not just a theory, but people can perceive medical mistrust as a protective factor for African American men. This protective factor seemed to reinforce the need for providers to approach therapeutic relationships with sensitivity and patience. As participant 4 explained, “Some clients struggle with trust based on the past because of fear of being hospitalized, committed, [so] they watch what they say.” This

fear or protective factor shapes how African American men approach mental health providers but also intersects with broader issues of stigma and masculinity which further perpetuate their willingness to seek, accept, and engage in therapy.

Theme 3: Stigma and Masculinity

Stigma and masculinity function as barriers to treatment for African American men, especially in the mental health field due to years of racial discrimination, and medical exploitation. Because of the stigma, African American men exhibit fragmented help-seeking behaviors. Although in recent years there has been a push for mental health awareness has occurred in recent years, African American men are still less likely to request treatment on their own. One therapist explained “Before Covid, talk about mental health was taboo, however, since Covid has ended there is a heightened level of awareness to connect with a provider.” One barrier African American men encounter is seeking treatment because they are ashamed and are often seen as being weak.

Subtheme 1: Perception That Seeking Help Affects Masculinity

Building on the broader theme of stigma and societal expectations, participants described perceptions regarding how African American men believe seeking help impacts masculinity. “Participant 3 explained, “A lot of men I work with see coming to therapy as weak, they are dealing with real trauma and pain, but at the same time they are worried about what others think about them”. This subtheme captures the internal fight African American men have trying to navigate fear, emotional pain and weakness when seeking help. The providers acknowledged that African American men are often worried about their masculinity and what people think of them, one provider explained they believe “it’s

a sign of weakness.” The participants noted that this perception of weakness and being emasculated prevents men from initiating treatment, fully engaging and being vulnerable and open. For example, “Participant 3 explained “A lot of them feel like if they ask for help, they’re not a “real man” anymore”. The participants perceptions on this point seem to convey a perspective that masculinity is societal protection although it impacts the African American man’s well-being. Some participants noted tensions are often evident when trying to provide therapy as the men are careful about how much they divulge. This is also a form of protective factor, the men not wanting to engage is a way for them to protect themselves due to fear.

Participant 1 explained,

My patients are often afraid of what society thinks. African American men who go to therapy are seen as weak, they are emasculated. When African American men would search for therapy, they were accused of not being strong enough in their community, that is why we see a lot of self-medication, it is prominent. A lot of times when men come to the mental health provider, they are very skeptical because of their masculinity being questioned. The stigma is harsher, and they assume they receive worse care than their counterparts. Prior to Covid, I did not have any African American men clients unless it was foster care, or court ordered so we are beginning to see an increase with African American men requesting therapy on their own. However, many of them are using substances to cope with life stressors.

Within this narrative, participant 1 highlights how masculinity norms influence therapeutic engagement, and it shapes how the men share and show up during therapy. Fear and appearing weak often compounds the existing mistrust they have, creating emotional layers the provider must break down to support their well-being. The providers appeared knowledgeable about the historical challenges African American men faced and their role in committing to providing a safe space for their overall wellness. “Participant 1 explained, “historically, African American men were labeled inaccurately, their diagnosis was always harsher than it needed to be, such as diagnosing them as schizophrenic or bipolar.”

Participant 2 explained,

Mainstream therapy is not geared toward African American men, it is for African American women, and non-White counterparts, however, not towards African American men due to stereotypes. We need to continue to provide a safe environment for our clients so they can continue to share. They seem to come to therapy by way of someone else, the wife, the girlfriend, and a colleague but they are not assertively searching for mental health on their own, they are a byproduct of therapy. This phenomenon was also noted by other providers I interviewed. I do see a lot of traumas among African American men and there are a lot of stigmas related to showing their emotions, such as crying. It is difficult because their emotions are their feelings and it is usually tied to a behavior which is exhibited differently for African American men. They have not been supported when they show their emotions. We stereotype our men when it comes to

emotions. It has been hard for African American men because we have never allowed them to identify their own emotions to their actions, again all about their masculinity. Stereotypes can influence how we approach them in therapy, so it is essential as providers we compartmentalize our biases.

The narratives demonstrate how masculinity is one help-seeking behavior and reveal how therapy is contingent on the providers' ability to recognize and navigate these societal and cultural challenges with their clients. Withing this theme the therapists' participants perceive stigma and masculinity to not only affect African American men seeking help but how these men engage or participate once they enter treatment. The providers know they need to take their time, build trust, and remove all biases. Providers were self-aware and all indicated wanting to engage and be more resolute with their therapeutic approaches.

Subtheme 2: Trauma and Masculinity

This subtheme highlights how African American men's past traumatic experiences become intermingled with expectations of emotional strength which shapes the way they think about therapy. "Participant 4 explained that many of his clients carry trauma such as violence, community stressors, family instability, or systemic discrimination and yet they feel like they can't release emotionally". There is always a need to suppress their true feelings, which often looks like they are stoic, angry, or non-emotional.

Participant 5 explained,

Trauma masked or disguised as toughness, as masculinity. You should not be impacted by that, because that is just what men do, or what men go through, or who men must be, or what real men have to see. But it is trauma. Trauma is the consistent theme, you know? I haven't heard many stories about medical mistrust. I have heard stories of them not feeling heard. You know, when they talk about their experiences with Caucasian doctors and things of that nature, they do not feel like they've been heard. I will say that. And what most of them want is they want to feel like somebody is listening to them. And I think that has been what has allowed me to build such great relationships is just because I always emphasize that I am here to listen.

Some participants noted this as a protective factor and identified the emotional experiences as embedded in African American men through their lived experiences and masculine conditioning often result in appearing to be withdrawn, disconnected, guarded during therapy or even angry. Trauma can intensify a man's reluctance to trust providers; emotional distance is a survival skill for them to continue to be able to show up in the world.

Summary

The findings of this study directly addressed the research question- How do mental health providers' sociocultural assumptions and biases manifest when treating and diagnosing African American men? The findings mirror documented trends in the literature review (Dolan, 2024; Johnson, 2024; Smith-Woods & Diggs, 2024; Teplan et al., 2022), while adding depth from the provider viewpoint. The participants also

described implicit bias as a normal dynamic that requires ongoing self-reflection to ensure your personal biases and stereotypes do not impact clients by under or misdiagnosing patients. Participants consistently identified how implicit bias, lack of cultural knowledge, stigma and medical mistrust can negatively influence therapeutic interactions with African American men. The participant perspectives demonstrate clinicians' awareness of these barriers; however, it is difficult to dismantle them solely through therapeutic interventions. The persistence of mistrust as well as bias suggests interventions should target stigma reduction but also systemic inequities that reinforce trust and bias at both the individual and institutional levels.

The themes and subthemes highlight many barriers African American men face. At the same time, the participants demonstrate self-awareness of their own implicit biases which can help strengthen how they engage and support African American men. When participants engage, they are better equipped to mitigate these barriers and build trust among African American men. Overall, the findings suggest that the challenges observed in therapeutic relationships are not rooted in client deficits but in broader sociocultural conditions and provider practices, underscoring the need for culturally grounded, relational, and ethically relevant approaches to mental health care for African American men.

In Chapter 4, I presented the stories from mental health therapists and the thematic findings that emerged from their stories, highlighting a descriptive account of their implicit bias, medical mistrust, stigma, and masculinity and how they can shape therapeutic interactions. While their stories demonstrate themes, I discuss their broader

meaning and implications Chapter 5, which moves to broader interpretations of findings within the context of literature addressing the similarities between what has been identified in the literature review and the results of the study. In this discussion I answered the research question, explored their significance for clinical practice, and outlined the implications and recommendations. Through this transition from results to interpretation, the study shifts from what was discovered to what these discoveries mean for mental health care with African American men.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In this study, I explored socio-cultural assumptions and biases among mental health therapists who diagnose and treat African American men. The purpose of this qualitative narrative inquiry was to explore how mental health providers' socio-cultural assumptions and biases manifest when diagnosing and treating African American men. The participants included mental health providers who, at the time of the study, were licensed in Mid-Atlantic area in the United States, had at least 3 years' professional experience, and diagnose and treat African American men. The mental health care providers served patients in community outpatient clinics, private practice, or large hospital systems. I used individual, virtual interviews as the method of data collection, aligning with narrative research, and thematic analysis based on Braun and Clarke's (2021) six steps.

Through my analysis processes, I generated three themes and six subthemes. The first theme (a) implicit bias and ethical dilemmas included the subthemes of limited cultural knowledge leads to implicit bias; self-awareness to avoid implicit bias; and self-awareness of own implicit bias to provide appropriate care. The second theme, medical mistrust consisted of two subthemes: trust takes time to build with African American men, and African American men lack trust due to fear. The third theme: stigma and masculinity included one subtheme are the perception that seeking help affects masculinity. The findings reveal that manifestations occur across multiple ecological levels. At the individual level, the mental health providers acknowledged their own

implicit biases. At the interpersonal level, the providers described how masculinity and stigma influence therapeutic relationships and it impedes how African American men seek mental health treatment. At the community level, the providers identified their role in ensuring trust among African American men. Finally, at the macro-societal level the providers noted that medical mistrust continues to inform African American men's reluctance to engage with mental health services. Together these themes related to how mental health provider bias and sociocultural assumptions include isolated circumstances and embedded circumstances within broader ecological systems.

Interpretation of the Findings

This section consists of a discussion regarding the interpretation of findings based on the literature review. The three themes identified are confirmed to be relevant to the research question and are organized by each theme in this section. This chapter explored what findings mean, why they matter, and confirm how they contribute to existing knowledge about mental health providers' social and cultural assumptions when working with African American men. I also connected the participants' stories to the ecological systems theory, demonstrating multilevel connection about how interactions across interpersonal, organizational, communal, and society systems shape individual beliefs and professional practices.

Theme 1: Implicit Bias and Ethical Dilemmas

The participants' lived experience as mental health providers shed light on implicit bias. More importantly, the mental health providers candidly identified their own implicit biases when diagnosing and treating African American men. Theme 1 connects

with researcher Teplin (2022) and related studies which highlight how unconscious provider bias influences diagnostic decisions and contributes to misdiagnosis or disengagement if the provider lacks self-awareness.

In this study, mental health providers shared their stories based on their lived experiences and openly discuss implicit bias, avoiding ethical dilemmas and noting the importance of their own self-reflection while also acknowledging barriers African American men encounter. All the therapists recognized at some point in their career there was implicit bias and sociocultural assumptions toward their client. However, they all acknowledged self-reflection practices to ensure their biases did not manifest in how they diagnose and treat African American men. The therapists' acknowledgment of their implicit bias addressed how biases and assumptions can influence diagnostic decisions.

Providers recognized that their assumptions could influence how they interpret client behavior and presented diagnosis and treatment plans; therefore, these therapists adamantly addressed the importance of supporting African American men mitigate their challenges. This recognition of how assumptions can influence their interpretations of African American clients' needs aligns with recent research. Alan (2024) found that implicit racial bias in clinical judgement could contribute to delayed or in appropriate treatment recommendations. Although the providers acknowledged bias and socio-cultural assumptions, they all recognized the importance of being aware and self-reflecting on their own personal biases. Through the findings I identified that mechanisms are in place to safeguard against biases, such as clinical meetings with the supervisor to ensure a supervisor can weigh in on the therapeutic plan and address the

concerns upfront. One provider noted the importance of the National Code of Social Work which required each provider to use the code of conduct when collaborating with patients to reduce biases and socio-cultural assumptions.

During the interviews I observed similarities across therapist's perspectives but with different lens based on their professional setting. I noted the providers' professional experiences were across different settings such as a large hospital system, local clinic, and private practice. Their experiences recognizing bias and its manifestation were different. For example, in large hospital settings time pressures could result in the clients feeling rushed or dismissed, which might lead to misinterpretations of African American men's needs. To this point, Slatton et al., (2025), contended that clinicians in a fast-paced hospital culture can reinforce racialized assumptions under the guise of efficiency.

In private practice, implicit bias did not include time constraints or challenges. From the providers' perspective this bias refers to worldviews and relational styles. Private practice lends itself to a certain type of client. Providers in private practice do not have to work with all types of patients, they have flexibility such as middle vs upper class, and state insurance versus private insurance clients. In some community based local clinics, bias manifests differently where providers noted subtle expectations regarding masculinity, spirituality and family dynamics can still influence the therapeutic process. While the therapists in this study acknowledged bias and sociocultural assumptions, their perspectives differed and referred to professional experiences and their specific clientele.

Theme 2: Medical Mistrust

This theme connects with Dolan (2024) who synthesized historical trauma and documented medical mistrust continues to shape African American men's perceptions of mental health services. All therapists indicated African American men struggle with trusting them as their mental health therapist. The therapists noted that African American men indeed have difficulty trusting the medical profession and the individual's mental health providers. During the interviews, the therapists described how it could take months for an African American man to build trust with their provider. The therapists indicated African American men are often made to feel ostracized or weak for seeking help. The therapists noted it takes time to build trust and open up, and often African American men may not be fully honest about their background, making it difficult to diagnose and treat appropriately. The lack of trust with African American men runs deep and goes back decades starting with one of the most known medical tragedies, the Tuskegee Syphilis Experiment as indicated in Chapter 2. As a result of this tragic experiment, African American men are skeptical of trusting health care providers. Medical mistrust is layered with historical and systemic challenges within the health care system as well as the actual provider.

The subthemes offered other points resulting from the interviews such as African American men lack trust due to fear, which can also be viewed as a protective factor and trust takes time to build with their providers. While the providers were sought to support their African American male clients; they noted the difficulties in navigating their therapeutic treatment plans. These therapists showed empathy toward the plight of the

African American males and echoed the limitations of mainstream therapy in that this service did not represent them.

The ecological theory provided a useful lens to interpret the findings. Providers' implicit biases were situated in the microsystems, directly shaping how client-provider interactions take place. The providers discussed their interactions with clients and aim to gain trust over time. Masculinity and stigma reflect influences at the mesosystem level, where family, peers and cultural expectations intersect in clinical practice. The providers discussed how often family norms and structure can impact whether an individual experiences success in therapy or not. The findings also provide insight into the influence of the therapists' family structure and their mental health treatment. Historical trauma emerges at the macrosystem level, reinforcing structural barriers to care. As both the provider and the client may have trauma, the importance of therapist self-reflection becomes clear for compartmentalization of their personal biases when treating African American men. The community, peer networks as well as faith-based institutions can be considered protective factors, and they represent the exosystem illustrating how cultural resources evolve over time which can foster resilience. The ecological theory highlights that bias consists of a process shaped by interlocking systems.

Theme 3: Stigma and Masculinity

This theme connects with Johnson's (2024) findings which suggest that traditional masculinity predicts stigma and a reduced willingness for African American men to seek services. This finding addresses the therapists' perceptions of how stigma and masculinity shape African American men's mental health decisions. They conveyed how

historical and socio-structural forces define acceptable expressions of manhood. In Chapter 4 participants described how African American men felt when it comes to their masculinity and stigma associated with seeking mental health treatment. African American men are compelled to present themselves in a strong manner and must always be considered self-reliant, at all costs they want to ensure they are not seen as weak. During my interviews I noted this theme was evident amongst multiple participants, they all reflected on similar scenarios with their clients, and their approach seemed to correlate with one another. African American men are expected to be resilient in the face of adversity; yet historically society does not allow them a safe space to be vulnerable. This dual expectation forces them to exist in both worlds and contributes to them internalizing their fear, trust, and stigma. Both can be protective factors as well as barriers to improving their mental health. Participants all seemed to be in tuned with their struggles and working feverishly to help them pull back the layers while guiding them to redefine what it means to be a “strong” black man.

Limitations of the Study

The study may not be generalizable due to targeting specific groups, such as African American male patients and mental health providers. While this study does offer insight into socio-cultural assumptions and bias among mental health providers there are limitations. First, the sample size and scope, although small and appropriate for qualitative studies, may not capture the full diversity of experiences and perspectives from providers across settings, demographics, or geographic areas within the region. Second, the data collected was through a self-reporting mechanism such as interviews

which can be influenced by what the participants reported or underreported such as negative influence or overstated implicit bias. Third, because this study was conducted in a specific cultural context, transferability to other populations or provider groups must be approached with caution. Fourth, when applying the findings researchers must consider the cultural and ecological settings when applying the findings to other contexts. Despite the noted limitations, the study provided contributions by mental health providers' lived experiences on sociocultural assumptions and bias, offering a foundation for future research.

Recommendations

Building on the findings as well as the limitations of this study, I offer several recommendations for future research:

- Expanding the study across disciplines and settings. Future research should include larger and more diverse populations such as psychiatrists, pediatricians, or primary physicians to capture sociocultural assumptions and bias and how it manifests among broader providers.
- Longitudinal studies. Future work could benefit from longitudinal approaches about clinical encounters to better understand how bias and sociocultural assumptions manifest over a period by observing real world client-provider interactions and document whether training translates into sustained practice change.
- Evaluate interventions. Interventions and additional research are needed to assess the effectiveness of bias awareness training to improve mental health

outcomes, specifically for African American men. Further research should explore intervention models that directly address provider bias, reflective supervision, cultural competency training specifically about African American men.

Implications

Mental Health Practice

Mental health providers' acknowledgment of implicit bias and sociocultural assumptions can be both a risk and opportunity. Unchecked bias can contribute to misdiagnosis and disengagement of their patient, the African American man who often is already feeling disengaged and not heard. As mentioned by Therapist 4, biases may not all be negative and acknowledging it is where self-reflection begins. Recognition of bias and stereotypes opens pathways for reflective practice, supervision, and training. Mental health providers must consistently adopt self-assessment and bias reduction strategies to enhance their culturally responsive care. One way to improve this is to increase the type and frequency of training available for mental health providers. Many of the participants indicated they have attended required training such as implicit bias training, however, none of those trainings focused on African American men and their cultural needs, challenges, and sensitivity. The trainings focused on other subcultures such as LGBTQ and marginalized communities; however, it did not focus on African American men. This is a missed opportunity for providers to learn about the barriers African American men encounter, the many levels of systemic barriers that impact how they see mental health therapy and why it may be difficult to connect with them.

Policy

At the macrolevel, organizational and institutional policies must address systemic inequities that perpetuate bias. For example, hospitals should incorporate cultural competency and equity benchmarks into performance measures and quality assurance (Slatton et al. 2025). Strategies to improve policy efforts are expanding funding for community-based clinics to reduce disparities in access and treatment. Expanding policies that support training, implicit bias reflective practices, and trauma-informed care are essential.

Positive Social Change

The findings of this study hold several implications for positive social change in mental health care. The findings contribute to a deeper understanding of culture and systemic barriers that limit access, trust, and engagement in mental health care. At the individual level mental health providers should participate in ongoing implicit bias and cultural humility training to ensure self-reflection and awareness to continue to reduce negative bias and minimize harmful diagnostic and therapeutic practices. When providers reflect on their implicit biases and socio-cultural assumptions, they create opportunities for healing and a more inclusive approach to mental health care. At the organization level, findings support the need to improve health systems to ensure training, supervision and accountability measures are in place to reduce negative bias among providers. To foster a more inclusive national approach across mental health organizations they must enhance their systems to integrate training to mitigate negative provider bias. At the community level the study underscores the importance of community partners and non-

traditional partners such as faith-based institutions as a protective factor. These trusted organizations can help foster inclusive connections and a sense of belonging to enhance mental health education and support within the African American communities.

From an ecological systems perspective positive social change must occur at all levels to improve mental health outcomes for African American men. As mentioned in Chapter 2, the ecological systems theory is a multilayered influence that impacts an individual, both the client and provider, at multiple levels-the microsystem (therapeutic relationships); mesosystem (community and family supports); macrosystems (policy); and chronosystem (social infrastructure, awareness, and advocacy). Positive social change is possible if all levels are aligned to promote equity, fairness, and accessibility to mental health care. The providers are a piece of the mental health system and thinking about this approach on a broader scale will improve positive social change. Given the complexities of African American men, we must move beyond awareness campaigns and implement systemic changes at multiple levels creating a safe and inclusive space for African American men while educating and supporting the mental health providers for future generations.

Conclusion

This study demonstrates that bias and sociocultural assumptions among mental health providers manifest at multiple ecological levels, shaping how African American men engage with mental health care. Implicit bias and sociocultural assumptions among mental health providers shaped the diagnostic and therapeutic experiences of African American men. Participants' recognition of their own biases, their awareness about

stigma, medical mistrust, trauma, masculinity norms, and their reliance on community pathways reveal both barriers and opportunities. Grounded in ecological theory, these findings underscored that advancing equity in mental health care requires strategies at multiple levels beyond the individual provider, client relationships, community partnerships, and system reform. By addressing these biases and sociocultural assumptions across the interconnected layers, providers and institutions can contribute to meaningful positive social change and improved mental health outcomes for African American men. While bias often manifests unconsciously, its impact is magnified by ecological contexts from system pressures, access to barriers to fragmented resources and limitations. Ultimately, reducing bias is essential not only to improve clinical accuracy, but to restore trust, advance equity, and promote the mental well-being of African American men.

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Appendix A: Participant Sampling Questionnaire

Study Title: Invisible Man: Mental Health Providers and How Implicit Bias Manifests When Treating African American Men

Purpose: The purpose of this qualitative study is to explore how mental health providers socio-cultural assumptions and biases manifest when treating and diagnosing African American men.

Confidentiality: Your responses are confidential and will be used solely for screening purposes.

Section 1: Demographic Information

1. Name: _____

5. Email Address: _____

6. Phone Number: _____

Section 2: Professional Background

7. What is your professional title?

- Psychologist (PhD, PsyD)
- Licensed Professional Counselor (LPC)
- Licensed Clinical Social Worker-Clinician (LCSW-C)
- Marriage and Family Therapist
- Other (please specify): _____

8. Are you currently licensed to practice mental health counseling or therapy in MD?

- Yes - No

9. How many total years have you worked as a mental health provider?

- Less than 3 years
- 3–5 years
- 6–10 years

- More than 10 years

10. Have you worked with African American male clients in your practice?

- Yes - No

11. If yes, how many African American male clients have you worked with?

- 1–5 - 6–15 - 16 or more

Section 3: Relevance to Study

12. Have you ever received formal training on bias, medical mistrust, cultural competency, or stigma in clinical settings?

- Yes - No

- If yes, please describe briefly:

Appendix B: Interview Guide

Conducted via Zoom

Study Title:

Invisible Man: Mental Health Providers and How Implicit Bias Manifests When Treating African American Men

Audience: Mental Health Providers who serve African American men.

Purpose: The purpose of this qualitative narrative inquiry is to explore how mental health providers socio-cultural assumptions and biases manifest when treating and diagnosing African American men.

Research Question: How do mental health providers' socio-cultural assumptions and biases manifest when treating and diagnosing African American men?

Note: The interview questions were developed to be broad enough and open-ended so the mental health providers could expand on their answers. The goal is to generate rich discussions and gain a deeper understanding through storytelling. The researcher aims to avoid the responses being yes/no.

I will begin with questions regarding your personal and professional background.

Intro:

Microsystem: Personal and Professional Background

1. Tell me about yourself.
 - Where did you grow up?
 - What school did you attend, high school and college?
 - Can you tell me about your family structure, i.e., parents, siblings, spouse, children etc.
2. Can you share your story of why you wanted to become a mental health provider?
 - And what was your journey to becoming a mental health provider?
3. What drew you to work with diverse populations, including African American men?
4. Did you learn about biases or socio-cultural assumptions in college?
 - How do you remain self-aware regarding your own biases?

Main: Mesosystem: Experiences Working with African American Men

1. Can you tell me about a memorable experience working with an African American male client?
 - How do you approach building trust with them?

- How did you navigate cultural or identity-based differences in that session?
 - What emotions or thoughts came up for you during or after that experience?
2. How do you think mental health services support or fail African American men?

Recognition of Bias

3. Tell me when you noticed or reflected on your own implicit biases in clinical work? If so, can you describe a time when this came into play?
4. Tell me about a time when you recall a situation where you observed bias—your own or others’—in how an African American man was diagnosed or treated?
 - What did you learn from that experience? Did it change how you practice?
5. Tell me about a time when you questioned implicit bias-either yours or the systems that may have shaped a diagnosis or treatment plan?

Ecosystems: Clinical Judgment and Diagnosis

1. Tell me a time when you may have questioned whether a diagnosis you made (or reviewed) may have been influenced by cultural assumptions or stereotypes?
2. Can you share a time when you reconsidered a clinical impression after gaining more cultural understanding?

Institutional and Systemic Reflection

3. In your experience, how do systemic factors (e.g., stigma, medical mistrust, poverty) show up in mental health care for African American men?
4. How do you see your role in addressing or mitigating these systemic influences?

Macrosystem: Cultural Competence Training

1. What formal or informal training have you had regarding cultural competency?
2. Can you describe a moment when working with an African American client changed or challenged your clinical perspective?

Conclusion:

Future and Recommendations

1. What do you believe is most misunderstood about African American men in mental health settings?
2. If you were training future therapists, what would you emphasize about bias and identity in clinical work?

Appendix C : Participant Recruitment Flyer

YOU ARE INVITED TO SHARE YOUR VIEWS FOR A STUDY TITLED: PHENOMENOLOGICAL STUDY OF PROVIDERS' SOCIO-CULTURAL ASSUMPTIONS IMPACTING AFRICAN AMERICAN MEN'S MENTAL HEALTH

ABOUT THE STUDY:

- One, 45–60-minute interview that will be audio recorded (no videorecording)
- You would receive a \$25 Visa gift card (no raffles or discount cards) as a thank you
- To protect your privacy, the published study will not share any names or details that identify you
- Interviews will take place during October 2025

Volunteers must meet these requirements:

- Licensed mental health provider in Mid-Atlantic Region
- Minimum of 3 years of professional experience
- Diagnose or treat African American men



**Click Link Below:
Participant Sampling Survey**

CONTACT THE RESEARCHER: