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African American Families' Expectations and Intentions for Mental Health Services

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Abstract

A cross-sectional qualitative descriptive design was used to examine the links among expectations about, experiences with, and intentions toward mental health services. Individual face-to-face interviews were conducted with a purposive sample of 32 African American youth/mothers dyads. Content analysis revealed that positive expectations were linked to positive experiences and intentions, that negative expectations were not consistently linked to negative experiences or intentions, nor were ambivalent expectations linked to ambivalent experiences or intentions. Youth were concerned about privacy breeches and mothers about the harmfulness of psychotropic medication. Addressing these concerns may promote African Americans' engagement in mental health services.

Keywords

African American; mental health services; expectations; intentions

African Americans, regardless of gender and age, use mental health services at much lower rates than do other ethnic groups (Angold et al., 2002). Because African Americans have rates of untreated mental health needs that are higher than other groups, and because African Americans are disproportionately exposed to traumatic events such as community violence, the disparity in mental health services is a pressing public health problem (Roberts et al.,

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2011; USPHS, 2000). Despite a large body of research on mental health service use by African American youth (e.g., Alegria et al., 2008; Kodjo & Auinger, 2004) and adults (e.g., Wu et al., 2001), the factors that determine their mental health service use are still poorly understood (Thompson et al., 2011). The limited research available has suggested that, among youth, boys are more likely to receive services than girls (Angold et al., 2008). Recent research has suggested that past experiences with mental health services may be related to expectations about services and that expectations in turn might relate to intentions to use services (Kerkorian et al., 2006; Thompson et al., 2011).

Links among African Americans' experiences, expectations, and intentions have been studied in relation to health behaviors (Romano & Nedand, 2010; Childs et al., 2008), cancer treatments (Marion & Schover, 2006), and medical decisions (e.g., Hammond et al., 2010), mainly with adults. However, few studies have focused on the relationship among these concepts to explain African Americans' mental health service utilization. As well, child welfare systems are often the means by which African American children and youth access mental health services (Lyons & Rogers, 2004), but there has been little research on the role of expectations, experiences, and intentions in these settings (Thompson et al., 2011), especially for mothers of these youth (Thompson, Tabone, & Cook, in press). Much of the literature reviewed focuses on urban families in high-risk settings, similar to the current sample.

Experiences with mental health service are prior encounters with mental health services either for oneself, family members, or friends (Thompson et al., 2011). *Expectations* about mental health service are beliefs that mental health services will be pleasant and beneficial or aversive and harmful (Kerkorian et al., 2006). *Intentions* about mental health service utilization are one's willingness to seek mental health services (Cauce et al., 2002). Though limited research has focused on the links among these concepts, there are some theoretical and empirical bases for focusing on these links to provide an understanding of African Americans' mental health services use.

The original Theory of Reasoned Action (TRA: Ajzen & Fishbein, 1980) proposed that important determinants of intentions are one's experiences and attitudes (defined as expectations about the outcomes of engaging in the behavior). One limitation of the original TRA was that intentions may not always translate into actions, because people may either lack the capacity to translate intentions into actions or perceive themselves as lacking this capacity; such capacity may be heavily influenced by norms, which can restrict what is seen as possible (Miller, 2005). The Theory of Planned Behavior (TPB; Ajzen, 1991), an expansion of TRA that included perceived and actual control over behavior to take into account this discrepancy.

Despite this difference, both TRA and TPB predict that intentions to engage in treatment arise from expectations about how useful, coercive, and sensitive treatment would be and the possible negative outcomes of treatment (Cauce et al., 2002). It has been successfully applied to African Americans' decisions regarding medical health care. Hammond and colleagues (2010) found that expectations strongly predicted African American men's intentions of getting routine health screening: positive expectations increased African American men's intentions for screening whereas negative expectations decreased such intentions. Similar links have been found between expectations and intentions for cancer screening for African Americans (Ross et al., 2007; Zimmerman et al., 2006). However, there has been limited research applying TRA and TPB to African Americans' mental health services utilization, despite some evidence that it is relevant in explaining mental health services use in predominantly White samples (e.g., Turner & Liew, 2010).

Empirical evidence, though limited, has shown that African American parents' expectations about mental health treatment for their children are influenced by their experience with past treatment, including not only the clinical outcomes of treatment, but also the quality of the relationship with the treatment provider and the autonomy afforded to them in treatment (Kerkorian, 2003). In other words, experiences tend to influence expectations, which in turn influence intentions (Kerkorian, 2003). African American adults are less likely than whites to be satisfied with the services they receive from mental health providers (Redmond et al., 2009; Thurston & Phares, 2008); less research has examined the expectations and experiences of African American youth, although the research that has been conducted suggests general similarities between African American youth and adults (Lindsey et al., 2006; Thompson et al., 2011). Negative aspects of experiences with mental health services for African Americans include inappropriately prescribed psychotropic medications and attendant side effects (Jaycox et al., 2006; Thompson et al., 2011; Ward et al., 2009), lack of respect or attentiveness on the part of providers (Blanchard & Laurie, 2004), and breaches in confidentiality (Draucker, 2005; Leis et al., 2011; Thompson et al., 2011).

Negative experiences with mental health services have been linked to negative expectations about possible future mental health service use. Several researchers (Kovandžić et al., 2011; Redmond et al., 2009) found that negative experiences with mental health services were associated with more negative expectations about future mental health service use for African American parents. Leis and colleagues (2011) in a study of low income African American expecting mothers, found that negative expectations centered around unpleasant interactions with providers, especially providers who were rushed and did not take the time to get to know clients. On the other hand, African Americans mothers' feelings that they had been respected in their children's treatment were associated with more positive expectations about future mental health service use (Kerkorian et al., 2003). Given the fact that African Americans are more likely than other ethnic groups to have negative experiences with mental health services, it is not surprising that African Americans also have more negative expectations around mental health services (Brown et al., 2010) and more distrust of mental health services than other ethnic groups (Suite et al., 2007; Thompson et al., 2004; Whaley, 2001).

Expectations are linked to intentions to seek or continue mental health services for African American adults. Expectations that treatment will be helpful and relevant are predictive of increased intentions to seek treatment, both for oneself (Gonzalez et al., 2011; Stevens et al., 2006) and one's children (McKay et al., 2001). On the other hand, for African Americans, expectations that treatment will include unhelpful or harmful medication (Leis et al., 2011) and that providers or "the system" are not trustworthy (Eiraldi et al., 2006; Power et al., 2005) predict reduced intentions to seek services. Limited research has also revealed that African Americans frequently have ambivalent experiences with mental health services (Thompson et al., 2011) and that ambivalent experiences often lead to ambivalent expectations and intentions about these services (Ward et al., 2009). Ward and colleagues (2009) further noted that many African American women are "torn" between a belief that mental health services could help and a reluctance to use medication.

The purpose of this research was to examine qualitatively the links among expectations about mental health services, experiences with mental health services and intentions about mental health services in African American mothers and their youth from a low-income urban community with a high rate of child welfare involvement. The research questions were:

1. Do mothers and youth who report positive expectations about mental health services also report positive experiences with mental health services and positive intentions to seek mental health services in the future?

2. Do mothers and youth who report negative expectations about mental health services also report negative experiences with mental health services and negative intentions to seek mental health services in the future?
3. Do mothers and youth who report ambivalent expectations about mental health services experiences also report ambivalent experiences with mental health services and ambivalent intentions to seek mental health services in the future?

Methods

Research Design

A cross-sectional qualitative descriptive research design was used to examine mothers' and youths' expectations about mental health services, experiences with mental health services, and intentions about mental health services. This design allows respondents to share their perceptions in everyday language and thus allows clear communication of participants' perspectives (Sandelowski, 2000). While a full description of the research methods can be found in a previous publication (Thompson et al., 2011), a brief description of the research methods is provided.

Sample

The sample was drawn from the Capella Project, a larger longitudinal quantitative study of the long-term outcomes of child abuse and neglect for 245 mother-youth dyads who were followed from infancy through young adulthood. The Capella Project sampled mother-infant dyads from districts that were high in poverty and high in rates of calls to child protective services. Dyads with a report of maltreatment were oversampled; 60% of the original sample had been reported as maltreated. Two thirds of the Capella Project sample was African American. From dyads participating in the Capella Project, we selected a purposive sample of 32 African American dyads of mothers and youth who met the following selection criteria: youth between the ages of 13 and 19, and both mothers and youth reporting using mental health services. All interviews were conducted at the research offices of the Juvenile Protective Association, except five, which were conducted in participants' homes (Thompson et al., 2011).

Measures

Two semi-structured interview guides, the Mother Interview Guide and the Youth Interview Guide (Thompson et al., 2011), were developed to elicit information about mothers' and youths' experiences with and expectations and intentions about mental health services utilization. Mothers' and youths' experiences, expectations, and intentions were elicited with three open-ended requests for information. The request for information about experiences was: "Tell me about your experiences with mental health services for you, your family, and non-family members (friends, etc.)." The request for expectations was: "Tell me about what you expect when you think about the possibility of getting mental health services for yourself." The request for intentions was: "Tell me how likely you would be to try to get mental health services if you thought they were needed." Mothers were also asked to talk about experiences with mental health services, expectations about mental health services, and intentions to get mental health services for the target youth. Each request had probes to elicit more comprehensive information. For example, to elicit more information about positive or negative experiences with treatment, respondents were asked, "What things did you like about [the services]? What things didn't you like?" The interviews were conducted in a conversational style allowing for a natural interaction between the research participants and the interviewer (Patton, 2002). The interview guides were revised based on feedback

from experts in qualitative research as well as African American parents (Thompson et al., 2011).

Procedure

The study was overseen by the Institutional Review Boards of the first and second authors, and the interviews were conducted between June of 2008 and July of 2009. After written informed consent and permission was obtained from each mother, and assent obtained from each youth, the mother and youth participated in separate interviews that took place in separate private interview rooms at the research office or in the home. Interviewers were graduate students with prior experience conducting interviews. They were trained extensively on the interviewing process and each conducted several practice interviews observed by the senior investigators (RT, BD).

All interviews were recorded audio-digitally. Interviews ranged in length from 22 minutes to 86 minutes for mother participants and from 20 minutes to 59 minutes for youth participants. Participants were reimbursed for their time and transportation costs (Thompson et al., 2011).

Data Analysis

Qualitative content analysis process, proposed by Sandelowski (2000) for qualitative descriptive research, was use to analyze the data. This framework focuses on summarizing, rather than interpreting information generated by participants (Sandelowski, 1998). All interviews were digitally recorded and then transcribed verbatim from digital recordings by professional transcriptionists. Each interviewer listened to the digital recordings and compared the transcripts against the digital recordings for accuracy. At the time of checking the transcripts for accuracy, the interviewer removed all identifying information about mothers, youth, family members, and providers from the transcripts and made notes on the transcript to capture nonverbal behaviors during the interview, such as pauses or crying (Creswell, 2003). The corrected interview transcripts were entered into Atlas.ti, a software package developed to support qualitative data processing. Relevant quantitative data collected through the Capella Project (e.g., child gender, age) was condensed on SPSS and used to produce quantitative descriptive summaries of these variables.

An initial codebook was developed by reviewing the first few transcripts. Research team members were paired and independently coded each transcript to enhance reliability. The results of the two independent codings were then compared and discussed until consensus was achieved. Definitions of codes and code subcategories were refined based on discussion of discrepancies. Following Miles and Huberman's (1994) guidelines, a series of matrixes that summarized the data for each code across all participants was developed. Themes from the codes were determined based on how frequently they occurred (Hsieh & Shannon, 2005).

For the purposes of these analyses, experiences with mental health services were categorized as positive, negative, and ambivalent, depending on reported satisfaction with these experiences (Thompson et al., 2011). Expectations about mental health services were categorized as positive when they included beliefs that engaging in mental health services would be pleasant and/or beneficial, and negative when they included beliefs that engaging in such services would be aversive and/or harmful. Those who reported both substantial positive and negative expectations were categorized as having ambivalent expectations. Intentions about mental health services were categorized as positive when respondents indicated a plan or willingness to seek mental health services for themselves or their children, if needed. Having no plans or being unwilling to seek such services were

categorized as negative. Uncertainty about whether to seek or avoid such services was categorized as ambivalent.

Strategies used to ensure trustworthiness of this qualitative study were credibility and transferability (Lincoln & Guba, 1985; Krefting, 1991) and methodological coherence and sampling sufficiency (Morse, Barrett, Mayan, Olson, & Spiers, 2002). To ensure credibility, we held regular team members to counter any research team member's biases that may have impacted the research process; collected data from two sources, mothers and their youth; and used multiple interviewers who received extensive training in qualitative interviewing, including mock interviews. To ensure transferability, we provided detailed information about the mother-youth dyads and the research site to assist the readers in determining if the results are transferable to their clientele. Our focus on developing and maintaining maximal compatibility among our research questions, research design, data collection methods, and data analysis guaranteed methodological coherence. Lastly, we ensured sample sufficiency through our purposive sample of 32 mother/youth dyads who had experience with mental health services utilization. According to Morse (2000), a sample size of at least 30 is adequate to provide rich data when the data collection method is semi-structured interviews.

Results

Participant Characteristics

The mean age of the mothers in the sample was 41.10 years (*SD* = 6.16); the mean age of the youth was 15.20 years (*SD* = 1.38), with a range of 13 o 18 years old. The median family income was between $15,000 and $20,000 per year; 67.5% of participating families had incomes under $20,000. Slightly more than a third (37.5%, n = 12) of the dyads included a male youth; the remainder of the dyads included female youth. Pseudonyms have been used in reporting participants' quotes.

POSITIVE EXPECTATIONS

Mothers: Of the 32 mother participants, 16 (50.0%) reported positive expectations of mental health services. Of these 16 mothers with positive expectations, 11 (68.8%) reported both positive experiences with mental health services and positive intentions to use mental health services. The remaining five (31.3%) mothers with positive expectations reported: ambivalent experiences and positive intentions (n = 2), positive experiences and ambivalent intentions (n = 2), or negative experiences and positive intentions (n =1). The mothers with positive expectations are presented in the first column of Table 1.

Thus for more than two-thirds of the mothers with positive expectations, positive expectations of mental health services were linked to positive experiences with mental health services and to positive intentions to use mental health services for themselves or their family members, generally their children. For example, Mary, the mother of 13 year old Diana, reported her positive expectation of mental health services after observing the benefits of these services for her own mother, resulting in her having positive intentions to use mental health services for her own daughter:

> As a child, I could see that she [mother's mother] was really having a rough time with it. But after she started seeing the psychiatrist, we could feel that she was coming back into herself and feeling better and getting stronger and accepting it better.... it actually gave me a positive view of counselors, psychiatrics.
>
> ...I know that they have counselors at her [daughter's] school. So, that probably would be the first place I would go...I would hope that at the least that she would be able to face what's wrong. Because I feel like if you're able to express what's

> wrong, verbalize it, then that's the step towards resolving what the issue is or coming to terms with the issue. I'm hoping that the first session would at least get her talking about it.
>
> -Mary

Sally, the mother of 16-year-old Tariq, also linked her positive expectations and positive intentions to past positive experiences:

> As far as counselors and therapists I never really had a problem or nothing as far as finding one or if I need one I know that it's okay and I can feel comfortable. Each person have their own vibe. When you meet a person you know if you feel welcome or you want to hold back. You know that in the beginning when you meet a person, a least I would anyway. And I never had nothing against having counselors and family counselors and stuff ... I think they're very helpful because of my past experience with them.
>
> ...I would most definitely find a counselor. I would most definitely because of my past experiences has been very good. If it came to that part I would most definitely find a therapist either through the church or through my doctor.
>
> -Sally

Youth: Of the 32 youth participants, 14 (43.8%) reported positive expectations of mental health services. Of the 14 youth with positive expectations, most (n = 9; 64.2%) reported both positive experiences with mental health services and positive intentions to use these services. Five (35.7%) reported either positive experiences with mental health services and ambivalent intentions to seek mental health services (n=2) or positive experiences and negative intentions (n=3). The youth with positive expectations are presented in the first column of Table 2.

All of the 14 youth with positive expectations reported positive past experiences. Nearly two-thirds of the youth with positive expectations of mental health services reported both positive past experiences and positive intentions. In some cases, youth expressed a desire to reconnect with a particular provider. For example, Tiara, a 13 year old girl who had had positive experiences at a counseling center, cited her positive experience and her intention to seek out the same counselor if needed.

> Since I had a positive experience like it made a big impact on me like I just think about all counselors that they're nice...And like if you have a problem with your mother like they'll sit you down and for both of you all to talk and stuff like that.... I would call her to see if she could get me connected back with [Counselor] to see if I could talk to her again.
>
> -Tiara

Diana, a 13 year old girl who discussed a friend's positive experience with school counseling, talked about her own positive expectations around counseling, especially confidentiality. Although this youth thought it was unlikely that she would need counseling, she expressed willingness to do so, if family members were not available. She said:

> People can go to them to talk about their problems. Because they said that whatever you tell them, they won't tell your parents and stuff like that.
>
> ... I think counselors are okay. But I'm not the type of person who would go to a counselor, myself... it probably may be a situation where my brother might not be around or my mother might not be around. He or she might be the last person that I could, maybe, turn to or try to talk to.

-Diana

NEGATIVE EXPECTATIONS

Mothers: Seven of the 32 mother participants (21.9%) reported negative expectations. Of these seven mothers, two (28.6%) reported both negative experiences with mental health services and negative intentions to seek mental health services. The remaining five (71.4%) mothers reported either positive experiences and positive intentions (n=1) or negative experiences and positive intentions (n=4). The mothers with negative expectations are presented in the second column of Table 2.

Less than a third (n = 2) of the mothers with negative expectations about mental health services reported both negative experiences and negative intentions. These mothers believed that engaging in mental health services would result in being stigmatized and wished to avoid this negative consequence for their children. Brenda, the mother of 16 year old Shenice, stated:

> Once you get in to see a psychiatrist, ...they already got you labeled, that's the biggest rough part about any mental thing you are labeled from once you start off seeing the psychiatrist don't never get admitted. You are labeled, so therefore you stunt your own life, okay. You can't get some jobs...
>
> ...I wouldn't put her [daughter] through that because I didn't see no help and it basically messes up your whole record for your entire life.
>
> -Brenda

Two concerns were discussed among the five mothers with negative expectations and either positive or negative experiences with mental health services and positive intentions to seek mental health services: privacy, particularly in the context of group therapy, and medication. Regarding privacy, Nikki, the mother of 14 year old Travis, said:

> I'm not good with groups. I'd rather deal with it one on one instead of having all my business out there and it's supposed to be private groups but anybody could come out and see you anywhere and tell your business.
>
> ...I'm basically in the process of trying to move and get some health problems situated and that's another reason why I'm not working and just get a lot of my health problems dealt with and then maybe if after that I think I still need some mental health, then I'll probably seek her [counselor].
>
> -Nikki

Concerns about medication centered on potential side effects. Christina, the mother 13-year-old Malcolm, noted, “Sometime it [medication] changes the way you act. Now how would I be able to be there for my kids thoroughly if I'm drugged up?” However, this mother added that she would seek mental health services if her condition worsened:

> If it [depression] gets to the point where I just, I mean, to the point where I'm just, I just don't want to get out the bed, I just have no motivation to do anything, then I'm going to have to because that could hurt me.
>
> -Christina

Youth: Five of the 32 youth participants (15.6%) reported negative expectations. Of these five youth, two (40.0%) reported both negative experiences with mental health services and negative intentions to seek mental health services. The remaining three (40.0%) reported: positive experiences and positive intentions (n=1), positive experiences and ambivalent

intentions (n=1), and ambivalent experiences and ambivalent intentions (n=1). Most youth with negative expectations reported either negative (n = 2) or ambivalent (n = 1) experiences. The youth with negative expectations are presented in the second column of Table 2.

Further, only 40% of the youth who reported negative expectations about mental health services also reported both negative experiences and negative intentions. These youth had concerns centered around confidentiality, and reported either that they had enough support from family and friends, that mental health services would never be needed, or that they needed services but would avoid them because of concerns over privacy. For example, Rachel, a 15 year old girl, discussed concerns with privacy and expressed unwillingness to seek services, even though she felt a need for such services.

> They probably won't keep it confident....They'll start trying to put me down, and I don't like that....Trying to tell me that's dumb, “Well, that's wrong. You shouldn't have ever did that,” starting in telling me that.
>
> ... I probably wouldn't do nothing. I probably just stay to myself....sometimes I just need somebody to talk to, but if I ain't got nobody to talk to, I just hold it in. But when I hold it in I just get mean and I have attitude with everybody.
>
> - Rachel

For those youth with negative expectations and ambivalent intentions, their beliefs that they could not trust therapists to maintain confidentiality led to ambivalent intentions. Tarita, a 17 year old girl, with negative expectations and ambivalent intentions said:

> I don't look for nobody to talk to....I won't because there's so many crooked people you could talk to that is a therapist and they're really not, they just want to be in your business.... I want to know you first. I'm going to get to know you first. I at least got to know you for a year before I even think about telling you any of my business. If I see you can keep your mouth shut and don't talk about nothing, then I'm respecting.
>
> - Tarita

AMBIVALENT EXPECTATIONS

Mothers: Nine (28.1%) of the 32 mother participants reported ambivalent expectations about mental health services. Of the nine mothers with ambivalent expectations, none had both ambivalent experiences with mental health services and ambivalent intentions to seek mental health services. Five of the nine mothers reported ambivalent experiences with mental health services and positive intentions to seek mental health services. The rest reported: negative experiences and positive intentions (n =1), negative experiences and ambivalent intentions (n = 1), positive experiences and ambivalent intentions (n = 1), or negative experiences and negative intentions (n = 1). The mothers with ambivalent expectations are presented in the third column of Table 1.

Mothers with ambivalent expectations and experiences and positive intentions (n = 5) tended to express relatively positive views about mental health services’ possibilities. However, they reported greater variation in likely outcomes, depending on either the attitude of the service recipient or the service provider. For example, Jane, the mother of 14-year-old Antonio, had ambivalent experiences and positive intentions. She reported that success depended on the recipient being “open-minded” and expressed doubts about whether such services might work for her. However, Jane reported that she was willing to seek mental health services for her son after evaluating alternative approaches and obtaining input from

others. Jane noted that recipients' motivation might be one reason why services might not work in practice:

> The person getting help have to be open and willing to seek help. And then once they seek the help, they got to be open-minded that this person is not out to hurt them, they out to really help them. And they got to really, really want to help themselves, because can't nobody help you if you don't help yourself.... Is it going to really help, or is it a waste of my time? But I think those just natural feelings anybody would have having to deal with somebody, you know, a outsider.
>
> ...I would talk to him [son] first. Then if I thought it may be a medical problem, I would talk to his doctor after consulting with my mother. Because she plays a important role in both our lives. And whatever his doctor, like, if his doctor said, well, I think he need to go in drug treatment or something like that, then his, you know, his steps-- so I would follow the steps to the end to get him all the help that I can, anything that's in my power, not in my power. I would seek outside help if I had to.
>
> - Jane

The ambivalent expectations of those mothers who had positive intentions (N = 6), regardless of experience, were centered on the type of provider encountered. These mothers had positive intentions to seek mental health services because they perceived that the seriousness of the need for mental health services overshadowed uncertainty around type of provider encountered. For example, Maria, the mother of 17 year old Tarita, reported:

> Sometimes [daughter] gets so angry, I can't deal with it, you know what I'm saying? ... So rather than me putting my hand on [daughter], you know what I'm saying, I'd rather for her to be in some kind of program...Even though she's not in a program, but I'm going to be honest with you, I have thought about getting her back into the program, I really have. And I think that's what I'm going to do, call the lady next week and I'm going to get her back in. Both of us, we gonna go to the program. You know, because see, all that acting out, that ain't good.
>
> - Maria

Youth: Thirteen (40.6%) of the 32 youth participants reported ambivalent expectations. Of these 13 youth, none reported both ambivalent experiences and intentions. Instead, they reported: positive experiences and positive intentions (n =3), positive experiences and negative intentions (n = 2), positive experiences and ambivalent intentions (n = 1), ambivalent experiences and positive intentions (n =1), negative experiences and positive intentions (n =1), negative experiences and negative intentions (n =3), and negative experiences and ambivalent intentions (n =2). The youth with ambivalent expectations are presented in the third column of Table 2.

The youth (n = 3) with ambivalent expectations but negative experiences and negative intentions expressed a lack of an opinion about mental health services, or uncertainty as to whether such services were truly useful. Their negative intentions centered on the expectation that their confidentiality would be violated. For example, 17-year-old Claudia stated:

> I just have this like little feeling inside me that they're going to tell somebody. But they're not, that's what they say...So I sometimes believe them. I believe they're going to tell my parents or something like that or just anybody. So I just don't feel comfortable. I used to think that but like as I grow up now and I go to school, I really don't think that anymore. I used to. Sometimes I do...But not like I used to.

- Claudia

Claudia did not intend to talk to a counselor, saying, “If I have something going on, I just talk to my mom...So my mom, I know she won't tell nobody. So she's like my best friend. And yeah, so I trust her like a whole lot.”

The youth (n = 3) with ambivalent expectations but positive experiences and positive intentions were typically unsure of what to expect from services, thinking that the counselor might not like them or the counselor might be boring. But at the same time youth reported having thoughts such as “Well yeah, I want to talk” and that talking to the counselor “might be good when I have a problem”. As such, they intended to go to a counselor, reporting, for example, “So I'm a just try it out”. 15-year-old Daron said:

> Because like I mean, I feel like if you need help, you need help. Just do it. I'm really independent, so I don't need my mama or nobody telling me like, ‘You need to go talk to the therapist’. I know what I need. So like I don't see nothing wrong when you're going to talk to a therapist, as long as they're helping you and not making you feel crazy. Then it's cool... It's not hard to go to a therapist, psychiatrist, counselor, or nothing.
>
> - Daron

Discussion

Previous research suggested links among an individual's expectations, experiences, and intentions to engage with mental health services (Gonzalez et al., 2011; Kerkorian et al., 2003; Leis et al., 2011). We found that 68.8% of mothers and 64.2% of the youth who reported positive expectations about mental health services also reported both positive experiences with and positive intentions to seek mental health services. There was less consistency among expectations, experiences, and intentions for both mothers and youth who reported negative or ambivalent expectations. Specifically, only 28.6% of mothers and 40.0% of the youth reporting negative expectations about mental health services also had both negative experiences with and negative intentions to seek mental health services. No link existed when expectations were ambivalent; none of the mothers and youth with ambivalent expectations about mental health services also had both ambivalent experiences with and ambivalent intentions to seek mental health services.

These data suggested that the TPB worked best when explaining the links among positive expectation and its corresponding positive experience and positive intention, and then only for roughly two thirds of the mothers with positive expectation. For both mothers and youth, TPB had limited ability to explain the links among negative expectations and their corresponding negative experiences and negative intentions as well as the links among ambivalent expectations and their corresponding ambivalent experiences and ambivalent intentions. A plausible explanation is that the other TPB concepts, subjective norms and perceived behavior control, may play an important role in explaining intention to seek mental health services. Subjective norm is the mothers’ and youths’ perceptions of important people's approval or disapproval of their seeking mental health services (Ajzen, 1991). Perceived behavioral control is the mothers’ and youths’ perceptions of how easy it would be for them to seek mental health services (Ajzen, 1991); what internal and external barriers may interfere with them seeking mental health services. In their meta-analysis, McEachan, Conner, Taylor, and Lawton (2011) disclosed that even though attitude was the strongest predictor of intention, when it was combined with subjective norms and perceived behavior control, the combination explained almost 45% of the variance in intention. Similarly, Armitage and Conner (2001) concluded from their meta-analysis that attitude plus subjective norm and perceived behavior control explained on average 39% of the variance in intention.

Additionally, perceived behavior control, not attitude, was the strongest predictor of intention as indicated by two meta-analyses (Armitage & Conner, 2001; Topa & Moriano, 2010). As such, the inclusion of subjective norms and perceived behavior control may help explaining intentions to seek mental health services (Thompson et al., in press).

For our sample, internal barriers that influenced their decisions not to seek mental health services were their concerns about being prescribed psychotropic medications, about their confidentiality being violated, and about receiving a pejorative label and the stigma resulting from this label. Similar to Breland-Noble's et al. (2011) and Ward's et al. (2009) results from African American samples, our results revealed that mothers and their youth perceived prescribed psychotropic medications as not helpful. Leis et al. (2011) also revealed that African American women were reluctant to seek mental health services because they perceived that the therapist prescribed psychotropic medication with horrible side effects as the first and primary mode of treatment without obtaining a clear comprehensive understanding of the patient. African Americans viewed psychotherapy as more beneficial than psychotropic medication, but perceived that therapists preferred psychotropic medication over psychotherapy (Ward et al., 2009).

In regards to loss of confidentiality, Mishra and colleagues (2009) reported that stigma was closely related to loss of confidentiality related to mental health. They disclosed that once a person is known to have sought mental health services and/or have a psychiatric diagnosis, it was highly likely that the person would be stigmatized. Due to their fear of loss of confidentiality and stigma, African American women (Ward et al., 2009), African American mothers of youth (Murry, et al., 2011), African American youth between 12 and 18 (Molock et al., 2007), and depressed African American adults (Cruz et al., 2008) preferred not to see a therapist; they would talk to family members or friends before talking to a therapist. In fact African American young adults who received mental health services as adolescents reported not trusting therapists because therapists had violated their confidentiality. This concern was also present when parents of such young adults considered mental health treatment (Breland-Noble et al., 2011).

Contextual factors such as the external barriers to seeking mental health services may further our understanding of the disconnect between intentions, expectations, and experiences in these families. In particular, many of the ambivalent and positive intentions suggested by the respondents were provisional and conditional. As well, services are often simply not available, as limited by cost and geographical distance (Kovandžić et al., 2011; Snowden et al., 2006). This is especially true of low-income African Americans living in inner cities (Koizumi et al., 2009), which was true of most of the families in our study. Finally, in some cases, the services received in the past had been mandated and were not likely to be available outside of child welfare mandates due to the cost and/or lack of health insurance. These real barriers, while not mentioned explicitly by respondents, may have influenced their thinking in linking expectations, experiences, and actions.

Consistent with Mulvaney-Day's and colleagues' (2011) report that intentions were often provisional, our sample reflected considerable uncertainty about whether to seek mental health services because of their experiences with former providers. Ambivalent intentions may reflect a significant source of the high rate of early drop-out and low uptake of services by African Americans (Murry et al., 2011).

Limitations

The primary limitation is the lack of African American fathers' and adult males' perspectives, given that the sample comprised urban low-income mothers and their children. The sample had a high number of families with a history of reports to child protective

services and included several families who had been mandated by child protective services to receive mental health services (Thompson et al., 2011). Thus, many of the mothers had viewed these services as a means by which they would regain, or keep, custody of their children, an especially coercive context for mental health services. African Americans are more likely than other groups to receive mental health services in a coercive context, especially in the context of child welfare (Chow et al., 2003). However, this sample may not be drastically different from the general population of African Americans receiving mental health services. These findings are unlikely to generalize to African American adult males, and further research should examine African American adult males and fathers. Research suggests that African American men are especially resistant to mental health treatment (e.g., Gonzalez et al., 2005; Lindsey, Korr, Broitman, Bone, Green, & Leaf, 2006). In addition to concerns about stigma, African American adult men also have been shown to have concerns about being perceived as weak and not masculine (Lindsey et al., 2006).

Youth age may have influenced the findings. We sampled youth from all stages of adolescence: early adolescence, middle adolescence, and late adolescence (Spano, 2004). However because there were no apparent differences in themes based on youth age or gender, we have some confidence in the applicability of the findings across these stages as well as across gender (for youth). It is also important to acknowledge that this study was cross-sectional and had no follow-up results, making causal inferences risky. Finally, this exploratory study did not include all elements of the TPB model, and future research should include subjective norms and perceived behavioral control.

Implications for Research and Theory

More comprehensive qualitative research is needed to explore African American mothers' and youths' intentions to seek mental health services. In addition to expectations about mental health services, experiences with mental health services, and intentions about mental health services, this comprehensive research should include subjective norms about mental health services and perceived behavioral control about mental health services. This would allow us to discern the links among mental health service related expectations, experiences, subjective norms, perceived behavioral control, and intentions. The inclusion of all concepts of TPB may greatly enhance our understanding of this population's intentions to seek mental health services and may provide some indication regarding what other factors need to be examined in future exploration of intentions to seek mental health services. Once there is a comprehensive understanding of factors influencing African American mothers' and youths' intentions to seek mental health services, researchers will be positioned to develop culturally relevant evidence-based assessment instruments and to develop culturally relevant evidence-based interventions to promote African American mothers' and youths' mental health service utilization. Future research should also focus on the congruency of the mother/youth dyads to discern if they report similar linkages among mental health service related expectation, experiences, subjective norm, perceived behavioral control, and intention. Lastly, the comprehensive explorations of the concepts of TPB can provide needed data to inform the development of policies for promoting the utilization of mental health for African American youth and their families. These policies could conceivably be used to address issues related to psychotropic medication and loss of confidentiality.

Implications for Practice and Policy

Because positive expectations are usually linked with positive intentions, health care providers should work to create a therapeutic environment that promotes positive experiences with and expectations about mental health services. Recognizing that African Americans' negative and ambivalent expectations include receiving psychotropic medication and fear of a breach in confidentiality, mental health care providers need to

counter these expectations as a first step in the development of a productive therapeutic relationship. At a public health level, education and public awareness targeting expectations is also likely to have beneficial effects on rates of service use, especially if appropriately targeted to African American families.

Addressing early in the therapeutic relationship the possibility that mothers and youth may have negative or ambivalent expectations about mental health services may help toward promoting mothers' and youths' trust and engagement in the therapeutic process. African American mothers and youth may be especially sensitive to interpersonal cues that providers are not sensitive to their needs, do not listen, or are interested in a "quick fix" (Thompson et al., 2011). Future work should address ways of clearly communicating concern and building relationships with African American families. In addition to training on interpersonal communication, providers may benefit from structures that formally incorporate the input of African American parents and youth, through community consultation (Frazier et al., 2007) or routine opportunities for families to provide feedback (Kovandžić et al., 2011). Community consultation is an innovative structure in which some parents act as consultants, assisting with engagement and guiding service delivery (Frazier et al., 2007). This model, developed in school settings, could be adapted for other modes of service delivery. A structured mechanism for them to provide feedback beyond client satisfaction questionnaires, possibly mediated by community consultants, has the potential to both provide a sense of empowerment and make treatment more effective in meeting client needs. The piloting of such extensions of the model is likely to be a good investment in improving access to mental health services and possibly reducing the disparities noted earlier.

As noted earlier, African Americans often receive mental health services in a coercive context (Chow et al., 2003), and a large number of the mothers in the study had received such services in a child welfare context. In addition to being aware of the concerns around psychotropic medication and confidentiality, special efforts are needed to promote therapeutic alliance in such a context. As has previously been discussed, the quality of services provided in the child welfare context is not consistently high (Bringewatt & Gershoff, 2010; Kerker & Dore, 2006). As well, it is especially important for case workers who make referrals to be clear with themselves and with the families that they serve about the links between the particular problems faced by the families they are serving and the particular goals of recommended or required therapies. In such a coercive context, it is especially important to focus on therapeutic alliance and to not assume that compliance with mandated services represents beneficial engagement with these services.

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Table 1

Mothers' Expectations, Experiences, and Intentions (n=32)

	Positive Expectation	Negative Expectation	Ambivalent Expectation	TOTAL
+ Experience + Intention	11	1		12
+ Experience - Intention				
+ Experience ↔ Intention	2		1	3
- Experience + Intention	1	4	1	6
-Experience -Intention		2	1	3
- Experience ↔ Intention			1	1
↔ Experience + Intention	2		5	7
↔ Experience - Intention				
↔ Experience ↔ Intention				
TOTAL	16 (50.0%)	7 (21.9%)	9 (28.1%)	32

+ = positive

- = negative

↔ = ambivalent

Table 2

Youths' Expectations, Experiences, and Intentions (n=32)

	Positive Expectation	Negative Expectation	Ambivalent Expectation	TOTAL
+ Experience + Intention	9	1	3	13
+ Experience - Intention	3		2	5
+ Experience ↔ Intention	2	1	1	4
- Experience + Intention			1	1
-Experience -Intention		2	3	5
- Experience ↔ Intention			2	2
↔ Experience + Intention			1	1
↔ Experience - Intention				
↔ Experience ↔ Intention		1		1
TOTAL	14 (43.8%)	5 (15.6%)	13 (40.6%)	32

+ = positive

- = negative

↔ = ambivalent