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ORIGINAL PAPER

# Engaging African Americans in Therapy: Integrating a Public Policy and Family Therapy Perspective

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**Abstract** The field of marriage and family therapy faces a growing imperative to reach historically underserved populations. African Americans are a prime example of a minority group in the United States that continues to be underserved by the current mental health system. We integrate Andersen's (1995, *Journal of Health and Social behavior, 36*, 1–10) public policy model of health service use with Fox et al. (1995, *Journal of Health Care for the Poor and Underserved, 6*, 434–468) revision of the rural de facto mental health services model (Regier and Goldberg, 1978, *Archives of General Psychiatry, 35*, 685–693) to develop a more inclusive and culturally sensitive framework that captures salient factors influencing African Americans' entry into and engagement in therapy. Recommendations for overcoming barriers and suggestions for future research are presented.

**Keywords** Engagement · Public policy and family therapy · Racial and ethnic mental health disparities

## Introduction

Differences in the access rates and utilization patterns of mental health treatment are well documented for many minority groups in the United States (Snowden 1999; U.S. Department of Health and Human Services 2001). The former surgeon general, Dr. David Satcher, wrote a comprehensive report on mental health, noting that the needs of minority racial and ethnic groups still remain largely unmet in America (U.S. Department of Health and Human Services 2001). His report, which is still the most up to date and comprehensive, stated that racial and ethnic minorities have less access than Whites to mental health care, they are less likely to receive mental health care when they need it, and when they do receive care, it is more likely to be of poorer quality.

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Researchers from diverse disciplines including medicine, marriage and family therapy, and public policy, have noted that a combination of factors, including contextual, cultural, organizational, and financial, seem to account for why ethnic minority groups continue to be underserved by the current mental health system (Chow et al. 2003; Cooper-Patrick et al. 1999; Snowden and Cheung 1990; Taylor et al. 1989). Although diverse disciplines have explored this important topic, to date there is no clear systemic model that captures most of the relevant socio-cultural variables that influence minority groups' entry into and engagement in mental health treatment from both the patient's and the provider's perspectives.

Before intervention researchers and clinicians can develop effective ways to overcome these barriers to engagement and ultimately improve the quality of mental health treatment for ethnic minority groups in America, a more inclusive and culturally sensitive framework that represents the relevant factors identified in each of these disciplines needs to be developed. A systemic framework could capture more salient parts of the system and the ways in which they are interconnected. Therefore, this paper will focus on contextual factors and the person–environment interaction within the mental health system.

Public policy and mental health scholars who endorse a multicultural perspective have noted the importance of using a more inclusive approach in exploring factors within the individual, the social network, the provider realm, and the larger society to more fully explore the barriers to engagement and retention of ethnic minorities in therapy (Boyd-Franklin 2003; Dana 2002; Lim and Renshaw 2001; Nunez and Robertson 2006; U.S. Department of Health and Human Services 2001; Whaley 2001). Unfortunately, there remains a separation between public policy and mental health researchers, creating a barrier to collaborative clinical research and practice. We need to move towards bridging this schism between fields so that structures in which mental health services are provided will be created at the policy level with the invaluable clinical input from mental health researchers. This collaboration would help to create more feasible, culturally competent, and optimal mental health services that can be provided to all Americans.

The disciplines of both public policy and mental health¸ therefore, are needed to overcome racial and ethnic mental health disparities in America. The field of marriage and family therapy is well suited to help build this collaboration between disciplines with its systemic theoretical perspective and long tradition of shaping and providing family therapy training and treatments in culturally sensitive ways (e.g., Boyd-Franklin 2003; McGoldrick et al. 2005). In keeping with this tradition, we describe a more inclusive and culturally sensitive mental health model that integrates Andersen's (1995) public policy model of health services use (see Fig. 1) and Fox et al. (1995) revision of the rural de facto mental health services model (Regier and Goldberg 1978) (see Fig. 2).

The integrated model (see Fig. 3) more fully conceptualizes the contextual, person–environment interaction, diagnosis, referral to treatment, and outcome variables that influence the engagement and barriers to treatment for historically underserved populations in America (see Fig. 3). Finally, recommendations both for overcoming barriers to engagement and for future research are presented.

## African Americans and the Mental Health System

Since each ethnic minority group has a distinct and unique history, which is beyond the scope of this paper, we focus on a single minority group, African Americans. We define this minority group as American born Blacks who self-identify as African American and who trace their ancestry back to slavery (Billingsley 1999). African Americans are a salient

example of a minority group that continues to be underserved by the current mental health system (Cooper-Patrick et al. 1999). Many African Americans feel uncomfortable with the current mental health system due to a 400 year history of being perceived and treated differently from and inferior to other Americans. According to many scholars, African Americans developed their own cultural guidelines for interacting with the larger society, which includes the mental health care institutions, in order to cope with their perceived social status and often daily experiences of a lack of cultural sensitivity and racial prejudice (Burg and Seeman 1994; Carr Copeland 2005; Cooper-Patrick et al. 1999; Dana 2002).

Although this article with its integrated model (see Fig. 3) focuses on the engagement of African Americans in the current mental health system, we do not want to suggest that alternative forms of support in the African American community might not be more helpful and at times even preferable. Sometimes, family, friends, school, church, and the community may offer better support and more helpful solutions than the current mental health system (Sanders Thompson et al. 2004)

Researchers have noted that African Americans as a group tend to use mental health services inconsistently, in part due to general attitudes about seeking mental health services (Diala et al. 2001; Sanders Thompson et al. 2004). Mental illness in the African American community tends to carry a stigma that may impede engagement in treatment due to a fear of being ostracized and not being accepted (Cooper-Patrick et al. 1999). Additionally, researchers have noted that cultural beliefs may delay engagement in mental health services when there is a need due to a prevalent belief that problems need to be resolved within the family and kinship network as well as the expectation that African Americans' demonstrate strength and not show weakness to outsiders (Sanders Thompson et al. 2004).

Mistrust of mental health providers and a fear of cultural insensitivity from clinicians and clinical researchers have been noted as prevalent attitudes in the African American community (Boyd-Franklin 2003; Carr Copeland 2005; Dana 2002; Whaley 2001). Fears of misdiagnosis, labeling, or of not being fully understood due to inadequate knowledge about African American life are common reasons African Americans have felt they could not trust mental health providers (Dana 2002; Sanders Thompson et al. 2004; Whaley 2001). For example, some issues such as racism, discrimination, community trauma, and daily financial stressors may not be openly discussed due to fears that White therapists would not understand (Sanders Thompson et al. 2004; Whaley 2001).

In addition, there is a more recent legacy of abuses of African Americans by clinical providers and researchers in the Tuskegee syphilis study (Freimuth et al. 2001). This was a clinical study conducted between 1932 and 1972 in Tuskegee, Alabama, where 399 African American sharecroppers were denied treatment for syphilis. This study was conducted without informed consent or proper care, as the participants were not informed of their diagnosis. Many African Americans still remember this injustice and it rightfully adds to their mistrust of mental health providers and clinical researchers. Overall, a lack of trust in mental health providers can make the engagement in therapy difficult for African Americans.

## Prevalence Rates and Mental Health Treatment Utilization

Disparities in mental health treatment utilization are prevalent among ethnic minorities in America (Cheung and Snowden 1990; Chow et al. 2003; Cooper-Patrick et al. 1999; Fox et al. 1999; Hu et al. 1991; Snowden and Cheung 1990). Although ethnic groups differ with regard to their use of Western mental health services, several common themes have been noted, particularly among African Americans, Hispanic Americans, and Asian Americans.

According to the most up to date report (Breslau et al. 2006), African Americans who are living in the community tend to have overall rates of mental illness similar to those of non-Hispanic Whites. Despite this similarity in prevalence of mental health issues, only one-third of all African Americans with a mental illness get mental health treatment when they need it, while two-thirds of non-Hispanic Whites receive mental health care when they need it (U.S. Department of Health and Human Services 2001).

Although nationally representative studies have been conducted in the community to understand racial and ethnic differences regarding the risk of experiencing a mental health issue and engagement in mental health treatment (Breslau et al. 2006), many researchers have noted that these studies under-estimate the prevalence and need for mental health treatment because some ethnic minority groups are over-represented in high need and hard to survey populations (Sue and Chu 2003). For example, even though African Americans only make up 12% of the American population, 40% of people who are homeless are African American, about 50% of people who are incarcerated are African American, and African Americans of all ages are more likely to be victims of serious violent crime as compared to non-Hispanic Whites and thus are more likely to experience trauma (U.S. Department of Health and Human Services 2001).

Hispanic Americans are the fastest growing ethnic minority group in America and, like African Americans, tend to have overall rates of mental illness similar to those of non-Hispanic Whites (U.S. Department of Health and Human Services 2001). Like African Americans, Hispanic Americans tend to mistrust formal mental health services for a variety of reasons, including lack of health insurance, need for Spanish speaking clinicians, and general mistrust of outsiders. Among those who are experiencing a mental health problem, fewer than 10% contact a mental health provider, while less than 20% contact a general health provider for any health-related problems.

Asian Americans comprise about 4% of the US population and are a very diverse ethnic group, representing many different Asian countries (e.g., China, Japan, India, the Phillipines, Korea, Vietnam). Overall, the prevalence rates for mental illness seem to be similar to those of other ethnic groups, but Asian Americans seem to have higher levels of depression than do non-Hispanic Whites. In terms of engaging in mental health services, about half will have difficulty due to not speaking English, about 20% do not have health insurance, and relative to the other ethnic groups, they have very low utilization of mental health services due to cultural stigma and shame.

Disparities in mental health treatment utilization have a variety of causes. Minority racial and ethnic users are less likely than White users to have been referred to mental health treatment by themselves, family members, or friends (Fox et al. 1995; Taylor et al. 1989). Many studies have suggested that there are different paths of access to mental health treatment taken by minority racial and ethnic groups like African Americans (Cooper-Patrick et al. 1999; Fox et al. 1995, 1999; Hu et al. 1991; Padgett et al. 1994; Taylor et al. 1989).

When mental health problems do surface and a decision is made to seek out formal treatment, African Americans appear to rely more on primary practitioners or general medicine as their first entry point into mental health services (Andersen 1995; Cooper-Patrick et al. 1999). This particular ethnic minority group tends to be over-represented in inpatient psychiatric care because they may delay seeking treatment until symptoms become so severe that they need inpatient care (Snowden 1999). Indeed, their rate of utilization of psychiatric inpatient care is about double that of Whites (Snowden and Cheung 1990). Over-representation in inpatient care can be due to a host of factors as there is evidence that primary care physicians tend to misdiagnose mental illness in African Americans. Therefore, a patient might be hospitalized needlessly due to an incorrect

diagnosis, or misdiagnosed and sent home without proper care, which suggests a need for ways to improve culturally sensitive practice by providers (Dana 2002; Fox et al. 1999; Hu et al. 1991; Regier and Goldberg 1978; Whaley 2001).

As previously discussed, parts of two well-known models of health and mental health utilization in the public policy and mental health fields were used to develop a more inclusive and culturally sensitive framework: Andersen's Behavioral Model of Health Service Use (Andersen 1995) and Fox et al. (1995) revision of the rural de facto mental health services model (Regier and Goldberg 1978). Andersen's (1995) behavioral health utilization model (see Fig. 1) was expanded because prior research indicates that primary medical care is typically the first entry point for ethnic minorities, in particular for African Americans who are in need of mental health treatment (Berkman et al. 2000; Chow et al. 2003; Norquist and Regier 1996; Whaley 2001).

## Andersen's Behavioral Model of Health Service Use

Andersen's (1995) behavioral model of health service use, initially developed more than 25 years ago, illustrates a public policy model of how individuals access health services. Over the years this model, in its many revised forms, has been applied to diverse populations seeking medical services. Andersen has altered his model to better describe the essential components of how individuals access health services.

This particular behavioral model of health services (Andersen 1995) begins with *environmental or contextual factors*, for example whether the external environment is rural or urban, along with physical, political and economic variables that might shape the context in which health services are delivered. Then, there is a component labeled *population characteristics*, which is divided into three general areas: *predisposing characteristics*, *enabling resources*, and *need*.

*Predisposing characteristics* refer to demographic variables like age, race, gender, ethnicity, socioeconomic status, and health beliefs that can influence engagement in

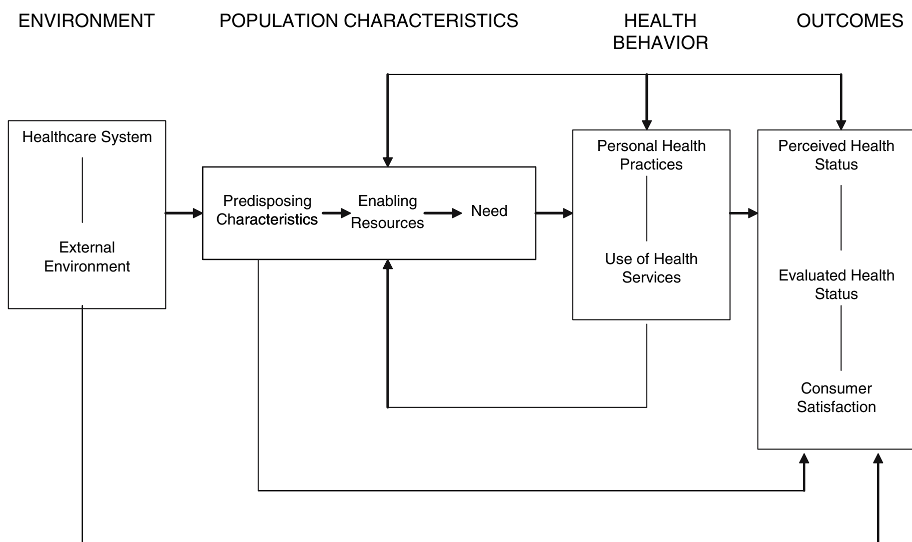


**Fig. 1** Andersen's behavioral model of health service use. Adapted from: Andersen (1995)

healthcare. *Enabling resources* refers to the social networks that can either aid or inhibit access and entry into health care, including family, community, church, health personnel, health insurance, as well as travel and waiting times. Finally, *need* refers to both perceived need by the patient and evaluated need by a health professional.

The next component of the model is *health behavior*, which refers to the personal health practices and use of health services or type, site, and purpose of particular health services. Finally, *outcome*, the last component of the model, refers to perceived health status, evaluated health status by a health professional, and consumer satisfaction. According to Andersen (1995), it is possible to intervene and change both the *health beliefs* of individuals, for example beliefs about engaging in mental health treatment, and *enabling resources*, which refers to adapting an individual's social networks, like mental health personnel, family views, and community or social support. Andersen, however, does not fully explore either the importance of also intervening and changing the provider's view of the patient or promoting cultural competence in delivering services.

Based upon the extant literature, relevant parts of this public policy model (Andersen 1995) were used to develop an integrated model that is more systemic and culturally sensitive (see Fig. 3) to illustrate different ways of accessing mental health services. In particular, the contextual factors or *external environment* (rural/urban; healthcare system; politics; physical; historical; and economics), *predisposing characteristics* (demographic, socioeconomic status, age, race/ethnicity, gender, mental health beliefs), *enabling resources* (family, friends, school, church, criminal justice, employer), and *outcomes* were included in the integrated model (see Fig. 3).

## Rural De Facto Mental Health Services Model

During the 1940's, there was a massive migration from the rural south to northern and western urban areas for economic reasons (e.g., Dana 2002). Social networks were and still are especially important for African Americans living in both rural and urban areas because

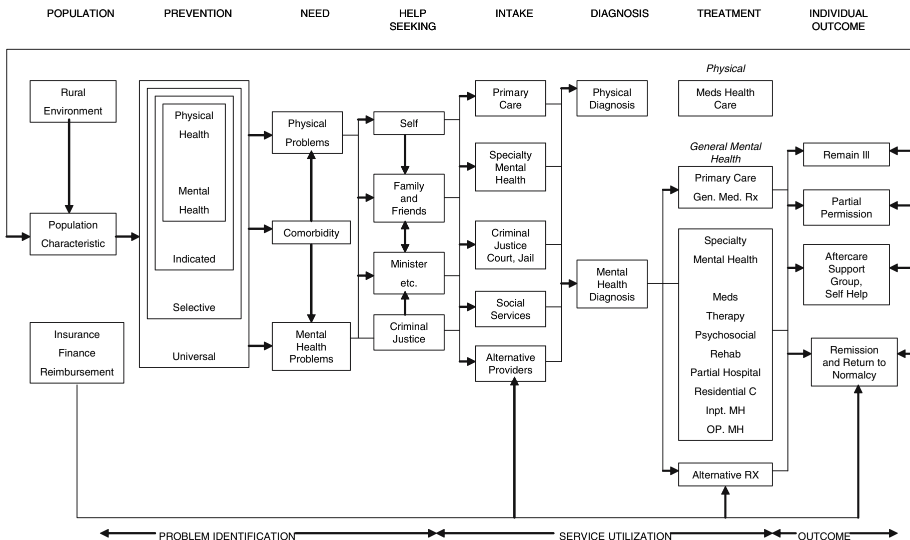


**Fig. 2** Rural De Facto mental health services model. Adapted from: Fox et al. (1995)

of the potential stigma of mental illness. Key constructs from the Rural de facto mental health services model were integrated because of the especially relevant socio-cultural history of African Americans (Fox et al. 1995; Regier and Goldberg 1978).

As noted by Regier et al. (1978) and Fox et al. (1999), African Americans are more likely to seek primary care for a possible mental health issue after *first* relying upon family, church, home remedies, and friends, due to the carry over of beliefs from the rural south about social support networks and mental health issues. This particular model was described first by Regier and his colleagues in 1978, as the *de facto* mental health service system in contrast to a *formal* mental health service system.

The de facto system combines specialty mental health services with general medical services like primary care, nursing home care, ministers, counselors, self-help groups, families, and friends. The salient parts of this mental health model incorporated into our integrated model (see Fig. 3) include: (1) Help seeking variables, or in our model *Local Network* (family, friends, school, church, criminal justice); (2) Intake, or in our model *Entry Point* (primary care, specialty mental health, criminal justice, social services, alternative providers); (3) *Diagnosis* (physical diagnosis, mental diagnosis); (4) *Treatment* (medication, health care, primary care, medication, specialty mental health); and (5) *Outcome*.

## Integrating a Public Policy and Mental Health Model

Each major construct in the integrated heuristic model (Fig. 3) is described below.

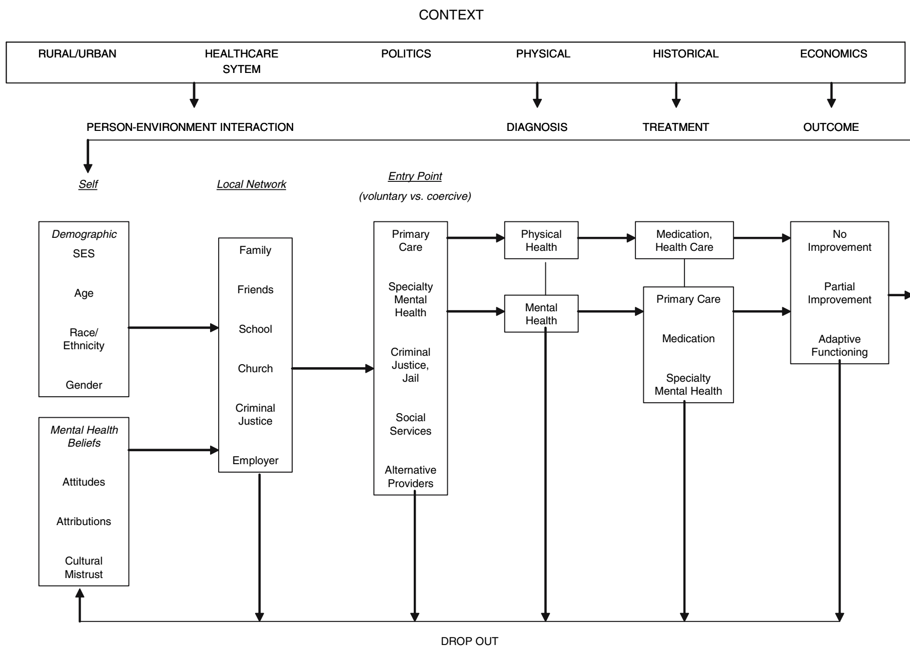


**Fig. 3** Integrated heuristic model: elaborating Andersen's model

## Context

The following contextual variables are depicted in a horizontal box above the integrated heuristic model: *rural/urban; health care system; politics; physical; historical; and economics*. All of these contextual factors can affect the engagement of African Americans in mental health services. For example, the first contextual variable refers to whether it is an *urban* or *rural* area.

While stigma about mental illness and seeking formal treatment is still prevalent in urban as well as rural areas, this is especially the case in smaller rural towns where anonymity is difficult to maintain at mental health clinics (Fox et al. 1999; Gonzalez et al. 2005; Lim and Renshaw 2001). The absence of mental health services and providers who are culturally and racially sensitive has been cited as a major factor in the low rate of mental health seeking in this population (Padgett et al. 1994; Taylor et al. 1989). What is more, many state of the art mental health services are not being delivered in rural areas (Fox et al. 1995, 1999; Regier and Goldberg 1978).

Likewise, the *health care system* and *politics* can influence engagement of African Americans in the current mental health system. Some members of ethnic minority groups do not have health insurance and, therefore, do not have access to mental health treatment in traditional settings (U.S. Department of Health and Human Services 2001). Politics can influence the availability of mental health services in particular areas of the country in terms of advocacy and culturally sensitive mental health services. Similarly the *physical* location of mental health services can influence engagement in services, especially when community mental health centers are located in hard to reach locations for families who do not have a car (U.S. Department of Health and Human Services 2001).

*Historical* influences on engagement in traditional mental health treatment are especially relevant for ethnic and minority groups in the United States. Research documents that many members of minority groups like African Americans fear, or feel ill at ease with the current mental health system (Kurasaki et al. 2000; Lim and Renshaw 2001; Whaley 2001). As noted earlier, mistrust among African Americans may stem from their experiences of segregation, racism, and discrimination in America over their 400 year history (Dana 2002).

Finally, *economics* certainly relate to the historical experiences of ethnic and minority groups in America as reflected in differences in economic, social, and political status, with the most measurable difference relating to income (Hu et al. 1991; Padgett et al. 1994; Regier and Goldberg 1978). Evidence demonstrates that compared with Whites, African Americans have lower incomes, less education, lower rates of private health insurance coverage, and in turn, greater dependence on public health care programs, all of which can impede their ability to obtain timely mental health services (U.S. Department of Health and Human Services 2001).

## Person–Environment Interaction

Social relationships have been found to have a powerful influence on individuals, both negative and positive, in terms of seeking mental health treatment (Berkman et al. 2000; Burg and Seeman 1994). There is, however, no one theory that fully describes the relationship between social networks and engagement in mental health treatment (Norquist and Regier 1996). A better understanding of the effect of social networks, or the *person–environment interaction* construct in our integrated model on mental health decision

making, can make a very important contribution to the design of effective clinical interventions, especially for underserved minority groups like African Americans (Dana 2002; Whaley 2001).

Our integrated public policy and mental health model (see Fig. 3) begins on the far left with the person–environment interaction, which contains three major constructs: *Self* (demographic, or socio-economic status, age, race, ethnicity, gender; mental health beliefs, attitudes, attributions; and cultural mistrust); *Local Network* (family, friends, school, church, criminal justice, and employer); and *Entry Point both voluntary and coercive* (primary care, specialty mental health, criminal justice, jail, social services, and alternate providers).

At any point indicated in our integrated model, individuals may choose to drop out and not seek mental health treatment, as illustrated by the arrows pointing downward throughout the model. According to this model, ethnic minority patients may drop out due to 1) a lack of trust in the mental health establishment and worry that they will not receive culturally sensitive treatments; 2) influence from social relationships; and 3) providers not being trained in an ongoing manner to deliver culturally competent and culturally sensitive mental health services. The major constructs in the person–environment interaction are described briefly below.

## Self

### *Demographic (Socioeconomic Status, Age, Race/Ethnicity, Gender)*

The demographic characteristics of an individual can affect the patterns of engagement in formal mental health systems (Norquist and Regier 1996). For example, older African American adults and younger African American children tend to underutilize outpatient mental health services (Black et al. 1997). African American women tend to seek mental health services more than African American men (Gonzalez et al. 2005). Poverty or lower socio-economic status has been negatively associated with help seeking for mental health problems (e.g., Padgett et al. 1994). Among some ethnic minority groups like African Americans, negative beliefs and cultural mistrust have been found regarding the use of professional mental health services (Dana 2002; Norquist and Regier 1996).

### *Mental Health Beliefs, Attitudes, and Attributions*

African Americans in lower poverty areas tend to attribute mental health problems to religious and other culturally sanctioned beliefs (Billingsley 1999; Dana 2002). They tend to deny the threat of mental illness and strive to overcome mental health problems through self-reliance and determination (Snowden 1999). African Americans’ attitude toward mental illness is one of the many barriers to seeking mental health care. Mental illness retains considerable stigma and seeking treatment is not always encouraged by the local network (U.S. Department of Health and Human Services 2001).

### *Cultural Mistrust*

For many African Americans there is a prevalent belief that mental health providers will not be culturally or racially sensitive (Tidwell 2004; Whaley 2001). Researchers have

suggested that ethnic minority groups, like African Americans, who have historically been subjected to chronic and serious forms of racism will exhibit higher prevalence rates for mental disorders and a mistrust of mental health professionals (e.g., Sue and Chu 2003). Addressing cultural mistrust, therefore, is very important to the facilitation of engagement in mental health treatment for ethnic minority groups with a historical legacy of racism and slavery (Dana 2002; Sue and Chu 2003; Whaley 2001). Additionally, from a systemic perspective it is imperative to incorporate cultural knowledge and culturally sensitive practice into care delivery so that ethnic minority patients feel understood, respected, and valued (Nunez and Robertson 2006).

## Local Network

The local network for African Americans often consists of *family*, *friends*, *school*, and *church*, which all play a very important role in making decisions about seeking help. Overall, members of this population tend to feel more comfortable with support services found in churches, hospital emergency settings, or from their local network than with formal mental health services (Dana 2002). A number of alternative resources, including clergy, physicians, and an informal support network are relied upon *first* or often no help is sought.

The *church* community is an important source of social support for many African Americans (Billingsley 1999; Dana 2002; Tidwell 2004). However, some churches may perpetuate stigma unintentionally. For example, some fundamentalist churches interpret mental illness as an outcome of sinful living that can be resolved through repentance and not through seeking formal mental health services (Cooper-Patrick et al. 1999). Some religious African Americans tend to rely on faith in God to the exclusion of seeking appropriate mental health care. Strongly religious clients are often reluctant to explore their emotions, express anxiety or fear, or acknowledge the need for additional support. There seems to be a fear associated with losing faith or of not being admitted to heaven if they seek out other more worldly assistance.

## Entry Point (Voluntary vs. Coercive)

According to our integrated model (see Fig. 3), there are myriad paths African Americans can take into the mental health system. For example, the local network, which often is comprised of family, friends, school, church, or criminal justice, might encourage an individual to see a primary care doctor or could directly refer that individual to mental health treatment with a therapist. During a primary care visit with a physician, a client might describe psychological symptoms and then be referred to specialty mental health treatment.

Although there are many more paths into mental health treatment (as described in Fig. 3), prior research suggests that *primary medical care* is typically the first entry point for minority groups, in particular for African Americans, who are in need of mental health treatment (Berkman et al. 2000; Chow et al. 2003; Dana 2002; Hu et al. 1991; Norquist and Regier 1996; Whaley 2001). According to Norquist and Regier (1996), approximately 25% of African American patients seen in a primary care practice have a mental health disorder. Therefore, most African Americans who suffer from mental health or addictive disorders do not go to specialty mental health first, but to a primary care doctor

(U.S. Department of Health and Human Services 2001). According to our integrated model clients may enter at any point (see Fig. 3), however, prior research indicates the first point of engagement tends to be *primary care*, then *specialty mental health*, followed by *criminal justice, social services*, and finally *alternative providers.*

After entering primary care, African Americans are more likely than Caucasians to terminate treatment prematurely and drop out before receiving a referral to mental health treatment (Hu et al. 1991). They may be affected by the amount of time spent with their providers, lack of trust, and concerns related to whether or not the provider is African American (Cooper-Patrick et al. 1999). Communication during medical interactions plays a very important role in decision-making, especially relative to remaining in treatment and possibly seeking a mental health referral if recommended by a primary care doctor (Ashton et al. 2003). Indeed, some African American patients who go to their primary care doctor may drop out due to poor communication (Ashton et al. 2003; Berkman et al. 2000; Carr Copeland 2005; Lim and Renshaw 2001).

Medical doctors generally are trained to be more direct and assertive in their communication while collectivist cultures like that of African Americans tend to be more indirect, deferential, and accommodating (Ashton et al. 2003). The race and ethnicity of the doctor and the patient, therefore, can affect the ability to communicate effectively. There may be a mismatch ethnically in styles of communicating, thus preventing the doctor and the patient from negotiating a shared view of health issues, including those related to mental health:

> The gap between patient and provider expectations and communication is not new…patients often want to be heard, understood, and to have physicians understand the larger context of their lives…experts on the working of the human body may be less comfortable addressing aspects of the patient encounter that seem intangible and cannot be measured. (Nunez and Richardson 2006, p. 375)

Given a predicted demographic shift for the United States to be comprised in the 21st century of more minority ethnic groups than ever before, it is of particular importance to develop multicultural education and ongoing clinical training and supervision for health professionals so that the members of both the mental and the physical health professions have the skills needed to meet the needs of an increasingly diverse patient population (Boyd-Franklin 2003; Dana 2002; Lim and Renshaw 2001; Nunez and Robertson 2006; U.S. Department of Health and Human Services 2001; Whaley 2001).

## Diagnosis, Engagement in Treatment, and Outcome

The last three constructs or columns in the integrated model (see Fig. 3) refer to how individuals are *diagnosed*, *treated*, and the *outcome* of a particular treatment. For the purpose of this article, primary medical care will be described since African Americans appear to rely more on primary practitioners or general medicine as the first entry point into mental health services after first going to their local network for support (Andersen 1995; Cooper-Patrick et al. 1999).

### *Diagnosis*

Patients' race and ethnicity can affect the accuracy of how White primary care physicians diagnose mental illness (Carr Copeland 2005; Cheung and Snowden 1990; Cooper-Patrick

et al. 1999; Dana 2002; Padgett et al. 1994). Compared to White patients, African American patients have been under-diagnosed mistakenly with depression and over-diagnosed with schizophrenia (Snowden 1999; Sue and Chu 2003). Other research suggests that African Americans receive poorer care during doctor-patient interaction than do Whites (Kurasaki et al. 2000). African Americans tend to rate visits with their physicians as less participatory than do Whites (Padgett et al. 1994).

Since for African Americans primary care tends to be the first point of entry into mental health care, these trends suggest that many likely will drop out or are misdiagnosed before receiving a referral to appropriate specialty mental health services. Failure to receive outpatient care early during episodes of mental illness can play an important role in the increasing numbers of emergency room visits and inpatient hospital stays for African Americans.

### *Engagement in Treatment*

If an individual is properly diagnosed and does not drop out, he or she should receive an appropriate referral to mental health treatment from the primary care doctor. According to the integrated model he or she could be referred to: *Medication and Health Care; Primary Care; Medication only; or Specialty Mental Health*. Again, at any point an individual may drop out of treatment for a variety of reasons. According to Tidwell (2004), after a referral has been made for mental health treatment there could be structural issues for some ethnic minority patients in terms of making that first appointment. Such issues may include transportation problems, babysitting problems, conflicts with school, lack of or inadequate health insurance, scarcity of providers, and long waiting lists (Carr Copeland 2005; Richardson et al. 2003; Tidwell 2004).

Mental health providers need to be culturally sensitive in their style of engagement with minorities (e.g., Dana 2002; Whaley 2001). Before accepting services, for example, African Americans tend to seek affirmation of a clinician's humility, cultural sensitivity, and lack of prejudice. Dana (2002) suggests that clinicians as well as primary care physicians need to communicate an understanding of the pervasive effects of racism and discrimination in their daily lives to promote trust with ethnic minorities and engage them into mental health services.

### *Outcome*

The last construct in the model refers to the possible outcomes of treatment. An individual may drop out of treatment prematurely, experience *no improvement*, *partial improvement*, or attain optimal outcome or *adaptive functioning* (see Fig. 3). Overall, African Americans seem to respond well to treatment once they engage in mental health services (Snowden 1999), but there is concern about the cultural sensitivity of some of the more evidenced-based treatments that have been developed primarily with Caucasians (Nunez and Robertson 2006). More research needs to be conducted with African Americans to adapt treatments so they are culturally appropriate. Research, however, does suggest that African Americans tend to drop out of formal mental health treatment prematurely (U.S. Department of Health and Human Services 2001). Dr. Satcher observed that, “A history of racism, discrimination, and economic impoverishment can combine with mistrust and fear

to deter minorities from using services and receiving appropriate mental health care" (U.S. Department of Health and Human Services 2001, p. 3).

Poverty, a disinclination to seek help right away, lack of appropriate mental health services and providers who are responsive and culturally sensitive, lack of community or social support to seek help in formal mental health systems, and clinician bias in diagnosis are major contributors to delays by African Americans in seeking mental health treatment until symptoms become so severe that they need inpatient care (Carr Copeland 2005; Dana 2002; Lim and Renshaw 2001; U.S. Department of Health and Human Services 2001). African Americans, therefore, have been found to view mental health services less positively and to underutilize formal systems of mental health treatment in America for a variety of larger systemic issues both within the established mental health system and because of the person–environment interaction as illustrated in our integrated model (see Fig. 3) (Richardson et al. 2003; Snowden 1999).

## Discussion

Our current mental health system in America is not designed to adequately meet the needs of racial and ethnic minority populations. As couple and family therapists and other helping professionals face the growing imperative to reach historically underserved populations, there is a greater need for innovations in the design of mental health treatments that are culturally and racially sensitive and are informed by collaborative research with other disciplines like public policy. Using the integrated model just described to gain a clearer understanding of the different ways in which African Americans and other ethnic minority groups engage in mental health treatment, recommendations for overcoming barriers to engagement can be designed to reach historically underserved populations in America.

According to Andersen (1995), the parts of the health service model that are most open to change include variables from the *person–environment interaction* construct in the integrated model (see Fig. 3). It is, however, equally important to address the larger systemic issues, for example, by intervening and changing the providers' views and ways of engaging ethnic minority patients in order to deliver more culturally sensitive services. Therefore, targeting the following factors in the combined model could be a viable way to improve the engagement of minorities in the current mental health system: *mental health beliefs, attitudes, and attributions, cultural mistrust, engaging the local network, and improving primary care.*

Some factors located in the *self*, or the mental health beliefs, attitudes, attributions, and cultural mistrust, can be targeted by public policy campaigns. For example, a national campaign could be developed that informs African Americans and other racial minority groups about the benefits of mental health care. This effort could utilize multi-media, the internet, television, radio, etc., for conveying information to large groups of people. It might be beneficial to have same-race celebrities speak publicly about the warning signs of different types of mental health issues such as depression, as well as the importance of getting treatment as soon as possible. This type of campaign could be designed to educate African Americans and other racial minority groups about the warning signs and benefits of mental health care (Whaley 2001).

In order to address cultural mistrust, community mental health centers and other therapy providers could have regular open information sessions to address cultural and racial perspectives about mental health issues (Dana 2002). The sessions should focus on the

ability to convey that staff is culturally sensitive, genuine, and approachable. Mental health service providers, from the top down, need to be more aware of the historical and cultural influences on ethnic minority groups like African Americans. Clinicians and primary care practitioners, therefore, need to be better prepared to provide culturally competent care.

## Recommendations for Practitioners and Educators

Providers and graduate schools need to recruit more ethnic minority clinicians to the field in order to be able to provide a better match between therapists and clients. Additionally, ongoing cultural competency training for all clinicians and providers needs to be provided. Diversity in the medical and therapy professions is important in providing quality mental health services and engagement in treatment. Clients who are the same race or ethnic background as their providers report higher levels of satisfaction with their care and greater participation in decisions involving their health (Snowden 1999). Providers and educators also should reach out to the local networks, such as churches and schools. A successful strategy that public policy researchers have utilized is to identify natural helpers in the community whom people trust, and then to train them to give talks on mental health and engage members of the community who might need mental health treatment (Eng and Parker 1993; Eng and Young 1991).

Since primary care is the most common way African Americans and the members of other ethnic minority groups get referred for mental health treatment, medical doctors and clinicians need more ongoing cultural sensitivity training. The field of marriage and family therapy is well suited to partner with other health and mental health providers, like physicians, to conduct cultural competence training and research in this area. This could be accomplished by offering mandatory trainings and ongoing clinical supervision that address the required knowledge, attitudes and skills to recognize, understand, and better manage socio-cultural issues that providers may encounter (Dana 2002; Nunez and Robertson 2006; Whaley 2001).

Use of a culturally acceptable way of delivering services can increase engagement in mental health treatment (Boyd-Franklin 2003; Dana 2002). Medical providers tend to be too task-oriented and impersonal. They need to first establish a level of rapport in order to join with ethnic minority clients, who often do not trust the medical establishment (Richardson et al. 2003; U.S. Department of Health and Human Services 2001; Whaley 2001). Communication during interactions between physicians (or therapists) and clients needs to be improved, especially with racial and ethnic minority clients. According to Ashton et al. (2003), there are four general ways in which physicians and clinicians can improve communication with their ethnic minority clients in terms of engagement: (1) prompt clients to give a fuller narrative of what is occurring in terms of physical and mental health; (2) ask more questions during the narrative to get more detail; (3) express concern; and, (4) encourage clients to be more assertive about the course of treatment.

There is an increasing interest in the integration of family therapy and medicine with more MFT training programs focusing on coursework and clinical experiences in primary care settings (Edwards et al. 2001; McDaniel et al. 1992; Seaburn et al. 1993). A best practice, therefore, might be the integration of mental health care into primary care settings across the country. This would help to reduce the stigma of mental health issues, better reach underserved populations, and provide supports to primary care doctors for earlier screening and treating of mental health issues in culturally competent ways (U.S. Department of Health and Human Services 2001).

The integrated model (see Fig. 3) could be presented and used as a teaching tool for medical practitioners and MFTs in trainings, clinical supervision, and continuing education. Explaining the influence of the local network, mental health beliefs, attitudes, and cultural mistrust would help providers adapt the ways they engage and treat ethnic minorities so culturally sensitive care is more likely to be provided.

## Future Research

Marriage and family therapists (MFTs) need to conduct more research on best practices to help improve the engagement of ethnic minority clients in treatment and support ongoing cultural sensitivity training for providers. More process and outcome research on the optimal ways to integrate cultural competency training into mental health and primary care practice settings can help to improve mental health screening and the earlier treatment of mental health issues in individuals, couples, and families, in particular members of minority groups who tend to go first to their primary care physicians when a mental health issue surfaces.

MFTs need to collaborate with public policy researchers to conduct cutting edge clinical research on best practices with racial and ethnic minority groups. Since the local network of social relationships (e.g., family, friends, church, school) plays a very influential role, both negative and positive, in the seeking of mental health treatment, MFT researchers are well suited to conduct this research collaboratively with public policy professionals. More qualitative and quantitative research needs to be conducted with racial and ethnic minority families, both clinical samples and community samples, looking more closely at mental health beliefs, attitudes, attributions, cultural mistrust, and the existing mental health system in which current services are provided. This might help inform how to best eliminate current disparities in receiving mental health treatment for racial and ethnic minorities in America.

MFTs and other mental health providers provide treatment within a larger mental health system in America with a structure that directly affects the quality and type of treatment. It is recommended that the field of marriage and family therapy actively partner with public policy disciplines to inform that structure as a viable way to make substantial contributions to the goal of reaching historically underserved populations, ultimately reducing and someday eliminating racial and ethnic disparities in mental health treatment.

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