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ABSTRACT

Little is known about African American families' experiences with mental health services. A purposive sample of 40 dyads of African American youth (aged 13 to 19) and their mothers participated in a cross-sectional qualitative research design using semi-structured interviews that elicited information about their past experiences and satisfaction with mental health services. Though rarely received, group and family therapy were perceived favorably. Both mothers and youth reported dissatisfaction centered on medication and lack of professionalism, confidentiality, and concern by providers. The failure of mental health services providers to meet basic standards of quality and professionalism may explain the low rate of service use by African Americans.

Despite an emphasis in public health and mental health services research on access to services among African Americans (Thompson, 2005; USPHS, 2000), little is known about African Americans' experiences and satisfaction with mental health services. This is a crucial prerequisite to efforts to improve the rate at which African Americans use services and their satisfaction with these services (Cauce et al., 2002; Kerkorian, McKay, & Bannon, 2006; Thompson, 2005). Thus, the purpose of the current study was to describe African American youths' and their mothers' perceptions of, and satisfaction with, mental health services for themselves and family members.

Much of information available with regard to African American families' subjective experiences with mental health services comes from a researcher-driven quantitative perspective. In other words, researchers decide what aspects of the service experience to ask about, rather than relying on African American families to identify the most salient aspects of their experiences (Blanchard & Laurie, 2004; Redmond, Galea, & Delva, 2009). In addition, this research usually compares aspects of African Americans' mental health experiences with those of White clients, which may not identify the most relevant aspects of the treatment experience for African Americans (Brown et al., 2010; Neighbors et al., 2007).

With these limitations in mind, these quantitative studies have suggested aspects of experience in treatment that may be important. In terms of modality, African Americans are more likely than other ethnic groups to receive services from school professionals or from physicians, although overall rates are still lower than those for whites (Barker & Adelman, 1994; Barksdale, Azur, & Leaf, 2010; Snowden & Pingitore, 2002). African Americans are more likely than other ethnic groups to have received

emergency, rather than routine, mental health services (Snowden, Catalano, & Shumway, 2009), and to receive referrals for mental health services in coercive contexts such as law enforcement or child protective services (Cusack et al., 2007). Little is known, however, about African Americans' satisfaction with these different modalities..

In terms of patterns of usage, African Americans who receive services typically receive smaller amounts of services than other consumers, and are more likely than other groups to terminate services very early after intake (Harrison, McKay, & Bannon, 2004; Olfson et al., 2009). This may be related to the fact that African Americans are less likely than whites to be satisfied with the services they receive from mental health providers (Olfson et al., 2009; Thurston & Phares, 2008). This appears to be true across a variety of modalities, including care received from physicians (Barlow, Wildman, & Stancin, 2005), psychologists (Redmond et al., 2009), and institutional settings (Cusack et al., 2007). Specific complaints about services among African Americans include: side effects of psychotropic medications (Jaycox, Asarnow, Sherbourne, Rea, LaBorde, & Wells, 2006; Kranke, Floersch, Townsend, & Munson, 2010), disrespect by providers (Blanchard & Laurie, 2004), and poor interpersonal skills of providers (Snowden & Yamada, 2005). Mental health services provided to African Americans are especially likely to fall short of standards of quality, such as wait times, follow-up, and patient safety (Cusack et al., 2007; Kozumi, Rothbard, & Kuno, 2009; Raghavan, Inoue, Ettner, Hamilton, & Landsverk, 2010). In turn, there is some evidence that such indicators of quality and provider behavior predict whether African American families stay in, or return to, treatment (Kerkorian et al., 2006). In a study by Kerkorian and colleagues

(2006), parents who had previously had contact with mental health services for their children and had recently been referred for more services were asked about the nature of these past experiences and their current intentions about seeking services. Parents who had felt disrespected in the past and who felt that providers were substandard were more doubtful about the usefulness of mental health treatment. Beyond this, however, little research has examined the reasons behind decisions to terminate or continue with treatment.

There is also small body of qualitative research on mental health services received by African Americans. This literature focuses on either patients with serious mental illness (Bergner, Leiner, Carter, Franz, Thompson, & Compton, 2008; Biegel, Johnsen, & Shafran, 1997; Gerson et al., 2009; Rose, Mallinson, & Walton-Moss, 2004) or youth with attention-deficit hyperactive disorder (ADHD: DosReis, Mychailyszyn, Myers, & Riley, 2007; Leslie, Plemmons, Monn, & Palinkas, 2007). Some qualitative research has also examined attitudes about treatment among potential patients, such as those with mental health problems who are not receiving treatment (Edge, 2008; 2010; Lindsey, Korr, Broitman, Bone, Green, & Leaf, 2006; Molock, Barksdale, Matlin, Puri, Cammack, & Spann, 2007). Perceptions of providers as being not respectful toward African Americans (Lindsey et al., 2006), ambivalence about the use of psychotropic medication (Ward, Clark, & Heidrich, 2009), and general mistrust of mental health providers (Molock et al., 2007) emerged as important factors in attitudes about treatment. It is also important to distinguish this research from a larger body of research examining expectations and perceptions on the part of African Americans who have not yet received services (e.g., Conner et al., 2010).

Overall, there is a need for more knowledge about the aspects of services associated with African Americans' satisfaction and dissatisfaction with mental health services. The current study was an attempt to address this need by providing a client-driven understanding of African Americans' perceptions of the mental health services they have received and the factors that determine their satisfaction with these services.

Methods

Research Design

A cross-sectional qualitative descriptive research design was used to examine mothers' and youths' experiences with mental health services. This design uses moderately structured open-ended interview questions to allow the collection of both expected and unexpected information from participants. This approach focuses on the presentation of the respondents' perceptions in their everyday language and is thus ideal for providing practitioners and policy makers with information about respondents (Sandelowski, 2002).

Sample

The sample was drawn from the Capella Project (Thompson, 2005), a quantitative study of 245 mother-youth dyads. From infancy through young adulthood, the Capella Project compared the long-term outcomes of youth with child abuse and neglect (60%) with those of youth who had not experienced child abuse and neglect (40%). (Runyan et al., 1998). From families participating in or recently having completed the Capella Project, a purposive sample of 40 dyads with youth between the ages of 13 and 19 was selected for participation in the current study. It is important to highlight that

the Capella Project and the current study had distinct research questions and procedures; the only commonalities were the participants and the location of the research. The selection criteria were: 1) both the mother and youth self-identify as African American; and 2) the mother had reported that she or the participating youth had received mental health services. The sample size of 40 dyads exceeds most recommendations regarding sample size (15 to 30; Lindsey et al., 2006). The youth who were interviewed are referred to as the target youth to distinguish them from other youth members of the family.

Setting

The interviews were conducted at the research offices of the Juvenile Protective Association for 35 dyads or in the participants' home for 5 dyads. The five dyads who were interviewed in their homes were those who had trouble reaching the research offices due to distance or mobility issues.

Measures

Two semi-structured interview guides, the Mother Interview Guide and the Youth Interview Guide, were developed by the researchers to elicit information about mothers' and youths' experiences and satisfaction with mental health services. Experience was defined as any prior interaction with the mental health services that was reported by the mothers and the youth. Satisfaction with mental health services was defined as mothers' and youths' positive or negative evaluation of the services.

Both interview guides covered two topics with probes that allowed a conversational style of interaction with the research participants as proposed by Patton (2002). In this approach, open-ended requests for information permit the participants to

"tell their stories," followed by probes to allow the interviewer to elicit more detailed information. The open-ended requests for information in the Mother Interview Guide were: "Tell me about your experiences with mental health services for you and for your child" and "Tell me about your satisfaction with the services received by you and your family." The open-ended requests for information in the Youth Interview Guide were: "Tell me about your experiences with mental health services", "Tell me about your satisfaction with the services received by you and your family"

To determine the appropriateness of the content, each interview guide was reviewed by experts in qualitative methodology, African American family processes, and adolescent health behavior. In addition, three African American parent-youth dyads were asked to critique the guides for clarity and understandability of questions. Both guides were revised based on these critiques.

Procedure

The study was approved by the Institutional Review Boards (IRBs) of the first and second authors. Written informed consent and permission and written informed assent were obtained from mothers and youth participants, respectively. As part of this process, we explained in detail the distinction between participation in the Capella Project and the current study, and ensured that mothers and youth participants understood that they were volunteering to be in a research project that was separate from both the Capella research project and the clinical services provided by the Juvenile Protective Association.

After the written informed consent and permission and the written informed assent were signed, the mother and the youth participated in separate and

simultaneous interviews that took place in private interview rooms at the research

offices or in two separate rooms at the participants' homes. Using separate rooms for

the interviews allowed for the perspective of each member of the dyad to be elicited

without the influence of the other dyad member and enhanced confidentiality of the

data. These interviews were digitally audiotape recorded and lasted between 16 and 84

minutes for each member of the dyad. The incentive for each mother and youth was

$50.. If they traveled to the research offices, they were reimbursed for transportation

costs.

Data Analysis

After the interviews were transcribed verbatim the transcripts were checked for

accuracy, corrected as needed, and entered into Atlas.ti. All identifying information was

removed from the transcripts. Data were analyzed using the directed qualitative content

analysis described by Hsieh and Shannon (2005). This analytic technique led to a

descriptive summary (Hsieh & Shannon, 2005) of the research participants' experiences

and satisfaction with these experiences.

A code list was developed based on the key concepts from the interview guide:

experiences and satisfaction. Working independently and using the developed code list,

two research team members coded the transcripts and compared the results of their

coding. Differences were discussed and resolved by refining definitions of codes and

code's subcategories. The thematic codes and subcategories were determined by the

frequency for each code and subcategory (Hsieh & Shannon, 2005). Statements by

respondents were included in these analyses if they referred to experiences with mental

health services regardless of whether these statements occurred in response to the

target questions, or were spontaneously made at a different point in the interview, allowing information about experiences with services to emerge over the course of the whole interviews. Data collection and analysis occurred concurrently and when data saturation occurred no more interviews were conducted.

Descriptive statistics were used to analyze demographic data collected through the larger quantitative project. This data included mother and youth age, youth gender, and family income (reported on in $5,000 increments), youth child abuse or neglect history, and reported past history of contact with mental health services

Results

DESCRIPTION OF SAMPLE

The mean age of the mothers in the sample was 41.10 years ($SD = 6.16$) and the mean age of the youth was 15.20 years ($SD = 1.38$). Of the 40 youth, 65.0% (26) were female, and 55.0% (22) had a history of child abuse or neglect. The median family income was between $15,000 and $20,000 per year; 67.5% (27) of participating families had incomes under $20,000.

MOTHERS REPORTING ON SERVICES FOR SELF

Types of Services Received. Over the course of the whole interview, 29 (72.5%) of the 40 mothers reported having received mental health services for themselves. Of these 29 mothers, 24 (82.8%) reported receiving formal individual counseling or therapy from social workers, psychologists, primary care physicians, family doctors, or psychiatrists. Five mothers reported receiving medication only. Of the 24 mothers, 6 (25.0%) reported receiving group therapy and 5 (20.8%) reported family therapy.

Of these 24 mothers who received individual formal counseling, five (20.8%) reported that they had been mandated by court to receive counseling or therapy through the state Department of Child and Family Services (DCFS) as a requirement for the return of their children.

Eleven (45.8%) of the 24 mothers reported having received formal mental health services through drug treatment centers. These services included individual and group sessions as part of drug counseling, inpatient treatment, methadone maintenance, and Narcotics Anonymous.

Satisfaction with Services. Mothers varied in their satisfaction with the mental health services they received. Fourteen of the 29 mothers (48.3%) reported being generally satisfied with the mental health services received. These mothers are exemplified in the following statements:

Talking to them, it kind of helped me out, too, you know because they opened my eyes to some things, too. They didn't just talk to me and try to make me feel like I was just crazy or something. They would talk to me about life, really, you know.

We had groups. We had one-on-one. And everyone, we had to meet one-on-one, and we had group if you don't want to share. It was hard for some people to share at first, I guess in a lot of people's mind. I liked being one-on-one but I didn't have no problem with sharing because all of us was there for the same reasons, you know, and it helped me by doing that.

Six of the 29 mothers (20.7%) reported that they were dissatisfied with the mental health services received. Dissatisfaction was often related to psychotropic medication, as described by these mothers:

And then they [hospital mental health clinic] switched me over to a guy. And he would barely ask anything. He would basically just sit there and write medication. I'm not fond of medication. I don't like taking nothing that's gonna take me out of my mind. I want to stay on my Ps and Qs at all times. Now if you can help me like that, then we can go. But when you start writing down medication, pills, all that, no.

After I had [Youth], the doctor was trying to give me Zoloft, because I was going through depression. … my mom told me not to. She advised me strongly against it. She said that it's not good. She said that whatever it is that's bothering me, all I have to do is sit down and take a look at everything that I'm going through and try and figure out exactly what it is that's bothering me, that's making me depressed, and deal with it, and I don't need medication to help me.

Dissatisfaction was also related to their perceptions of service providers as not being invested or interested in them as indicated in these statements:

I've been wanting to get me another doctor for quite some time but I've been with him so long, I really just hate to change the doctor.…I don't think he is listening. I really don't. 'Cause I'm talking to him, he's writing. I don't know if that's the way he do things or how he operate but I be like, "Are you listening to me?" And he started writing and the next thing I know, he had tear off some sheets and so he

will go, "Get this medicine." I'm a person who likes to ask a lot of questions. So I don't think he be listening.

I didn't like the part of her trying to tell me about me and she don't know me. I didn't like that part. I feel like if I'm coming to you and I'm talking to you about something, how would you know me if you don't listen to me, 'cause you don't know me. You know what I'm saying? You have to get to know me and see what the problems is before you can even make any kind of decisions.

However, 9 of the 29 mothers (39.1%) reported both satisfaction and dissatisfaction with their experiences. This mixture of satisfaction and dissatisfaction was often related to the perception that some, but not all, counselors behaved professionally, as exemplified in the statement below:

My primary counselor… She was real nice. She helped me a lot…. She was just overall sweet person. She wasn't like most of the other counselors on the unit. She had degrees. She had more than the CADC certification. She had a degree in drug treatment. She could actually run the unit. Whatever I needed help with she was just there to help me, you know… she didn't speak harsh to nobody. I heard her scream, or, raise her voice one time…. You know, she was professional, and that stood out. Because there were some of the other counselors, that was there, that had been there longer than her. They wasn't professional….They would blurt out the other clients' or patients' business to other clients, and that's a no-no. They shouldn't do that. It ain't nobody business if a person had HIV.

Mixture of satisfaction and dissatisfaction was also related to disappointment with the lack of comprehensiveness of the counseling received. Two mothers said:

I'm not sure if [Agency] knew about the 14-year abusive relationship that I was in. So all those questions that you just asked me play a huge part in what I was going through. During that time, I know I was depressed. I didn't have to go see a doctor, because I couldn't get out of bed, I couldn't take care of my kids, I couldn't take care of myself. The crying spells were uncontrollable. I didn't have any hope. I needed somebody to talk to. I knew something wasn't right with me. I did receive help from [Agency] and talked to God, of course. But the help I got, it dealt with my feelings towards a lot of the stuff I was going through, being a young mom and having a bunch of kids and being on public aid. But it didn't deal with the actual abuse that I suffered. So I'm still angry about it. The help I've gotten over the years in individual counseling and the family counseling has been beneficial to me and the kids, but not the domestic violence part, because we didn't cover that.

MOTHER REPORTING ON SERVICES FOR FAMILY

Types of Services Received. Among all mothers, 26 (65.0%) reported that family members had received services. Ten mothers (38.5%) reported on services for the target youth, 8 mothers (30.8%) reported on family members other than the target youth, and 8 (30.8%) mothers reported on services both for target youth and other family members. The mental health services mothers reported had been received by family members were individual counseling from school-based and non-school-based venues. Of the mothers reporting that family members had received services, 12

(46.2%) said that a family member received school-based treatment. Eleven mothers (42.3%) reported family members receiving counseling from a non-school-based provider. Three of the mothers (11.5%) reported that family members received both school- and non-school-based services.

Satisfaction with Services. Thirteen of the 26 mothers who reported that a family member had used services (50.0%) reported satisfaction with the mental health services received by their family members. Satisfaction was driven by perceptions of counselors as facilitating concrete changes in family members' problem behavior, and being supportive of the family member. For example:

> Oh, I liked the idea that she [target daughter] opened up to [school counselor]. There wasn't anything I didn't like. Because I like that she opened up and let her know what's going on with her and what's going in her life. And that was good. That was good. That's a way to breathe other than just the family. She could say, sit and have her time and explain to them why she was so angry all the time….And that's what they said, she had did a big turnaround. I mean, at the elementary school they said, "Oh, [Youth] has turned herself around. She is really doing good. She's steadied herself now, she do what she got to do, and she has really did a big turnaround." And she's more into school.

> The counselors are at the school so she'll talk to them about her behavior, because, I don't know, just school and her just don't get along…she said she talks to-- well when I went up there the guy was telling me that he talked to her and he had talked to me too about her behavior… I like it because then I think

he'll probably press some issues to her that she haven't even heard before so hopefully she'll take them in. She took them in, them issues, and she changed a little bit. She changed. She tries to change and so far I haven't been getting a call saying, 'Come up to the school.'

Of the 26 mothers who reported that a family member had used services, 3 mothers (11.5%) reported dissatisfaction with the mental health services received by their family members. This dissatisfaction was generally related to mothers' perceptions that medication was not helpful, as indicated in the following quotes:

They gave her medicine, because when she had ADHD, just writing her out a prescription that just made her be like 100 pounds overweight. And you know I'm exaggerating, but she lost most of it… I think that made her act out a lot more…the weight, because she would always fight- fight or had a attitude because people would call her fat.…Eight or nine, and they had her on Ritalin and everything…She was in school, and then she was having problems at school, beating people up. It was always because they was calling her fat…

It was just like, I don't know, frustrating because no one would like really help me with what I need to be helped with. I mean, like, the medication, for instance. I know she don't need that medication. She didn't need that medication. She probably needs some, but not that one you know, and they all prescribed her the same thing without even, you know, trying to see what was wrong with her so.

Of the 26 mothers who reported that a family member had used services, 10 (38.5%) reported both satisfaction and dissatisfaction with the mental health services

received by their family members. In every case, this was due to mothers being satisfied with a particular service received by one family member, and dissatisfied with another service received. For example, the following two quotes came from the same mother, describing two different services:

> She had a counselor in eighth grade, and she have a counselor now, uh-huh….**.**Counselor in school, uh-huh. She see her I think every Tuesday and Thursdays, pulls her out of class every Tuesday and Thursday I think for like 30 minutes to an hour…she tells her that she can do it, don't never say that she can't. She always can do it, just don't never give up. And that's what I like for her.

> Basically he [psychiatrist] wanted to start medication, but he wasn't actually listening to-- I don't think he was listening to what the situation was actually, because they just be quick to put the kids on medication. And sometimes they really don't need it…. I don't want her like that, because she's already emotional, so I don't want that for her…. I don't think he was hearing me, because he was steady trying to write this prescription for this medication. I'm like, "No, just is there any other way that I can deal with this?" I told him, "If I wanted medication, I could have got it from her. I wouldn't have had to come here." I wanted some type of talk, some type of conversation to help…. I don't want to see him again.

YOUTH REPORTING ON SERVICES FOR SELF

Types of Services Received. Twenty-one of the 40 youth (52.5%) reported having received mental health services. All 21 of these youth reported receiving individual counseling at school. Ten of the 21 youth who reported receiving services

(48%) also received mental health services in other contexts other than the school (e.g., child protective services, psychiatrists, or private counseling).

Satisfaction with Services. Eleven of the 21 (52.4%) youth who reported receiving mental health services reported being satisfied with the services they received, as indicated in the statements below:

> I like going to see her, because it helped me get stuff off my chest. If I don't want to talk about it with nobody else, I can talk about it with her…Like, something's going wrong, there is something at home or school, and I don't want to talk about it to nobody else, I'll just be, like, "I need to go talk to [School Counselor]." And then, I just go in there and talk to her.

> I went to that counseling and my counselor was named [counselor]. Like I would go to her every Wednesday, but I don't know, I haven't been going to her in a while…. And I've been going to her, she like helps me with my problems, and stuff like she'll ask me like different questions and stuff like that. … She was very helpful, because it's like, like when I told you that I realized that I did have a attitude like then I started to feel better because she was like telling me that I didn't have a attitude and that like helped me to strive better to not have one. So it was like, you know, it would make me feel better, stuff like that… It wasn't anything that I didn't like… Like if I told her like what happened like if I were mad at that time that anger didn't come back like if I was talking to her and stuff. Like she was a real calm person like she didn't, you know, wasn't rough or nothing like that…. we didn't only talk about like counseling like, you know, like stuff like if I had an attitude.

Five of the 21 (23.8%) youth who reported receiving services reported dissatisfaction with the mental health services they received. Dissatisfaction was related to medications and the relationship with counselors. Regarding medication, one youth said:

So they thought I was depressed, and then they put me on, like, several different medications. But for like-- they put me on two at a time, though. Like I was on two medications, but then they switched one of them so I was on a different one. Then they switched both of them. And then they-- I finally was like, "I'm not taking these no more," you know? So they thought I was depressed. It wasn't depression. It was just anger management problems, whatever. But the pills were making me like a zombie. I was gaining a lot of weight. I was tired all the time. So it really wasn't doing anything but making me tired.

Dissatisfaction with the counselor is indicated in the following quotes:

Well there was a counselor at a program I was in and I was supposed to be going, but I stopped going on my own…It was at a, like, after school program and she was a counselor and I just stopped going…We all went to the interview and we had set dates for me to go there every Monday to see her. It was going good until she started getting personal.… we started talking about my family and she wanted to go way back into time somewhere and it just got too personal… Questions like have I ever been molested and stuff like that…Because I didn't want to talk about it….I answered her questions but I never went back."

I started going to [Agency] with this woman. She just graduated from college or something like that. She wasn't too good. She didn't understand what I was talking about. Every time I asked her about some things, she'll say she don't know…. I was running away. She [mother] decided to put me talking to a social worker. I did that, because my best friend, she's in DCFS. She told me to go. It could be nice, so I went. I didn't like it, maybe because of the person who was talking to me, because she really didn't hear what I was saying. She just wanted me to tell her that my mom was on drugs and so she can go back and tell somebody else. But I'm not stupid. Why would I tell you some stuff like that, if it's not true?

Of the youth who reported receiving services, 5 (23.8%) reported both satisfaction and dissatisfaction with the services they received. This mixture was sometimes related to ambivalence about the motivations of the provider. One youth said:

We [youth and school counselor] were talking about why my grades were so bad. And pretty much I wasn't doing the work 'cause the work was hard…. I actually listened to him….Because he said he would help me…I thought he was cute. …He was trying to talk to me about my family and stuff but I really didn't want to because he was white….I always thought Caucasian people were stuck up…You don't talk about your personal problems; it just would've been uncomfortable…. He asked me if I wanted to talk about it and I was like, "No," and he left it alone… I thought he either cared or he was just nosey…I don't think he should've been asking… I guess since he's the counselor, he's kind of supposed to.

Mixture of satisfaction and dissatisfaction was also related to partial relief of the youth's presenting problem. One youth said:

> Sometimes she [school counselor] would care, but sometimes she doesn't. What I like about her is that she cares about people who has feelings…. There was one time I was like really, really fed up with somebody at my school. When I get real mad, I start crying. So I went to her office and she started talking to me and calming me down. That's why I said she care about people who has feelings…. Sometimes she doesn't because she'd be busy or she's don't be busy….Like, when she talked to me, it only helped me half the way. It only helped me half. It only took care of half of what I am feeling when I'm feeling like I want to do something negative. When she's talked to me, she only helped 50% of the negative thing that I still want to do.

Finally, mixture of satisfaction and dissatisfaction was related to feeling shame about the need for services. One youth said:

> Adderall and Abilify…. I think I started taking them when I was in 6th grade.…It helps me to stay calm most of the time, except when the medicines start wearing off.… I don't like it…. It makes me feel like I'm crazy….Other people in my class can control theyselves by theyselves. I can't, I've got to take medicine.

Only three (7.5%) youth reported on services received by family members, while 37 (92.5%) did not. The three youth who reported on services received by family members mentioned siblings and/or cousins. Youth did not report on family members' satisfaction with these services.

Discussion

The participating youth and mothers provided a great deal of information about their experiences with mental health services, most of which focused on individual formal mental health counseling. A little less than half of the mothers and a little more than half the youth reported being satisfied with the mental health services they received. This is a higher rate of satisfaction than that suggested by a large body of research highlighting a variety of complaints African Americans have with mental health services (Lindsey et al., 2006; Whitley, Kirmayer, & Groleau, 2006).

Group and family therapy, although received by only a few of the youth and mothers in our sample, was very positively regarded overall by both mothers and youth. There is some research suggesting the benefits of group therapy and several recent attempts to produce culturally sensitive interventions for African Americans have focused on family and/or group modalities (Breland-Noble, Bell, & Nicolas, 2006). The current study suggests that such modalities are likely to be well-received, if administered with appropriate interpersonal skill and professionalism.

Consistent with previous research on attitudes toward psychotropic medication among African Americans more generally (Jaycox et al., 2006; Kranke et al., 2010; Snowden & Pingitore, 2002), most of the respondents reported dissatisfaction with medication. Similar to other research (dosReis et al., 2007; Edge, 2008), there were concerns about side effects reported by both mothers and youth. Participants often viewed medication as a "shortcut" on the part of the service provider; a way of providing nominal help without fully investing in the patient's well-being. This latter concern was most frequently voiced by mothers with regard to the medication received by their

children. Thus, even among respondents who had received mental health services, there was a great deal of discomfort with psychotropic medication.

The likelihood of receiving treatment in modalities that are less likely to be accepted (such a psychotropic medication) may also help in understanding the very low rates of service use among African Americans. Although mental health needs often go unmet (USPHS, 2000), the rates of service use among African Americans are particularly low (Thompson, 2005). Potential explanations for low rates of service utilization among African Americans include: concerns about relevance (Draucker, 2005), stigmatizing attitudes about mental health problems (Thompson, Bazile, & Akbar, 2004), and preference for informal services (Wu et al., 2001). There was little discussion of these issues by our participants, although several voiced concerns about institutional stigma. Preference for informal services and concerns about relevance may underlie some of the concerns about medications that our respondents reported.

Unprofessional or poor quality treatment of African Americans has also been proposed as an explanation for racial disparities in mental health service utilization (Blanchard & Laurie, 2004; Cauce et al., 2002; Kerkorian, 2003; Thompson, 2005). Among the respondents who were dissatisfied with the services they or their family members or acquaintances had received, professionalism was a prominent concern. As well, participants frequently cited a lack of respect, interpersonal skills, or interest on the part of providers. This is also consistent with previous quantitative (Kerkorian et al., 2006; Snowden & Yamada, 2005) and qualitative research (Chang & Berk, 2009). As recently noted by Mulvaney-Dey and colleagues (Mulvaney-Day, Earl, Diaz-Linhart, & Alegria, 2011), African American patients are particularly sensitive to providers' listening

skills. The appearance of unprofessional or disrespectful attitudes on the part of providers may be a key barrier to full engagement in treatment. Professionalism and respect were also key factors for the participants who reported satisfaction with services. This suggests that perceptions of professionalism and of respect are key drivers of African Americans' satisfaction with the mental health services they receive.

Recent research by Raghavan and colleagues has found that most mental health services fall short of minimal standards of quality (Raghavan et al., 2010); this is especially true of services provided to African Americans (Koizumi et al., 2009). Efforts to improve the uptake of mental health services by African Americans should focus, at least in part, on ensuring that basic standards of quality and professionalism are met (Larrison, Schoppelrey, Hadley-Ives, & Ackerson, 2008). From this perspective, a key component of treatment success is not the specific nature of the therapy offered, but these "common factors" of success: good interpersonal skills and communication of respect and caring (Blatt & Zuroff, 2005; Tracey, Lichtenberg, Goodyear, Claiborn, & Wampold, 2003).

Although previous research has suggested that African American parents tend to be more satisfied with mental health services than are youth (Copeland, Koeske, & Greeno, 2004), we observed no substantial differences in satisfaction with mental health services between mothers and youth in this sample. There was also broad agreement about the rates of services received by youth. However, one striking contrast between mothers and youth in this study was the difference in the rate at which they discussed services received by family members. Sixteen mothers reported on services received by family members that were not reported by the target youth. Other studies have also

found discrepancies between parent and youth reports in terms of exposure to violence (Lewis et al., 2010; Thompson et al., 2007), and youth psychiatric symptoms (Hawley & Weisz, 2003; Thompson et al., 2006). This discrepancy may also reflect that family members may not talk openly about mental health issues, especially with minors, or that parents, not youth, are responsible for mental health care of other family members. More research is needed to discern the degree to which youth are aware of mental health issues and mental health services in the family, what factors including stigma may underlie the lack of this awareness, and at what age youth might learn about the mental health issues of family and extended family members.

A central limitation of the study relates to the sample, which was primarily low-income and came from an urban center. African American culture is by no means a monolith (Robinson, 2010), and as such, the results may not be applicable to all African Americans. Although not a limitation, it is important to keep in mind that this research focused on those who had received services, not on attitudes among those not receiving services. As well, a large portion of the families in the study had a history of reported child abuse or neglect, which is a key avenue through which mental health services often occur (Lyons & Rogers, 2004).

In any case, the findings highlight the need to consider the quality of mental health services received by African Americans. Because African Americans as a whole have access to lower quality mental health services than do other groups (Blanchard & Laurie, 2004; USPHS, 2000), it is essential that mental health care providers ensure that mental health services include a fundamental level of quality, professionalism and respect. Additionally mental health care providers should be cognizant that African

American are not overwhelmingly satisfied with the mental health services they received and that the primary reason for this dissatisfaction was prescribed medication. Mental health care providers should understand that African Americans do not view psychotropic medications in a positive light, especially from health care providers who do not demonstrate an interest in the patient's well-being. Mental health care providers should taking the time to develop a trusting relationship with the patient, to get to know the patient, to listen attentively to the patient, to show genuine respect to the patient, and to develop a treatment plan that includes both psychotherapy and prescribed medication and a rationale for both treatment modalities. These steps may promote the patient's acceptance of prescribed medication, and can also help the course of psychosocial interventions..

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