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Barriers to Treatment for Socially Anxious Black American Students in Urban Public Schools

Grace Martin

Abstract

Social anxiety is frequent and debilitating for Black adolescents with associated

impairment (La Greca & Stone, 1993; Stein & Kean, 2000; Van Ameringen et al., 2003). Despite

its prevalence and severity, Black adolescents are less likely to seek mental health treatment due

to systemic and social barriers such as accessibility and social stigma (Bains, 2014; Lindsey et al.,

2006; Lindsey et al., 2013). Barriers to seeking treatment, particularly for socially anxious Black

adolescents, are mostly absent in the literature and thus require investigation. To understand

culturally specific factors related to social anxiety symptoms as well as to investigate perceived

barriers to seeking treatment, interviews were conducted at an urban public high school in the

northeastern United States with seven Black adolescents ages 15 to 18 years old. Questions

included perceptions of social anxiety, treatment barriers, and school-based treatment

components in relation to their racial/ethnic background. Thematic analysis was used to devise a

coding scheme and capture the relevant experiences of students. Results indicated that all

participants had experienced or could identify cognitive and behavioral symptoms of social

anxiety, with reports of racism and social norms as culturally distinct contributors to social

anxiety symptoms. Barriers to seeking treatment included stigma and judgment, speaking about

issues with others, perceived effectiveness of treatment, and caregiver obstacles. We propose an

anti-stigma approach for practitioners to address racism and social stigma. Moreover, creating an

open and safe environment, explicitly noting the benefits of treatment, and providing

psychoeducational or joint sessions with caregivers of Black adolescents are warranted.

Keywords: social anxiety, Black adolescents, barriers to treatment, psychology

MONTCLAIR STATE UNIVERSITY

Barriers to Treatment for Socially Anxious Black American Students in Urban Public Schools

by

Grace Martin

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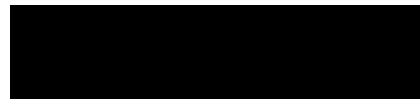In Partial Fulfillment of the Requirements

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BARRIERS TO TREATMENT FOR SOCIALLY ANXIOUS BLACK AMERICAN

STUDENTS IN URBAN PUBLIC SCHOOLS

A THESIS

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Introduction

Social anxiety disorder (SAD) is a mental health diagnosis characterized by an intense

fear of negative evaluation and social situations (La Greca & Stone, 1993). Those with SAD

often display behavioral symptoms, such as avoiding social and performance situations.

Moreover, individuals may experience psychological, and sometimes physical, distress when

introduced to these situations (La Greca & Stone, 1993). Social anxiety has a worldwide

prevalence rate of around 8% among children and adolescents (Merikangas et al., 2009).

Recently, this number has surged, displaying a significant increase during the pandemic with

29.5% of youth reporting clinically elevated levels of social anxiety symptoms (Hawes et al.,

2021). Social anxiety also has been known to impair quality of life. For example, youth with

elevated levels of social anxiety are more likely to indicate life dissatisfaction (Stein & Kean,

2000; Van Ameringen et al., 2003).

Academic performance is a particular concern for those with a social anxiety diagnosis as

they are more likely to obtain a failing grade and drop out of high school compared to those

without a clinical diagnosis (Stein & Kean, 2000). Socially anxious youth also tend to perform

poorly in social situations, such as speaking fewer words in response to prompts and

experiencing slower speech response latency, as compared to their non-anxious peers. Moreover,

their poor performance then fosters negative social reactions from peers (Spence & Rapee, 2016).

Among school-refusing adolescents, those with social anxiety disorder are most likely to meet

diagnostic criteria after treatment compared to other anxiety disorders, demonstrating social

anxiety as particularly resistant to treatment (Heyne et al., 2011). Given the prevalence and

impairment of socially anxious individuals and treatment's inconsistent success, it is especially

important to intervene to reduce social anxiety symptoms.

When observing racial differences, lower social anxiety disorder prevalence rates are

reported for Black Americans as compared to White Americans. However, it is important to note

that social anxiety disorder in Black Americans typically persists at a higher severity and is

associated with increased functional impairment (Himle et al., 2009). Age is also necessary to

take into account when examining racial differences in social anxiety as higher rates of anxiety

disorders are observed for Black adolescents compared to White adolescents (Merikangas et al.,

2010). To understand the current increased severity and prevalence of social anxiety among

adolescents, it is important to consider the unique experiences of Black Americans, such as

discrimination.

The American Psychiatric Association (2006) officially noted the harmful effects of

discrimination on mental health in their 2006 position statement, calling clinicians and

researchers to be mindful of such impacts on mental health interventions and clinical interactions.

Although Black Americans' rates of mental illness are no higher than White Americans, Black

Americans are overrepresented in high-need populations due to incarceration and confinement to

mental institutions resulting from various systemic barriers such as legal involvement, coercion,

poverty, and homelessness (Snowden, 2001; Takeuchi & Cheung, 1998). In fact, Black

Americans' higher rates of poverty, resulting in increased use of Medicaid, was correlated to

higher hospitalization rates due to mental health issues, as opposed to rates of those insured

privately (Freiman et al., 1994). This overrepresentation has constituted a distrust of mental

health services, and thus Black Americans are less likely to voluntarily seek outpatient mental

health treatment (Hines-Martin et al., 2003; Snowden, 2001). As discussed, systemic

barriers to mental health treatment among Black individuals are rooted in historical structural

experiences, such as racism and discrimination, and are difficult to ameliorate in the treatment-

seeking process.

Negative experiences Black individuals face, such as racism, are often contributors to

social anxiety. Kline et al. (2021) observed a unique positive association between internalized

racism and social anxiety symptoms among 182 Black university students. Here,

microaggressions against Black students were identified as a predictor for elevated concerns

about negative evaluation, specifically the internalization of negative stereotypes among their

racial group. Negative evaluation of oneself (e.g., the internalization of negative stereotypes) is a

key component in the expression of social anxiety and thus was found as a predictor for social

anxiety symptoms in Black university students. Similar elevated concerns of negative evaluation

are seen in Black adolescents, as 31 Black female high school students felt elevated anxiety

surrounding their experiences of the acting White accusation, in which they are accused of not

acting "Black" enough (i.e., "you are acting White;" Davis et al. 2018). This research reported

higher social anxiety symptoms for female Black high school students as they attributed this

interaction to bullying (i.e., negative evaluation; Davis et al., 2018). Further, this study displayed

that awareness of racism and cultural mistrust is a key indicator for the presence of social anxiety

symptoms in Black Americans as they bear the added concern of negative evaluation from

members of both similar and different racial groups. Thus, Black individuals' psychological

processing of these negative social experiences contributes to higher socially anxious symptoms,

following the Hunter & Schmidt, 2010 model of anxiety psychopathology. Seeing as social

anxiety is defined by the fear of negative evaluation and that Black adolescents carry the added

concern of others' negative evaluation emanating from racism, intervention approaches to

address racism's effects on Black experiences are required.

Distrust of mental health services further complicates and impairs access to treatment for

adolescents. In a qualitative investigation conducted by Jon-Ubabuco & Dimmitt Champion

(2019), researchers observed that caregivers' past experiences with mental health services greatly

influenced their motivations to seek treatment for their child. Specifically, their reluctance

spanned across outpatient and school-based treatment for their adolescent due to stigma and

cultural mistrust. Further, caregiver perceptions are observed to be transgenerationally reflected

in adolescents' trust and belief in the effectiveness of mental health systems (Bains, 2014). As

synthesized by Bains, (2014), it was indicated that many teens acquired this perspective from

their family due to the vulnerable developmental period of adolescence. Historical experiences of

discrimination are still actively a barrier to seeking treatment for Black youth, as indicated by

their pervasiveness through family generations. Therefore, assessment of caregiver's opinions of

mental health services is warranted when assessing barriers for Black students.

Effective treatments for social anxiety for both adults and youth often include forms of

Cognitive Behavioral Therapy (CBT), including components such as exposure therapy, cognitive

restructuring, social skills training, and teaching applied relaxation techniques. CBT treatments

have also been shown to be effective when adapted for youth and group settings (Kerns et al.,

2013; Rodebaugh et al., 2004). However, there are gaps in the literature for addressing social

anxiety in Black adolescents. The lack of social anxiety intervention research among Black

adolescents may be due to a reluctance to seek treatment (Lindsey et al., 2006; Lindsey et al.,

2013). Lindsey and colleagues' research identified that Black adolescents experience barriers

related to family and peer stigma (e.g., bullying) and to feelings of "weakness" when unable to

handle mental distress individually (Lindsey et al., 2006; Lindsey et al., 2013). These perceptions

of stigma stem from the unique world views of Black adolescents and from social normative

influence within their network (e.g., friends, school climate, and community; Lindsey et al.,

2013).

Other barriers observed were clinician and therapeutic factors such as the counselor's

race or gender and the availability of mental health resources in their area (Planey et al., 2019;

Lindsey et al. 2013). Rather than seeking help, many Black adolescents will either isolate

themselves (i.e., handle on their own) or seek guidance from their family for depressive

symptoms. This help-seeking avoidance, in some cases, is due to distrust of mental health

services or perceptions that it is ineffective (Lindsey et al., 2013; Lindsey et al., 2020). Barriers

for Black adolescents have only been thoroughly examined by a few studies for general mental

health help-seeking. Most studies focus on general youth or on general communities of color as

indicated by the Planey et al. (2019) meta-analytic review. In their examination of barriers and

facilitators for Black youth aged 15 and under, they found that barriers are embedded in

availability concerns, stigma concerns, and caregivers' negative perceptions of help-seeking.

Planey et al. (2019) also denote that studies on barriers and facilitators for Black adolescents are

lacking in the literature as few researchers assess Black adolescents exclusively. For example,

the unique treatment barriers for Black male adolescents experiencing depression have only been

thoroughly assessed by Lindsey and colleagues, while barriers for Black adolescents

experiencing social anxiety symptoms are absent in the literature. This gap warrants an

exploration of the barriers to treatment, specifically for socially anxious Black youth.

Other valid treatments for social anxiety target prevention and intervention with CBT-

based programs in school-based settings (Scaini et al., 2016). In fact, some typical barriers to

treatment such as accessibility (e.g., transportation and location), cost, and stigma are partially

ameliorated in school-based treatment settings (Illback et al., 1997; Weist, 1999). When targeting

general anxiety, the most established school-based intervention and prevention programs seem to

be robustly effective and are shown to decrease anxiety symptoms (Neil & Christensen, 2009).

Moreover, school-based settings may be particularly effective given a major hurdle for youth is

that their most feared scenarios often occur in school-based settings (Masia Warner et al., 2016).

Few intervention studies have addressed social anxiety directly aside from Skills for

Academic and Social Success (SASS), a school-based group cognitive-behavioral intervention

developed and evaluated by Masia Warner and colleagues (Masia Warner et al., 2005; Masia

Warner et al., 2007). The SASS intervention emphasizes cognitive reappraisal, social skills

training, engaging in social situations at school, and in-vivo exposure outside school sessions.

Twelve 40-minute group sessions are provided and two individual sessions are provided weekly,

and caregivers may attend two psychoeducation sessions. SASS has shown efficacy in the

reduction of social anxiety symptoms when administered by psychologists as well as school

counselors and shows valid replication outcomes (Masia Warner et al., 2016; Mychailyszyn,

2017). However, a limitation is that, similar to many other interventions, it has primarily been

assessed for White students living in suburban neighborhoods among relatively small samples.

Although school-based intervention is notably effective and addresses many barriers to

seeking treatment in comparison to clinical settings, there are distinctive barriers to school

settings. Previous literature has indicated general barriers to school-based interventions include

obtaining parental consent for their child to receive treatment, adolescent confidentiality,

scheduling conflicts, effectiveness concerns, and adolescent general comfortability speaking in a

group setting (Girio-Herrera et al., 2019; Weist, 1999). These concerns are expected to be

brought up in our current study and give further justification to investigating barriers to the

SASS intervention. Additionally, considering that school-based intervention barriers for this

population have scarcely been investigated, we expect additional barriers to be reported

exclusively for Black youth experiencing social anxiety.

Current Study

We aimed (1) to assess symptoms of social anxiety specific to Black adolescents; (2) to observe the treatment needs and barriers for socially anxious Black high school students in urban schools to better understand the cultural, school, and community context of Black students in urban schools; and (3) to understand recommendations given from Black high school students for making evidence-based intervention techniques more culturally sensitive and welcoming. We hypothesized that barriers related to confidentiality, perceived treatment effectiveness, speaking to peers, and students' fear of negative evaluation due to judgment and discrimination will be highly prevalent. Given the importance of addressing social anxiety in Black youth, this information is useful for adapting future interventions geared toward alleviating social anxiety in schools or other community settings. Ultimately, data for this study are part of a larger data collection process to inform student uptake efforts and intervention adaptation and implementation for SASS.

Method

Participants

Participants included seven Black adolescents from urban public schools in the United States who were recommended by school personnel. Recommendations were based on the school

staff's perception of the students being especially nervous or shy as compared to other students.

As indicated by the Screen for Child Anxiety Related Disorders (SCARED), students mean score

were above the clinical cut off for social anxiety symptoms ($M = 9.43$, $SD = 2.82$). One out of

the seven adolescents identified as Latinx and one out of seven checked "prefer not to answer".

Participants included one male and six females in the 9th (n = 1), 10th ($n = 2$), 11th ($n = 3$) and

12th (n = 1) grades. Their mean age was 16.43 (SD = 1.13; range = 15 to 18 years).

Measures

Demographic Questionnaire

A demographic questionnaire was administered to the participants in order to evaluate

demographic characteristics such as age, gender, and race. This measure also included questions

about school involvement, such as extracurricular activities or absence from school, and social

interactions, such as the amount of time spent with friends and how many friends they have.

Classroom experiences were also recorded with questions about their level of interaction with

their teacher and their level of class participation.

Semi-structured Student Interview Guide

The research team developed a semi-structured individual interview measure lasting around 30 minutes. The interview assessed students' opinions of social anxiety and of different mental health school-based treatment components in relation to their racial/ethnic background based on Lindsey's Making Connections Intervention (MCI) guide (Lindsey et al. 2009). Questions regarding student views of social anxiety, barriers to school intervention in their communities, and cultural views of anxiety and mental health services were used. First, researchers asked students' opinions on general mental health treatment for social anxiety such as, "Do you feel that a group program designed to support very shy or nervous teens would be helpful?" Second, researchers asked further questions pertaining to the participants' experiences of racial discrimination and microaggressions, as well as how cultural factors impact social anxiety symptoms and help-seeking behavior, such as "What types of things do Black students face that are different from what other students face?" Lastly, questions pertaining to specific components of the SASS intervention were asked, such as asking students' opinions on implementing a fear hierarchy: "Do you feel that facing situations they fear would be helpful? If so, what might you include that would be helpful specifically for Black and Brown students?"

Screen for Child Anxiety Related Disorders (SCARED)

The Screen for Child Anxiety Related Disorders (SCARED) is a self-report instrument

used to screen for childhood anxiety disorders (Birmaher et al., 1997). This study utilized the

social anxiety subscale and generalized anxiety subscale of this measure, which consist of seven

social anxiety items and 22 generalized anxiety items such as "It is hard for me to talk with

people I don't know well" and "I worry about being as good as other kids." Participants rated

items on a scale of 0: "Not true", 1: "Somewhat True" and 2: "Very True." Items are summed for

each subscale. This score is referenced to the cut-off score which may indicate the presence of a

clinical disorder. A score higher than eight on the social anxiety scale indicates a potential social

anxiety disorder. Evidence indicates that the SCARED has adequate reliability and validity

(Birmaher et al., 1999; Muris et al., 2002).

Procedures

Emails were sent from the school principal or from the school mailing list to

caregivers/parents based on school staff recommendations. The emails contained a cover letter

and study consent links. Interested students' contact information was then relayed to the research

team for outreach to provide further information about the study. Consent from caregivers was

initially provided electronically in Qualtrics from nine Black American high school students'

parents/guardians. Assent forms were reviewed with students in person, and students signed a

hard copy or an electronic assent form on Qualtrics. Of those nine students, seven provided

assent and participated in the interviews. One student did not participate/provide assent due to

absence, and one student did not participate as they had been suspended on the day of the

interviews.

Students then completed a demographic measure and the SCARED in order to obtain

descriptive information about the participants prior to the interview. Measures completed by

students were not used for screening or exclusionary criteria as participation was based on school

personnel recommendations exclusively. In-depth interviews with students were conducted in

person by our team of researchers for an average of 32 minutes (range = 22 – 44 minutes).

Interviews were recorded for later transcription. Each student received a $50 Amazon gift card at

the end of the interview.

Qualitative Data Analysis

Data were analyzed using thematic analysis procedures to identify themes among

participants interviews. Following a process recommended by Braun and Clark (2006), core

features discussed by participants (e.g., negative experiences related to social anxiety) were

identified and defined as analytic themes by an initial team of two coders. Specific aspects

related to the analytic theme were then assigned subcodes. For example, a recent racist encounter

described by a participant was organized into the "Negative experiences related to social

anxiety" theme and given the "Racism" subcode. The coding scheme aimed to reflect the

students' understanding of social anxiety and its contributors within their culture, barriers to

seeking mental health, and their opinions/recommendations on features of our proposed

intervention.

The initial team of coders individually assigned a theme and/or subcode to each relevant

segment and then met to discuss discrepancies and come to a consensus on each code. Additional

analytic coding with this scheme of two transcripts by a set of two novel coders was conducted.

Secondary coders presented additional discrepancies, and all coders then met to analyze

discrepancies and refine definitions. Changes to the coding scheme involved tightening the

definitions of themes related to specific intervention components by elaborating which examples

students may provide to reflect a given theme. For example, examples such as "when a student

provides feedback on starting conversations" or "finding a good time to start a conversation"

were added to the definition for the theme of assessing students' feelings about the social skills

training. Using the updated coding scheme, secondary coders then coded the next transcription as training for the new scheme, followed by coding three additional transcriptions while continuing to meet as a team to discuss discrepancies. First and secondary coders came to a consensus on each interview, resulting in a final consensus among the whole coding team.

The tagged text assigned to codes and subcodes was organized and examined in the context of our particular analytic themes. This informed whether there was consensus or divergence in the opinions of participants. For instance, do all students agree that a barrier to help-seeking is a fear of negative outcomes? Understanding the differences between participants informed tailoring the intervention in ways that will maximize uptake and retention. Our analysis was embedded in the students' sociocultural worldviews and experiences, specifically with insights into Black students' anxiety levels, help-seeking barriers, opinions on mental health treatment, and recommendations. Our data provided insight into how the SASS intervention may be adapted for this population.

Results

The core themes identified from the interviews with representative student quotes reflecting the main essence of each theme are presented in Table 1.

A. Social Anxiety Symptoms

All participants identified cognitive, physical, and emotional symptoms of social anxiety

either in themselves or others. Participants described common physical anxiety symptoms such

as shaking, stuttering, and heart racing. Cognitive and emotional symptoms included a fear of

speaking to peers and strangers, hesitancy in displaying emotion, fears about being watched or

being the center of attention, and public speaking. One student shared:

> It's different for different people if I see with somebody who'd be like always constantly
>
> moving a leg, or quiet, sometimes maybe stuttering. With me, social anxiety, I do like
>
> bite my nails and stuff like that.

B. Social Isolation and Behavioral Avoidance

Other common socially anxious behaviors were avoidance or withdrawal from social

areas such as evading conversations or social events   ($n = 6$; 86%). Participants frequently

mentioned aversion to social situations such as keeping to themselves and avoiding social

interaction with other students. This mention of "keeping to themselves" was voiced by one

participant who said:

Like when I'm around a lot of people, I wouldn't talk or say anything unless someone

speaks to me. I wouldn't approach anyone or anything, just stay by myself and try to

avoid them.

C. Experiences of Black Students Related to Social Anxiety

All students indicated that Black students' experiences or witnessing of negative events

related to their race, ethnic group, and minority status contributed to social anxiety. This

included the effects of racism from peers or adults or pressures from the norms of their cultural

group. More specifically, this consisted of stereotypes about Black individuals (i.e., aggressive or

brazen), discriminatory behaviors from others, or expectations for what it means to be Black.

Racism was brought up consistently, with all students reporting being unfairly judged through

stereotypes and experiencing microaggressions, discrimination and bias. An illustration is as

follows:

For example, this morning, my friend, I just remembered. He was drinking, whatever,

grape juice, and he said um, oh this is all types of Black like to drink this, and they all

started laughing. I was sitting far away, but I heard. Things like that. They all say that

stuff among themselves too. Or like, for example, I once said to my friend that I don't

like, I don't eat fried chicken. He's like, how come? You're Black. And I was like my

God, woah! I think he meant it in a jokey manner, but still, you can't just say things like

that, unfiltered.

Almost all students relayed family, community, and social norm pressures (n = 6; 86%). This

encompassed students' experiences of standards or behavioral norms their peers and adults

expected from them based on their ethnic backgrounds (e.g., manner of dress, temperament, or

opinions). Many students explained that if they did not comply with these standards they would

be perceived as "weird".

I guess, the way you talk, the way you act, the way like, how do you explain it? Whatever

is cool at the time if you don't follow that, as like another person of color, then you're

like seen as an outcast, kind of, stuff like that. [...] I guess, music, the stuff that people

listen to, I will get, I don't want to say made fun of, but I don't listen to whatever they

listen to, like all that rap. I can't do that. And I tell them that, and they laugh at me and

stuff. I'm fine with it but other people might not be. They might keep it to themselves.

Things like that. It can be clothing too. Like if you don't wear whatever, like jewelry.

Like something that doesn't have a brand or whatever, they'll get on you for that, make

fun of you for that, like oh why do you have those on, whatever, stuff like that.

D. Fears of Judgment or Stigma

A fear of stigma or judgment related to seeking or receiving mental health treatment was

a common concern for Black students described by five students (71%). Students conveyed

specific concerns about negative perceptions from others due to help-seeking such as appearing

"crazy" and as if they had serious mental issues ($n = 3$; 43%). Fear of stigma and judgment

associated with displaying mental health symptoms was mentioned by many students, with

specific worries about looking crazy or weird ($n = 4$; 57%). One student shared:

I mean, like there's a chance that if people find out, they're gonna make fun of you for it,

make you feel like you're weird, or whatever for seeking out help.

E. Barriers to Help-Seeking

All participants disclosed barriers that prevented Black students from seeking mental

health help. In line with common socially anxious-based fears, four students rejected treatment

or described reasons why others would refuse treatment due to their discomfort with speaking to

an unfamiliar person (i.e., counselor, adult, service, or group) ($n = 4$; 57%). One student

described:

> I think that a lot of teenagers if they haven't already just wouldn't want to, because kind
>
> of like back to what we said in the social group, it's like if it's uncomfortable and it's like
>
> there's just the resistance of doing something that's uncomfortable. And it's also like, a
>
> big factor of social anxiety is not like not wanting to talk to people, and this requires
>
> talking to someone, and that's like no, it's my major thing.

Three students (43%) felt as though they would rather handle mental health struggles

individually than seek out help or knew others that felt this way. Numerous participants refrained

from seeking treatment due to their and others' perceptions that seeking help for mental health is

ineffective ($n = 3$; 43%). One student elaborated on their perception of the effectiveness of

mental health treatment:

> [...] and not just deny it in our head or anything because that's what most of us do, deny
>
> the help in our head, and then when we actually get, it's like, it's not gonna work either
>
> way.

One student reported concern for confidentiality in that that their personal information

would be expressed to peers and others if they were to seek help for mental health problems ($n =$

1; 14%). Additionally, one student described concerns that they feared a referral for more

intensive treatment if they were to seek help ($n = 1$; 14%). This student shared their thought

process:

> There's the major stereotype of I say one wrong thing, and they send me to the mental
>
> hospital, and I don't, I don't I think that's like a thing that happens that much, but it's very
>
> much a big understandable fear, then you're like that kind of carries on to the shut up and
>
> don't say anything thing, and you're like, that's scary.

F. Parent and Important Adults Factors Related to Help-Seeking

Nearly all students disclosed parent factors related to inhibiting help-seeking efforts ($n =$

6; 86%). Specifically, barriers to treatment associated with their parent or caregiver such as a

lack of understanding of mental health, difficulty discussing struggles with parents, or fears

surrounding asking for a therapist were a concern. This was described by one student who said:

> Oh, like they won't really take it seriously, from my parents' perspective like, I would say,
>
> but as me as a person, I would take it serious, but if we were talking about my parents,

they would think it's like a joke or something, and they'll say something like, Oh, it's in

your head and like you can control that and whatnot.

Conversely, one student (14%) noted parent or caregiver factors that make it easier to

seek mental health help by encouraging them to seek out a counselor.

G. Characteristics of Therapists

All seven students indicated their own preferences or perceptions of others' preferences

for therapist characteristics that would make them most comfortable discussing their mental

health and beginning treatment. Many of the students ($n = 4$; 57%) mentioned preferences for a

therapist of the same race. One student described:

If they're gonna get a counselor, I'm pretty sure they would want one that could relate to

them with like race and stuff. For example, like I'm from West Africa. If I had a

counselor that was from West Africa, I'd be able to relate to them on different types of

levels because we're both West African.

Three students (43%), on the other hand, indicated that they did not have a preference for

a therapist of the same race. Students also specified that they or others would prefer a therapist of

the same gender ($n = 4$; 57%). Conversely, three students (43%) noted that they had no

preference for a therapist of the same gender. Most students ($n = 4$; 57%) described that they or

other students had preferences for a higher level of rapport, or how much the therapist

"understands" what they are going through. One student described how they wanted a therapist

to understand them:

> Probably just to like, make sure the person is like open-minded, like make sure they
>
> know how to understand like every person's point of view, and not just, they're wrong.
>
> [...] Yeah, like make sure they understand, just because something is easy for you doesn't
>
> make it, make it easy for everybody else, and just because you grew up with something,
>
> doesn't mean everybody else did, too, everybody has different lifestyles.

H. Intervention Components

Opinions regarding the components included in school-based interventions or school

mental health services for social anxiety were relayed by all students. Students reported how a

group-based intervention format may be positive or negative for student engagement and

efficacy in treating social anxiety. Pros and cons of group-based treatment were mentioned by a

student:

I guess one on one would be better, but like if also having like a group you can also hear

other people's point of view and relate to the people in the group. So I guess having a

group or being individual has its pros and cons.

Moreover, this code also reflected student perceptions of seeking services within a school, such

as how socially normal it is to participate in treatment in a school setting versus outpatient.

Further, students articulated how school-based treatment may be normalized (i.e., calling group

treatment by a club name or building a sense of community with a treatment group). One student

elaborated on the comfort school-based services provided:

At school, I think they might be a little more comfortable than just going to somebody

random, somewhere far away, in their office, or whatever, I think, they probably be more

comfortable like, somewhere where there's a lot of other kids and a lot of other people

around.

Discussion

Overall, our sample of Black adolescents described socially anxious symptoms (e.g., fear

of negative evaluation), physiological symptoms (e.g., racing heart), and behaviors (e.g.,

avoidance) consistent with the typical presentation of social anxiety described in the literature

(La Greca & Stone, 1993). Symptoms included fear of being in social gatherings, hesitation in

displaying emotions, and discomfort being observed or watched. Anticipatory anxiety and worry

about falling short in social situations were also articulated by most participants. Other

symptoms involved avoidance or escape behaviors, such as " keeping to themselves" and

withdrawing from social situations. Thus, it appears that Black adolescents were experiencing

behaviors consistent with typically reported social anxiety symptoms in adolescents (La Greca &

Stone, 1993; Rao et al., 2007), with particular attention to negative evaluation and avoiding

social situations.

This study also found culture-specific implications for Black adolescents. Culturally

distinct influencers of social anxiety encompassed matters such as race-based judgments, racism,

and social norms. The Hunter and Schmidt (2010) model of anxiety psychopathology in Black

individuals suggests that the psychological processes originating from the awareness of racism,

stigma of mental illness, and prominence of physical illnesses contribute to elevated fears of

negative evaluation (Kline et al., 2021). Our sample of Black students mirrored this notion in that

many reflected on their own and their peers' experiences of racism as a key facilitator to their

elevated social anxiety symptoms, specifically indicating discriminatory situations as triggers.

Another factor related to socially anxious symptoms is the social norms in their

community as many felt pressure to be "Black enough" or to act a certain way to be "normal."

Our sample's descriptions were consistent with the notion that normative pressures and

expectations from their families to keep emotions internal contributed to the fear of negative

evaluation and thus social anxiety (Davis et al., 2018). When assessing and treating socially

anxious Black adolescents, the exacerbation of symptoms due to cultural factors (e.g., normative

pressures and racism) cannot be ignored. Providers instead have a responsibility to take these

obstacles into account by gaining an understanding of their client's culturally unique worldviews

and depersonalizing racist or stereotypical messages.

Culturally Specific Barriers to Treatment

Despite that socially anxious symptoms are often debilitating in adolescents' lives, many

adolescents do not seek treatment (Barksdale & Molock, 2009; Rickwood et al., 2007). Similar

to this, none of the socially anxious students from our sample had ever received mental health

services. Our observations indicated that there are also culturally distinctive barriers to seeking

mental health services for Black adolescents. Consistent with previous literature, our sample of

socially anxious Black high school students in urban schools indicated that barriers to treatment

stemmed from stigma (e.g., cultural norms pressure) and judgment, racism (e.g., victimization

and discimination), speaking about issues with others (e.g., disclosing symptoms), beliefs about

treatment (e.g., perceived effectiveness), negative parental and caregiver influence, and

counselor demographics (Hines-Martin et al., 2003; Jon-Ubabuco & Champion, 2019;

Planey et al., 2019; Lindsey et al., 2006; Lindsey et al., 2013; Molock et al., 2007).

Notably, reluctance to seek treatment originating from stigma and judgment was a

frequent concern for Black adolescents and their peers. When asked about treatment hesitancy,

our sample endorsed hesitations to share feelings and socially anxious symptoms with providers

and others. This echoes Lindsey et al.'s (2013) finding that depressed Black male adolescents

were reluctant to discuss mental health due to fears of social stigma such as being teased or

gossiped about by their peers. Given the large associations between social anxiety and

victimization for Black adolescents (i.e., stereotyping, discrimination, and bullying), it is not

surprising that students reported reluctance for themselves and others to seek treatment due to

fear of social-based repercussions (Davis et al., 2018; Hunter & Schmidt, 2010; Kline et al.,

2021). Moreover, other research among Black male adolescents examined how many do not

continue treatment due to factors such as fear of shame, the stigma of negative stereotypes, and

social normative influence (Lindsey et al., 2013; Samuel, 2015). Given our sample is mostly

females, these findings can now extend to female populations as well. Observations from the

Samuel (2015) study indicated that 100% of Black males who dropped out of mental health

treatment cited stigma and shame as deciding factors for their discontinuation of mental health

services. In contrast, multiple studies have observed that stigma can be ameliorated in school-

based settings that normalize treatment and increase accessibility and is also reflected by

students feedback (Illback et al., 1997; Weist, 1999). Overall, our sample also recognized this

threat of stereotyping and social normative influence, often depicting it as a main concern.

Another culturally specific barrier to seeking treatment for Black adolescents was the

uncomfortable feelings they and their peers have when speaking to unfamiliar people about their

problems. Most students attributed this discomfort to a group setting in that speaking about these

issues around many people would cause anxiety or discomfort. This concern expressed in our

current study is consistent with research indicating that school-based interventions, particularly

with group formats, had barriers related to teenagers' discomfort (Girio-Herrera et al., 2019;

Weist, 1999). Perhaps working in tandem, Black students also indicated that they would rather

handle mental health struggles individually or "on their own" as a barrier to treatment. The "pros

and cons" of a group-based treatment are reflected in our observations as many students

expressed that this may have higher efficacy and engagement outcomes but also produce barriers

related to their hesitancy disclosing symptoms.

A barrier related to the perceived effectiveness of treatment was articulated in our sample

of Black students and may highlight a culturally specific negative assumption about mental

health treatment. Specifically, there was a major distrust of mental health services to provide

helpful treatment outcomes for Black individuals. This distrust may be transgenerationally

acquired from the vast historical experiences of Black individuals in mental health treatment

(e.g., overrepresentation in outpatient settings and racism and discrimination experienced in

treatment; Planey et al., 2019). Many students believed that treatment is unproductive in that

they will never get "better" or that they would always have problems regardless of seeking

treatment, which is reflected in the literature (Bains, 2014; Girio-Herrera et al., 2019; Lindsey et

al., 2013; Weist, 1999). It is also important to note that our sample considered other students'

views as similar to their own regarding treatment effectiveness. Provider mistrust may contribute

as therapists who do not match their client's demographic may produce impediments in the

treatment process (Cabral & Smith, 2011; Wintersteen et al., 2005). Planey et al. (2019)'s meta-

analysis indicated that African American teens' adult gatekeepers' distrust was a main barrier to

treatment for both themself and their youth. Although provider mistrust is a notable obstacle in

the treatment-seeking process, our current study's findings observed that many Black adolescents

did not characterize counselor distrust as derived from a mismatched gender identity or racial

background.

There were mixed findings as to whether Black students had a preference for a counselor

of the same race or gender. Some Black students preferred someone of the same race or gender

while a few conveyed no preference. This is both similar and divergent to Lindsey et al.'s (2013)

study in which Black adolescents explained a counselor of a specific race was unimportant in

seeking treatment while a few adolescents delineated a preference for gender. Conversely, a

study by Yeh et al. (1994) indicated that Black adolescents paired with a therapist who did not

match their racial background were significantly more likely to drop out after one therapy

session. Multiple studies have found varying results for preferences of race and gender in Black

adults that were dependent on their racial centrality, defined as a higher resonance with their

Black identity (Nioplias et al., 2018; Townes et al., 2009). Specifically, higher Black centrality

was associated with a preference for a provider of similar racial background. Perhaps our sample

was displaying this effect in that students had varying levels of centrality, resulting in mixed

preferences for their therapist's ethnic background. In future research, measures evaluating the

level to which a Black adolescent ascribes race to their personal identity may be helpful when

considering their racial preferences for a provider.

Differential findings for gender preferences specifically for Black individuals seem to be

dependent on other variables such as presenting concerns and racial identity (Blow et al., 2008;

Duncan & Johnson, 2007; Helms & Carter, 1991). Among Black college students, it was

observed that a gender match was preferred based on the type of presenting concerns (i.e., racism,

sexism, feelings of isolation or depression, and poor interpersonal relationships; Duncan &

Johnson, 2007). Specifically, males who had personal concerns and a low   African self-

consciousness rating (i.e., higher racial centrality) preferred a male counselor while females who

had a high   African self-consciousness rating (i.e., lower racial centrality) preferred a female

counselor. It is possible that their diverse gender preferences reflect their particular concerns, or

more precisely, how their symptoms inhibited their lives and how secure they felt in their racial

identity. Given these findings, it is important for future studies to consider their presenting

concerns, their racial centrality, as well as establishing a supportive and trusting relationship.

Parental barriers, as discussed prior, may stem from parents' perception and distrust of

mental health services that they then extend to their children (Bains, 2014; Jon-Ubabuco &

Dimmitt Champion, 2019; Lindsey et al., 2006; Lindsey et al., 2013; Planey et al., 2019). Our

sample also described reluctance to disclose mental health symptoms to caregivers and attested

that others may feel the same way. Particularly, students mentioned worry that their parents

would not take their issues seriously, dismiss their symptoms, or simply would "not understand."

If students did disclose to a caregiver, they expressed a lack of action taken by caregivers, which

is reflected in previous research. In one study, it was found that Black adolescents' caregivers

generally did not encourage or enroll their child in treatment. Lack of encouragment stemmed

from previous negative experiences with mental healthcare services (i.e., distrust of services and

perceptions of social support) and stigma associated with mental illness (Burnett-Zeigler &

Lyons, 2010). Rather, treatment came from school-based interventions and counselors (Burnett-

Zeigler & Lyons, 2010). It is speculated that this "lack of understanding" regarding mental health

symptoms and services reflects their caregivers' own barriers to seeking mental health help,

influenced by systemic racism (Bains, 2014; Jon-Ubabuco & Champion 2019).

Treatment Barrier Implications

Our most prevalent findings were fear of judgment and stigma and the uncomfortable feelings that ensued when speaking to others about problems. Students' elaboration on these barriers seemed to stress that stereotypes and potential negative social consequences are key catalysts for not seeking treatment. As such, an anti-stigma approach for practitioners focusing on disputing stereotypes (e.g., perceptions of weakness or being "crazy") is warranted. To alleviate uncomfortableness among Black adolescents, discussing preconceptions, creating a safe open environment to disclose feelings, and promoting positive mental health attitudes are merited (Chandra & Minkovitz, 2007; Lindsey et al., 2013; Price & Hollinsaid, 2022). Countering students' perceptions, the efficacy of engaging in treatment should be voiced explicitly to the adolescent. Specifically, it may be helpful for professionals to note positive outcomes of social anxiety treatments (e.g., reduced anxiety in social settings, making more friends, and higher academic achievement).

Parents may influence their child's mental help-seeking opinions and behaviors. Given this, it may be helpful to extend caregivers outreach or offer a psychoeducational program to help them understand their child's issues. Studies indicate that parental involvement (i.e., caregiver psychoeducation sessions and caregiver joint sessions) in cognitive behavioral-based

interventions result in lower anxiety symptoms and better coping skills for youth as opposed to

child-only treatment conditions (Barrett, 1998; Mendlowitz, 1999). These studies also observed

fewer socially anxious symptoms for adolescents whose parents were involved in a school-based

treatment. Furthermore, given the contrast in opinions on the demographic characteristics of a

particular therapist, it is important to consider what counselor would be most advantageous for a

Black adolescent on an individual basis. In this way, Black adolescents can have a say in their

treatment course, and engaging in treatment may become more appealing.

Strengths & Limitations

This study was able to capture a comprehensive account of the experiences and barriers

of Black adolescents; however, limitations are still present. For one, although the data from the

qualitative interviews were informative, they originate from a relatively small sample in which

certain utterances were selected based on similarity to common themes. Thus, a study using

mixed methods may be required for future research, specifically asking questions such as "To

what level does a Black student's experiences of stigma, judgment, and racism significantly

affect enrollment and attrition levels for treatment?" or "How do caregivers' perceptions of

mental health treatment and social anxiety symptoms affect their child's enrollment and attrition

levels for treatment?" It is also important to mention that this sample was all from one high

school in the northeastern United States and may not reflect the experiences of other Black

adolescents from different areas and other schools. Further research with samples from diverse

locations and genders is needed to fully encapsulate socially anxious Black adolescents'

experiences and perceptions of treatment barriers.

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Table 1.

Major themes reflecting Black adolescents' contributors to social anxiety symptoms, barriers to treatment, and intervention opinions

Theme	Definition	Quotes
A. Social Anxiety Symptoms	Student endorses feelings of social anxiety or describes socially anxious cognitive/emotional symptoms students exhibit (e.g., shyness, worry/fear of talking with strangers, hesitancy in displaying emotions, other social situations, being observed, public speaking, and being the center of attention). This also includes socially anxious physical symptoms students exhibit (e.g., shaking, stuttering, and heart racing).	1. "It's different for different people if I see with somebody who'd be like always constantly moving a leg, or quiet, sometimes maybe stuttering. With me, social anxiety, I do like bite my nails and stuff like that." (P4) 2. "I would describe it as like just the way you feel around people, when I think of social anxiety, I think of like, just really, like, nervous around a group of people or any social interaction, like a public place, maybe with your own family sometimes." (P3) 3. "So it is something that people can't speak to other people partly like I guess, like around people they don't know. It's kind of like stage fright, like you go up to people and get shy and can't speak properly." (P12)

| **B. Social Isolation and Behavioral Avoidance** | Socially anxious behaviors students act on such as avoiding or withdrawing from social areas, avoiding social events, and escaping social situations (i.e. wearing headphones or keeping to themselves). | 1. "Like when I'm around a lot of people, I wouldn't talk or say anything unless someone speaks to me. I wouldn't approach anyone or anything, just stay by myself and try to avoid them." (P14)

2. "You see them in a crowd, and they're not interacting with people, they're just by themselves, keeping them to themselves." (P2)

3. "I have this thing, where the moment I think someone is mildly upset with me, I don't want to talk to them, not that I have anything against them, they'll say something, and I'm like I probably made them mad, and then I stop talking to them, and that has caused problems, cause they're like why are you ignoring me? (P1) |

C. Experiences of Black Students Related to Social Anxiety	Black students' experience or witness of negative events on the basis of their racial/ethnic group or minority status that contribute to social anxiety. This may include the effects of racism from others or pressure from the norms of their cultural group.	1. "Yes. Them too. For example, this morning, my friend, I just remembered. He was drinking, whatever, grape juice, and he said um, oh this is all types of Black like to drink this, and they all started laughing. I was sitting far away, but I heard. Things like that. They all say that stuff among themselves too. Or like, for example, I once said to my friend that I don't like, I don't eat fried chicken. He's like, how come? You're Black. And I was like my God, woah! I think he meant it in a jokey manner, but still, you can't just say things like that, unfiltered." (P3) 2. "I guess, the way you talk, the way you act, the way like, how do you explain it? Whatever is cool at the time if you don't follow that, as like another person of color, then you're like seen as an outcast, kind of, stuff like that. [...] I guess, music, the stuff that people listen to, I will get, I don't want to say made fun of, but I don't listen to whatever they listen to, like all that rap. I can't do that. And I tell them that, and they laugh at me and stuff. I'm fine with it but other people might not be. They might keep it to themselves. Things like that. It can be clothing too. Like if you don't wear whatever, like jewelry. Like something that

doesn't have a brand or whatever, they'll get on you for that, make fun of you for that, like oh why do you have those on, whatever, stuff like that." (P3)

3. "Because like if a lot of people are racist towards me or something, I wouldn't want to be around them anymore, or if people come around, I'd be anxious because I think they are gonna say something to me again very badly." (P14

4. "Racism, like being told that their issues aren't as big as they really are. I'd say it's like picking on them for the way they look or the way they sound or like being judged based on stereotypes before they even get to know the person." (P2)

D. Fears of Judgment or Stigma	Stigma/judgment related to seeking or receiving mental health treatment. This may include fearing discussing mental health symptoms and fearing negative perceptions due to help-seeking.	1. "I mean, like there's a chance that if people find out, they're gonna make fun of you for it, make you feel like you're weird, or whatever for seeking out help." (P2) 2. "Like some people might see that as there might be something really wrong with them, they might seem crazy. I could see things like that." (P3) 3. Interviewer: "Yeah, so how do you feel like, how do you feel that other students, other Black students in the school look at people with social anxiety? How do you think they think about them?" P14: "Well they probably think that we're weird." (P14)
E. Barriers to Help-Seeking	General barriers that prevent students from seeking mental health help including reasons why students avoid treatment. This includes students feeling uncomfortable with speaking to an unfamiliar counselor, adult, service, or group; feeling as though they would rather handle mental health struggles individually; and feeling as though treatment is not effective.	1. "I think that a lot of teenagers if they haven't already just wouldn't want to, because kind of like back to what we said in the social group, it's like if it's uncomfortable and it's like there's just the resistance of doing something that's uncomfortable. And it's also like, a big factor of social anxiety is not like not wanting to talk to people, and this requires talking to someone, and that's like no, it's my major thing." (P1) 5. "If I like, if I were really stubborn about

		whatever the issue was, I probably wouldn't want to go. I'd probably try to avoid it. [...] if I really needed help with some issue, or whatever like that, I probably wouldn't want nobody to help me. If I truly didn't want nothing to do with it, I would try to avoid it." (P3)
		3. "[...] and not just deny it in our head or anything because that's what most of us do, deny the help in our head, and then when we actually get, it's like, it's not gonna work either way." (P14)
		4. "There's the major stereotype of I say one wrong thing, and they send me to the mental hospital, and I don't, I don't I think that's like a thing that happens that much, but it's very much a big understandable fear, then you're like that kind of carries on to the shut up and don't say anything thing, and you're like, that's scary." (P1)

| **F. Parent and Important Adults Factors Related to Help-Seeking** | Anything related to the parent/caregiver (e.g., behaviors, reactions, beliefs, characteristics) that is a barrier (i.e., prevents) or strength (i.e., promotes) when it comes to seeking mental health help. This may include parental lack of understanding of mental health and mental health treatment, fears about discussing struggles with parents, and fears surrounding asking for a therapist. This may also include parental strengths such as open communication, a focus on mental health treatment, or a close relationship. | 1. "Oh, like they won't really take it seriously, from my parents' perspective like, I would say, but as me as a person, I would take it serious, but if we were talking about my parents, they would think it's like a joke or something, and they'll say something like Oh, it's in your head and like you can control that and whatnot." (P8)

 2. "Probably to keep a good image, I mean how do i say this, like my parents for example, they're also of color, they don't…They know that they're what color, they just don't want me to like, and the but the others like, just keep up a good image like, just don't do all that stuff." (P3)

 3. P14: "They say just get a counselor?" Interviewer: "Okay. Do you think seeing a counselor…what would happen if you did that?" P14: "Probably some things would be better." (P14) |

G. Characteristics of Therapists	Students' preferences on counselor/therapist characteristics that they would be most comfortable discussing their mental health and continuing treatment. This may include wanting a counselor of the same gender, or race and building rapport with the counselor before treatment.	1. "If they're gonna get a counselor, I'm pretty sure they would want one that could relate to them with like race and stuff. For example, like I'm from West Africa. If I had a counselor that was from West Africa, I'd be able to relate to them on different types of levels because we're both West African." (P8) 2. "Probably just to like, make sure the person is like open-minded, like make sure they know how to understand like every person's point of view, and not just, they're wrong. [...] Yeah, like make sure they understand, just because something is easy for you doesn't make it, make it easy for everybody else, and just because you grew up with something, doesn't mean everybody else did, too, everybody has different lifestyles." (P4)

| H. Intervention Components | Suggestions from students about how to improve the intervention or school mental health services to make them more appealing for students and promote engagement (e.g., group format and normalizing treatment) | 1. "I guess one-on-one would be better, but like if also having like a group you can also hear other people's point of view and relate to the people in the group. So I guess having a group or being individual has its pros and cons." (P8)

 2. "At school, I think they might be a little more comfortable than just going to somebody random, somewhere far away, in their office, or whatever. I think, they probably be more comfortable like, somewhere where there's a lot of other kids and a lot of other people around." (P4)

 3. P3: "I wouldn't call it counseling. I would change the name. Not disguise it, but to put it as like, don't make it seem what it really is." Interviewer: "What if it was to make people socialize more?" P3: "Yeah, something like where to hang out and talk to people." (P2) |