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African American Families' Expectations and Intentions for Mental Health Services

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ABSTRACT

A cross-sectional qualitative descriptive design was used to examine the links among expectations about, experiences with, and intentions toward mental health services. Individual face-to-face interviews were conducted with a purposive sample of African American youth and their mothers from 38 dyads. Positive expectations were linked to positive experiences and intentions. Negative expectations weren't consistently linked to negative experiences or intentions, nor were ambivalent expectations linked to ambivalent experiences or intentions. Youth were concerned about privacy breeches and mothers about the harmfulness of psychotropic medication. Addressing these concerns may promote African Americans' engagement in mental health services.

Key Words: African American, mental health services, expectations, intentions

Despite a large body of research on mental health service use by African Americans (e.g., Alegria et al., 2008; Kodjo & Auinger, 2004; Wu et al., 2001), the factors that determine their mental health service use are still poorly understood (Thompson et al., 2011). Links among African Americans' experiences, expectations, and intentions have been studied in relation to health behaviors (Romano & Nedand, 2008; Childs et al., 2008), cancer treatments (Marion & Schover, 2006), and medical decisions (e.g., Hammond et al., 2010). However, few studies have focused on the relationship among these concepts to explain African Americans' mental health service utilization.

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

The Theory of Reasoned Action (TRA: Ajzen & Fishbein, 1980) proposed that important determinants of intentions are one's experiences and attitudes (defined as expectations about the outcomes of engaging in the behavior). TRA predicts that intentions to engage in treatment arise from expectations about how useful, coercive, and sensitive treatment would be and the possible negative outcomes of treatment (Cauce et al. 2002). It has been successfully applied to African Americans' decisions

regarding medical health care. Hammond and colleagues (2010) found that expectations strongly predicted African American men's intentions of getting routine health screening: positive expectations increased African American men's intentions for screening whereas negative expectations decreased such intentions. Similar links have been found between expectations and intentions for cancer screening for African Americans (Ross et al., 2007; Zimmerman et al., 2006). There has been less research applying TRA to African Americans' mental health services utilization.

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

Negative experiences with mental health services have been linked to negative expectations about possible future mental health service use. For example, with a variety of underserved populations, including African Americans, Kovandzjik and

colleagues (2011) noted that negative expectations about mental health service tend to flow from negative experiences with mental health services. Redmond and colleagues (2009) found that negative experiences with mental health services were associated with more negative expectations about future mental health service use for African Americans. Leis and colleagues (2011) found that negative expectations centered around unpleasant interactions with providers, especially providers who were “rushed” and did not take the time to get to know clients. On the other hand, African Americans’ feelings that they had been respected in treatment were associated with more positive expectations about future mental health service use (Kerkorian et al., 2003). Given the fact that African Americans are more likely than other ethnic groups to have had negative experiences with mental health services, it is not surprising that African Americans also have more negative expectations around mental health services (Brown et al., 2009) and more distrust of mental health services than other ethnic groups (Suite et al., 2007; Thompson et al., 2004; Whaley et al., 2001).

Expectations are linked to intentions to seek or continue mental health services for African Americans. Expectations that treatment will be helpful and relevant are predictive of increased intentions to seek treatment, both for oneself (Gonzalez et al., 2011; Stevens et al., 2006) and one’s children (McKay et al., 2001). On the other hand, for African Americans, expectations that treatment will include unhelpful or harmful medication (Leis et al., 2011) and that providers or “the system” are not trustworthy (Eiraldi et al., 2006; Power et al., 2005) predict reduced intentions to seek services. Limited research has also revealed that African Americans frequently have ambivalent experiences with mental health services (Thompson et al., 2011) and that ambivalent

experiences often lead to ambivalent expectations and intentions about these services (Ward et al., 2009). Ward and colleagues (2009) further noted that many African American women are “torn” between a belief that mental health services could help and a reluctance to use medication.

The purpose of this research was to examine qualitatively the links among expectations about mental health services, experiences with mental health services and intentions about mental health services in African American mothers and their youth. The research questions were:

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

Methods

Research Design

A cross-sectional qualitative descriptive research design was used to examine mothers’ and youths’ expectations about mental health services, experiences with mental health services, and intentions about mental health services. This design allows respondents to share their perceptions in everyday language and thus allows clear

communication of participants' perspectives (Sandelowski, 2002). While a full description of the research methods can be found in a previous publication (Thompson et al., 2011), a brief description of the research methods is provided.

Sample

The sample was drawn from the Capella Project, a larger longitudinal quantitative study of the long-term outcomes of child abuse and neglect for 245 mother-youth dyads who were followed from infancy through young adulthood. From dyads participating in the Capella Project, we selected a purposive sample of 38 African American dyads of mothers and youth who met the following selection criteria: youth between the ages of 13 and 19, and mothers and/or youth reporting using mental health services. The 38 dyads resulted in a sample of 37 mothers and 34 youth who reported mental health services utilization. These 37 mothers and 34 youth constituted 33 dyads that included mothers and youth, one dyad that included youth only, and four dyads that included mothers only. All interviews were conducted at the research offices of the Juvenile Protective Association, except five, which were conducted in participants' homes (Thompson et al., 2011).

Measures

Two semi-structured interview guides, the Mother Interview Guide and the Youth Interview Guide (Thompson et al., 2011), were developed to elicit information about mothers' and youths' experiences with and expectations and intentions about mental health services utilization. Mothers' and youths' experiences, expectations, and intentions were elicited with three open-ended requests for information. The request for information about experiences was "Tell me about your experiences with mental health

services for you, your family, and non-family members (friends, etc.).” The request for expectations was “Tell me about what you expect when you think about the possibility of getting mental health services for yourself.” The request for intentions was: “Tell me how likely you would be to try to get mental health services for if you thought they were needed.” Mothers were also asked to talk about experiences with mental health services, expectations about mental health services, and intentions to get mental health services for the target youth. Each request had probes to elicit more comprehensive information. The interviews were conducted in a conversational style allowing for a natural interaction between the research participants and the interviewer (Patton, 2002). The interview guides were revised based on feedback from experts in qualitative research as well as African American parents (Thompson et al., 2011).

Procedure

The study was overseen by the Institutional Review Boards of the first and second authors. After written informed consent and permission was obtained from each mother, and assent obtained from each youth, the mother and youth participated in separate interviews that took place in separate private interview rooms at the research office or in the home. All interviews were recorded audio-digitally. Participants were reimbursed for their time and transportation costs (Thompson et al., 2011).

Data Analysis

Interviews were transcribed verbatim by professional transcriptionists. A member of the research team checked all transcripts for accuracy and removed all identifying information about mothers, youth, family members, and providers from the transcripts. Atlas.ti was used to manage the verified and de-identified data. A code list was

developed based the Theory of Reasoned Action, with a particular focus on the concepts of interest: experiences, expectations, and intentions. Research team members were paired and independently coded each transcript. The results of the two independent codings were then compared and discussed until consensus was achieved. Definitions of codes and code subcategories were refined based on discussion of discrepancies. Themes and subcategories were determined based on how frequently they occurred (Hsieh & Shannon, 2005).

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

Results

Participant Characteristics

The mean age of the mothers in the sample was 41.10 years (*SD* = 6.16); the mean age of the youth was 15.20 years (*SD* = 1.38). The median family income was

between $15,000 and $20,000 per year; 67.5% of participating families had incomes under $20,000. 34.2% (13) of the dyads included a male youth; the remainder of the dyads included female youth. Of the 33 dyads that included both mothers and youth, only three dyads (9.1%) contained mothers and youth who had similar reports of links among expectations about mental health services, experiences with mental health services and intentions about mental health services. All three of these dyads reported positive expectations, positive experiences, and positive intentions.

POSITIVE EXPECTATIONS

Mothers

Of the 37 mother participants, 18 (48.6%) reported positive expectations of mental health services. Of these 18 mothers with positive expectations, 12 (66.7%) reported both positive experiences with mental health services and positive intentions to use mental health services. The remaining 6 (33.3%) mothers with positive expectations reported: ambivalent experiences and positive intentions (n = 3), positive experiences and ambivalent intentions (n = 2), or negative experiences and positive intentions (n =1).

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

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

Another mother similarly linked her positive expectations and positive intentions to past positive experiences:

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

Youth

Of the 34 youth participants, 15 (44.1%) reported positive expectations of mental health services. Of the 15 youth with positive expectations, most (n = 9; 60.0%) reported both positive experiences with mental health services and positive intentions to use these services and six (40.0%) reported either positive experiences with mental health services and ambivalent intentions to seek mental health services (n=3) or positive experiences and negative intentions (n=3).

All of the 15 youth with positive expectations reported positive past experiences. As with mothers, nearly two-thirds of the youth with positive expectations of mental health services reported both positive past experiences and positive intentions. In some cases, youth expressed a desire to reconnect with a particular provider. For example, one youth who had had positive experiences at a counseling center cited her positive experience and her intention to seek out the same counselor if needed.

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

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

> People can go to them to talk about their problems. Because they said that whatever you tell them, they won't tell your parents and stuff like that.

> … I think counselors are okay. But I'm not the type of person who would go to a counselor, myself… it probably may be a situation where my brother might not be around or my mother might not be around. He or she might be the last person that I could, maybe, turn to or try to talk to.

NEGATIVE EXPECTATIONS

Mothers

Nine of the 37 mother participants (24.3%) reported negative expectations. Of these 9 mothers, two (22.2%) reported both negative experiences with mental health services and negative intentions to seek mental health services; the remaining 7 (77.8%) mothers reported: negative experiences with mental health services and ambivalent intentions to seek mental health services (n=2), positive experiences and positive intentions (n=1), or negative experiences and positive intentions (n=4). All but one mother with negative expectations reported past negative experiences.

Less than a quarter (2) of the mothers with negative expectations about mental health services reported both negative experiences and negative intentions. These mothers believed that engaging in mental health services would result in being stigmatized and wished to avoid this negative consequence for their children. One mother stated:

> Once you get in to see a psychiatrist, …they already got you labeled, that's the biggest rough part about any mental thing you are labeled from once you start off seeing the psychiatrist don't never get admitted. You are labeled, so therefore you stunt your own life, okay. You can't get some jobs…

> …I wouldn't put her [daughter] through that because I didn't see no help and it basically messes up your whole record for your entire life.

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

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

Regarding medication and its potential side effects, one mother noted, "Sometime it [medication] changes the way you act. Now how would I be able to be there for my kids thoroughly if I'm drugged up?" However, this mother added that she would seek mental health services if her condition worsened:

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

Youth

Six of the 34 youth participants (17.6%) reported negative expectations. Of these six youth, two (33.3%) reported both negative experiences with mental health services

and negative intentions to seek mental health services. The remaining four (66.7%) reported: positive experiences and positive intentions (n=1), positive experiences and ambivalent intentions (n=1), ambivalent experiences and ambivalent intentions (n=1), and negative experiences and ambivalent intentions (n=1). Most youth with negative expectations reported either negative (n = 3) or ambivalent (n = 1) experiences.

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

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

For those youth with negative expectations and ambivalent intentions, their beliefs that they could not trust therapists to maintain confidentiality led to ambivalent intentions. One youth with negative expectations and ambivalent intentions said:

> I don't look for nobody to talk to….I won't because there's so many crooked people you could talk to that is a therapist and they're really not, they just want to

> be in your business…. I want to know you first. I'm going to get to know you first. I at least got to know you for a year before I even think about telling you any of my business. If I see you can keep your mouth shut and don't talk about nothing, then I'm respecting.

AMBIVALENT EXPECTATIONS

Mothers

Ten (27.0%) of the 37 mother participants reported ambivalent expectations about mental health services. Of the ten mothers with ambivalent expectations, none had both ambivalent experiences with mental health services and ambivalent intentions to seek mental health services. Five of the ten mothers reported ambivalent experiences with mental health services and positive intentions to seek mental health services. The rest reported: positive experiences and positive intentions (n = 1), negative experiences and positive intentions (n =1), negative experiences and ambivalent intentions (n = 1), positive experiences and ambivalent intentions (n = 1), or negative experiences and negative intentions (n = 1).

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

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

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

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

> Sometimes [daughter] gets so angry, I can't deal with it, you know what I'm saying? … So rather than me putting my hand on [Youth], you know what I'm

> saying, I'd rather for her to be in some kind of program…Even though she's not in a program, but I'm going to be honest with you, I have thought about getting her back into the program, I really have. And I think that's what I'm going to do, call the lady next week and I'm going to get her back in. Both of us, we gonna go to the program. You know, because see, all that acting out, that ain't good.

Youth

Thirteen (38.2%) of the 34 youth participants reported ambivalent expectations. Of these 13 youth, none reported both ambivalent experiences and intentions. Instead, they reported: positive experiences and positive intentions (n =3), positive experiences and negative intentions (n = 2), positive experiences and ambivalent intentions (n = 1), ambivalent experiences and positive intentions (n =1), negative experiences and positive intentions (n =1), negative experiences and negative intentions (n =3), and negative experiences and ambivalent intentions (n =2).

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

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

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

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

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

Discussion

Previous research suggested links among an individual’s expectations, experiences, and intentions to engage with mental health services (Gonzalez et al., 2011; Kerkorian et al., 2003; Leis et al., 2011). We found that 66.7% of mothers and 60.0% of the youth reporting positive expectations about mental health services reported both positive experiences with and positive intentions to seek mental health services. There was less consistency among expectations, experiences, and intentions among mothers and youth who reported negative or ambivalent current expectations.

Specifically, only 22.2% of mothers and 33.0% of the youth reporting negative expectations about mental health services also had both negative experiences with and negative intentions to seek mental health services. No link existed when expectations were ambivalent; none of the mothers and youth with ambivalent expectations about mental health services also had both ambivalent experiences with and ambivalent intentions to seek mental health services.

As such, for this population, links among expectations, experiences, and intentions were complex: negative expectations about mental health services were linked with either positive, negative, or ambivalent experiences and with positive, negative, or ambivalent intentions. Similar to Breland-Noble et al. (2011) and Ward et al. (2009), our results revealed that negative expectations centered on respondents' belief that prescribed psychotropic medications were not helpful. Previous research (e.g., Breland-Noble et al., 2011; Murray et al., 2011) identified stigma as a key concern for African American parents; this research identified the concern that receiving mental health services would create a pejorative "label" that would follow the child. Only two of the participants in the current study reported this issue; it occurred rarely, even among those with negative expectations. Concerns about medication were much more common in the mothers in our sample. Youth focused primarily on the possibility of privacy breaches. There was little congruence between mothers and youth in their expectations about and intentions toward mental health services.

Similar to Ward and colleagues (Ward et al., 2009), we found that African Americans often hold ambivalent expectations about mental health services. Mothers with ambivalent expectations often reported positive intentions to seek mental health

services because they felt that, while the effectiveness of the mental health services was dependent on the provider and/or the motivation of the service recipient, these ambivalent expectations were overshadowed by the perceived need for mental health services, especially if the services were for their child. However, youth with ambivalent expectations reported either positive intentions or negative intentions, depending on whether they felt their needs were met within their families.

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

Limitations

The primary limitation is that the sample included urban low-income mothers and their children who were mandated by child protective services to receive mental health services (Thompson et al., 2011). Because African Americans are more likely than other groups to receive mental health services in a coercive context, especially in the context of child welfare (Chow et al., 2003), however, this sample may not be drastically different from the general population of African Americans receiving mental health services. Although the study included African American male youth, the views of adult African American men were not included.

Implications for Practice

This study found that positive expectations about mental health services were always associated with positive intentions to use these services. There was less

consistency among those with negative or ambivalent expectations; positive intentions were certainly not guaranteed, although they occasionally occurred. Health care providers should work to create a therapeutic environment that promotes positive experiences with and expectations about mental health services. Recognizing that African Americans' negative and ambivalent expectations include receiving psychotropic medication and fear of a breach in confidentiality, mental health care providers need to counter these expectations as a first step in the development of a productive therapeutic relationship.

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

possibly mediated by community consultants, has the potential to both provide a sense of empowerment and make treatment more effective in meeting client needs.

Implications for Research

Research is needed to provide more evidences for the link between expectations about mental health services, experiences with mental health services, and intentions to seek mental health service. Culturally relevant instruments need to be developed to assess African American mothers' and their youths' expectations about mental health services, experiences with mental health services, and intention to seek mental health service. This research laid a foundation for the development of these instruments by providing valuable descriptive information in mothers' and youths' own words related to their expectations, experiences, and intentions regarding mental health services.

Although stigma is widely cited as a concern for African Americans around mental health service utilization (e.g., Brown et al., 2010; Thompson et al., 2004), it was rarely mentioned by the participants in the current analyses. Further research should revisit the role of stigma in African Americans' attitudes toward mental health services; it is possible that recent secular trends have made this less of a concern. Alternatively, it may be a concern among only some subgroups of African Americans. Concerns around medication were much more widely cited by our participants, and further research should explicate in more detail the nature of these concerns. Additionally, this research has laid the foundation for enhancing training of mental health service providers. The training of mental health service providers can be greatly enhanced by incorporating into the curriculum information about African American mothers' and youths' expectation, experiences, and intentions and how to use this information to promote

productive therapeutic relationships with this vulnerable population. Future work should develop and test training models that integrate what is known about African Americans' expectations, experiences, and intentions, as current training models have had limited success in improving patient outcomes (Snowden et al., 2006).

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