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Black American Psychological Help-Seeking Intention: An Integrated Literature Review With Recommendations for Clinical Practice

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Cumulative research has indicated that Black Americans underutilize voluntary mental health services. This review article adopts the theory of planned behavior (TPB; Ajzen, 1991) model as an organizing conceptual framework to demonstrate how a variety of factors contribute to Black Americans' reluctance to seek psychological help. These factors include perceived negative consequences associated with seeking help (i.e., mental illness stigma); social pressure against psychological help-seeking (i.e., endorsement of beliefs, such as "Black people do not get mental illness," "Black people must be strong," and/or "Black people who seek professional help have less faith in God"); and perceived difficulties associated with seeking professional help (e.g., cultural mistrust, microaggressions in therapy). This article then suggests approaches that practitioners can use to encourage mental health service use in this population, such as reducing mental illness stigma through psychoeducation; discussing the influences of race/ethnicity and culture in therapy; and preventing and addressing microaggressions in therapy. Finally, the article discusses directions for future research to further investigate how to better understand and encourage psychological help-seeking intention in the Black community.

Keywords: Black Americans, African Americans, psychological help-seeking, mental health services use, theory of planned behavior

Although mental illness affects everyone, regardless of race or ethnicity, Black Americans¹ in the United States (U.S.) use mental health services less than other racial/ethnic groups (e.g., Cummings & Druss, 2011; Substance Abuse and Mental Health Services Administration, 2015). Similarly, in Canada, the Center for Addiction and Mental Health (2006) recognizes that Black Americans are typically underrepresented in voluntary mental health care. What remains unclear is *why* racial/ethnic disparities in psychological service use exist in countries like the U.S. and Canada.

Some research has suggested that such disparity is due to logistic reasons, such as financial or socioeconomic difficulties (e.g., costs or insurance coverage associated with psychotherapy; Snowden, 2001; Thompson, Bazile, & Akbar, 2004; United States Department of Health and Human Services, 2001), whereas recent data suggest more complex reasons involving other psychological, cultural, and systemic factors (Cummings & Druss, 2011; Substance Abuse and Mental Health Services Administration, 2015). One key factor that has emerged from research with Black Americans is the *intention* to seek help from mental health professionals, where findings indicate low intentionality within this population (Campbell & Long, 2014; Conner et al., 2010; Njiwaji, 2012;

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¹ For the purposes of this review, the term "Black Americans" is used to refer to individuals living in Canada and the United States who self-identify as Black or as being a person of African descent.

Thompson et al., 2004; Waldron, 2002). As a result, Black Americans who are seeking professional psychological help are likely doing so involuntarily or reluctantly.

Clients who have negative attitudes toward help-seeking are more likely to have poorer treatment outcomes than clients with positive help-seeking attitudes (Shaw & Morgan, 2011). Therefore, it is important for clinicians and mental health practitioners to understand more fully the nature of intentions, attitudes, and perceptions toward psychological help-seeking within the Black community. This understanding is important to ensure that appropriate action is taken to remedy this disinclination. Increasing Black Americans' willingness to seek psychological help increases the likelihood of Black Americans receiving relevant and needed mental health treatment.

Pursuing a clearer understanding of the variables associated with Black Americans' mental health help-seeking attitudes and intentions can potentially help bridge a critical knowledge and service gap for this population. In response, the present article offers an integrated review and synthesis of current research and knowledge about psychological help-seeking among Black Americans. To do so, the theory of planned behavior (TPB; Ajzen, 1991), a prominent explanatory model of health-related behaviors, is adopted to help organize, illustrate, and present relevant literature for this review. Taking a critical cultural, contextual, and theoretically grounded perspective, this review aims to provide practical information and insights to benefit clinicians and practitioners.

Understanding Help-Seeking Intention Among Black Americans Using the Theory of Planned Behavior

The research suggests that the TPB is a promising model for explaining psychological help-seeking among Black Americans (Compton & Esterberg, 2005). The TPB's central component is *intention*, which is defined as how hard an individual is willing to try in order to perform a behavior. The TPB asserts that an individual's intention to perform a behavior directly determines if the individual will act upon the behavior. More specifically, the TPB contends that intention is determined by three key factors: the individual's attitudes toward a behavior (i.e.,

the degree to which the person views the behavior as favorable or unfavorable), subjective norms (i.e., the degree of social pressure to either engage or not engage in the said behavior), and perceived behavioral control (i.e., the perceived level of difficulty or ease of performing the behavior).

On the basis of the literature review that follows, we contend that the current evidence about Black American psychological help-seeking corresponds closely with the taxonomy of beliefs proposed by the TPB (i.e., behavioral beliefs, normative beliefs, and control beliefs). Behavioral beliefs have to do with whether an individual believes the outcomes of a behavior will be positive or negative. As discussed in a later section of this article, Black Americans often associate psychological help-seeking with negative outcomes (e.g., "If I see a mental health professional, people will think I am weak"), which then leads to unfavorable attitudes toward help-seeking. Regarding normative beliefs (beliefs about whether people close to the individual would use mental health services), Black Americans are commonly exposed to anti-help-seeking beliefs and messages that are communicated and perpetuated by their family, friends, and community (e.g., "Black people do not get depressed"). Lastly, factors that make using mental health services more difficult for Black Americans (control beliefs) include perceived and/or actual negative experiences with mental health service use and negative perceptions of mental health professionals (e.g., "I will not be able to find a therapist who understands my experience."). The following sections review and expound on the behavioral, normative, and control beliefs that influence Black Americans' intentions to use mental health services.

The Effect of Mental Illness Stigma

As stipulated by the TPB, people tend to hold unfavorable attitudes toward behaviors associated with undesirable outcomes (Ajzen, 1991). In the case of Black Americans, one of the major negative outcomes commonly associated with psychological help-seeking is mental illness stigma. Mental illness stigma is conceptualized as the stereotypes, prejudice, and discrimination that accompany being labeled "mentally ill" (Corrigan, Druss, & Perlick, 2014).

Stigma is a powerful barrier to psychological help-seeking in general, but this is especially the case for the Black community. Gary (2005) described a concept called “Double Stigma”: a stigmatizing experience that occurs when a person experiences prejudice and discrimination not only from having mental illness, but also from being a member of a racial or ethnic minority group. A sample of depressed Black Americans in the U.S. reported experiencing the stigma of having depression compounded with the stigma of being a racial/ethnic minority (Conner et al., 2010). In addition, when compared to their White counterparts, Black Americans in Canada and the U.S. reported that it is much more stigmatizing for them to seek help for a mental health concern (Campbell & Mowbray, 2016; Conner et al., 2010; Schreiber, Stern, & Wilson, 1998). It has been reported that Black Americans stereotype and discriminate against other Black Americans who seek professional help for mental health concerns (Conner et al., 2010). Black Americans reported that after being diagnosed with a mental illness, family and friends became more socially distant and began treating them like outsiders (Alvidrez, Snowden, & Kaiser, 2008; Conner et al., 2010). Mental illness stigma also includes negative effects on one’s sense of self (Corrigan et al., 2014). Conner et al. (2010) found that depressed Black Americans believed that many people in their community endure “hard times” and they therefore concluded that they must not be very strong because they need professional help. Participants reported blaming themselves for being depressed and associated having depression with personal weakness.

Mental illness stigma may be particularly stigmatizing to Black Americans because of strongly held normative beliefs about the Black community being strong and invulnerable to mental illness or mental health concerns. These beliefs are discussed more in the following section.

Normative Beliefs and Subjective Norms Against Psychological Help-Seeking

The social norms that impede psychological help-seeking are conceptualized within the TPB as normative beliefs. The social pressure to

avoid psychological help originates from normative beliefs that Black Americans hold about themselves and about having mental illness (Ajzen, 1991). We focus here on the impacts of three strongly held normative beliefs within the Black community: (a) mental illness does not affect Black people; (b) Black people must be strong; and c) seeking professional help shows a lack of faith in God.

“Mental illness does not affect Black people”. The first of these normative beliefs seems to have initially appeared in Black mental health literature over two decades ago (Hooks, 1993). More recently, research has found that Black Americans in the U.S. still hold similar beliefs, such as “Black people do not get depressed” and that mental illness is a “White people thing” (Alvidrez et al., 2008; Campbell & Long, 2014; Conner et al., 2010). Focus group and interview studies, conducted in Canada, with mentally ill Black Americans reveal that they similarly perceive mental illness as something that is “not supposed” to occur in or affect the Black community (Njiwaji, 2012; Schreiber et al., 1998). Hence, the false belief that Black individuals are immune from psychological and psychiatric problems can lead this group to reject the value of mental health services. It is possible that Black Americans have this belief because mental health and mental illness have historically been researched and made known by White individuals (e.g., Sigmund Freud, Emil Kraepelin, Carl Rogers, etc.). In addition, mental health advertisements further lead Black Americans to believe that mental illness is a “White man’s issue” because these campaigns rarely included Black people or other racial/ethnic minority groups (Ahmed & Dere, 2017; Njiwaji, 2012).

“Black people must be strong”. This denial of mental illness in the Black community may be partly linked to this second normative belief—Black individuals must always exhibit strength and conceal vulnerability (Alvidrez et al., 2008; Thompson et al., 2004). In the U.S., Black Americans with depression indicated that trying to uphold the image of “the strong Black woman” or “the strong Black man” forces many Black Americans to hide or deny their experience with depression (Campbell & Mowbray, 2016). Such a belief is also found in Canada among Black women from the West Indies. Schreiber et al. (1998) showed that Black West

Indian Canadian women with depression felt that they are highly stigmatized and misunderstood within their own West Indian community, because West Indians are expected to be strong people. Therefore, many Black Americans are resistant to asking for professional help because it can be construed and perceived as an admission of one's vulnerability or weakness. The belief that "Black people must be strong" likely originated during the time of the transatlantic slave trade—when Black slaves were considered "the mules of the world" (Hooks, 1993, p. 2) because of the burdens they carried. This reputation of bearing hardship continued to follow the Black community through the civil rights movement. Present day, Black individuals continue to withstand adversity in the form of prejudice and discrimination.

"Seeking help from a professional shows a lack of faith in God". Considering that many Black individuals do not want to seem weak by seeking help from a mental health professional, many of them turn to spirituality for support instead (Neighbors, Musick, & Williams, 1998). In Conner et al.'s (2010) focus group study, Black Americans in the U.S. reported that the most culturally acceptable strategy for coping with depression was through prayer and connection to God. The same participants further asserted that seeking help from a professional for a mental health concern would suggest a lack of spiritual faith. Likewise, Campbell and Long (2014) found that Black American respondents identified several similar faith-based beliefs, which included "Black people turn to God for everything"; "Black people believe more in religion than medicine or therapy"; and depression is an "issue of faith."

Schreiber et al. (1998) found that Black West Indian Canadian women with depression felt that belief in the Christian doctrine was a powerful force within West Indian society. All the participants indicated that they were raised in the church, believed in God, and/or prayed regularly. Some stressed that God would replace their troubles with peace, comfort, and compassion. Others stated that they would be able to endure their problems because of God-given strength. Similarly, among Black Americans in Nova Scotia, Canada, spirituality was identified as important for deciding whether or not to seek professional help, as faith in God reportedly helped Black Nova Scotians cope with their

mental health concerns (Njiwaji, 2012). Normative beliefs similar to "seeking help from a professional shows a lack of faith in God" assumes that receiving spiritual support and professional mental health services are inherently incompatible.

In light of the above findings, this suggests that normative beliefs held by Black Americans can potentially give rise to strong in-group, social, or community pressure (i.e., subjective norms) against psychotherapy and psychological treatments. The degree of willingness to seek professional help among Black Americans is also a function of their perceived ability and comfort with (i.e., perceived behavioral control) accessing mental health services.

Control Beliefs and Perceived Behavioral Control Over Psychological Help-Seeking

As indicated earlier, the TPB refers to control beliefs as the factors that influence the ease or difficulty of psychological help-seeking (i.e., factors that influence perceived behavioral control; Ajzen, 1991). In a study testing the TPB model with a sample of Black American patients who were hospitalized for psychosis, Compton and Esterberg (2005) found that the patients' perceived behavioral control was the only significant predictor of their delay in seeking psychiatric services. Thus, control beliefs may be one of the most vital components to consider when explaining intentions to seek psychological help among Black individuals. As will be seen below, a review of the literature suggests that there are at least three key control beliefs that are particularly salient for this population: (a) cultural mistrust; (b) unavailability of Black psychotherapists; and (c) negative perceptions and experiences with psychological help-seeking.

Cultural mistrust. Black individuals have little trust in White society (Terrell & Terrell, 1981), and as most mental health professionals are White, by extension mental health services (e.g., Joseph, 2010; Thompson et al., 2004; Whaley, 2001). Cultural mistrust has been identified as a major factor in deterring Black Americans from accessing mental health services (Conner et al., 2010; Njiwaji, 2012; Thompson, Worthington, & Atkinson, 1994; Waldron, 2002). Terrell and Terrell (1981) argue that, historically, the Black community in the U.S.

has developed a mistrust of the White community through having experienced direct or vicarious mistreatment by the White community. The Black community's mistrust of the medical community dates back to the pre-civil-war era (Neal-Barnett & Smith, 1997). This mistrust manifests itself in the therapeutic relationship as Black Americans disclosing less in therapy and prematurely terminating therapy (Terrell & Terrell, 1984; Thompson et al., 1994). As a corroboration, Joseph (2010) found that Black Canadians with elevated levels of cultural mistrust were significantly more likely to prefer seeking treatment from a Black mental health professional.

Scarcity of Black psychotherapists. Underrepresentation of Black professionals in mental health services has been identified as yet another common obstacle that impedes access to psychotherapy and mental health treatment by individuals in the Black community. Thompson et al. (2004) found that Black Americans in the U.S. reported doubting mental health professionals' ability to adequately understand their circumstances or address their concerns. This observation is further validated by Joseph's (2010) study with Black Canadians, which found that participants would be more willing to seek psychological services if the mental health professional treating them was also Black. It stands to reason that Black clients' preference for Black psychotherapists may also be motivated by the perceived or actual negative experiences Black clients have had with White psychotherapists.

Negative impressions and experiences with mainstream psychological professionals and services. Emerging evidence has also pointed to the fact that when Black Americans seek psychological treatment from mainstream mental health services, their experiences with these organizations have frequently been unfavorable (Thompson et al., 2004), leading to another major help-seeking barrier for this population. In a national U.S. study, researchers found that Black Americans' attitudes toward using mental health services were worse after receiving mental health services compared to before receiving the services (Diala et al., 2000). Similarly, in Canada, Joseph (2010) found that past experience seeking professional psychological help predicted unfavorable attitudes toward psychological help-seeking among Black Canadians

(Joseph, 2010). Black Canadians in Nova Scotia attributed their negative perceptions of the mainstream mental health system to their experiences with systemic racism (Njiwaji, 2012). Examples include Black clients having higher rates of inpatient admission compared to White clients (Bhui et al., 2003). Furthermore, compared to White clients, Black clients on inpatient units are four times more likely to experience a compulsory admission.

Racial microaggressions. In countries such as Canada and the U.S., "overt racism" is gradually and subtly being replaced with "covert racism" against racial/ethnic minority populations, including Black Americans, often in the form of *racial microaggressions* (Sue et al., 2007). Racial microaggressions are defined as "brief everyday exchanges that send denigrating messages to people of color because they belong to a racial minority group" (Sue et al., 2007, p. 273). Disconcertingly, prior research indicates that most racial/ethnic minorities in the U.S. who sought psychological treatment have experienced at least one microaggression during the process (Hook et al., 2016; Owen et al., 2011; Owen, Tao, Imel, Wampold, & Rodolfa, 2014).

Researchers have observed that microaggressions perpetrated against Black Americans commonly happen when clinicians deny racial/ethnic client-therapist differences (e.g., "I don't see you as Black, I just see you as a regular person"), minimize or dismiss the importance of racial/ethnic issues (e.g., "I'm not sure we need to focus on race or culture to understand your depression"), and/or make assumptions based on racial/ethnic group membership (e.g., "I know that Black people are very religious;" Constantine, 2007; Hook et al., 2016; Sue et al., 2008). The negative consequences of racial microaggressions for Black Americans can include poorer therapeutic relationships, lower perceived counselor competence, and less satisfaction with psychological treatment (Constantine, 2007). These negative experiences and perceptions about help-seeking can lead Black clients to prematurely terminate therapy and be reluctant to undergo professional psychological services in the future (Sue et al., 2007). Moreover, second-hand information about these negative experiences with mental health services might prevent other Black individuals from initiating psychological treatment.

Implications for Clinical Practice

Overall, insights about Black American behavioral, normative, and control beliefs help explain why members of the Black community with and without mental health concerns are less willing to seek help from mental health professionals. Based on these findings, we provide directions for addressing this community's unwillingness to seek psychological help. In discussing practical strategies and recommendations for clinicians and practitioners that can promote psychological help-seeking for Black Americans, we focus on mental illness stigma, anti-psychological-help-seeking normative beliefs, and factors that contribute to negative perceptions of/experiences with mainstream mental health services (e.g., cultural mistrust, scarcity of Black psychotherapists, and racial microaggressions).

Responding to Mental Illness Stigma

As discussed previously, Black individuals avoid using mental health services because of stigmatizing beliefs that are endorsed by the Black community. Although mental health professionals and clinicians may be unable to change mental illness stigma at a societal level, they can help reduce Black clients' internalized stigma around psychological help-seeking by educating them about mental health and mental health services. To our knowledge, Alvidrez et al. (Alvidrez et al., 2008; Alvidrez, Snowden, & Kaiser, 2010; Alvidrez, Snowden, Rao, & Boccellari, 2009) are the only researchers to specifically investigate methods of reducing stigma among Black Americans. Alvidrez et al. (2009) found that their culturally tailored psychoeducational brochure was effective in reducing mental health stigma in a sample of Black Americans in the U.S. who were in need of psychological services. In a separate study, Alvidrez et al. (2010) discussed the development and contents of this culturally tailored brochure. It was found that the following techniques helped reduce stigma among Black Americans: discussing confidentiality, normalizing and validating the feelings of shame, and normalizing mental illness by making the analogy to physical illness.

Similarly, practitioners can address the stigmatizing beliefs that Black clients might have

about seeking professional psychological help (e.g., "Seeking professional help will make people think I am crazy or weak," or "Seeking help from a professional means I am not strong enough to handle my own problems") by utilizing some of the content from the brochure (Alvidrez et al., 2010) and from interviewee responses (Alvidrez et al., 2008). The following example illustrates how this work can be applied with a Black American female client who refers herself because she is experiencing concerns surrounding depression and anxiety. During the first therapy session, the therapist asks the client, "How do you feel about deciding to come to therapy? Were you at all hesitant about seeing a therapist?" The client explains that even after realizing that her concerns have been persistently detrimental to her well-being, she states, "It took me a while to pick up the phone and call. I didn't want people to think that I couldn't handle my problems on my own." The therapist empathically validates and normalizes the client's concern of judgment from others. The therapist also makes it clear that client confidentiality is a top priority and "family, friends, or co-workers do not have to know about your treatment." The therapist then asks the client if she feels any negative feelings toward herself for not being able to 'handle [her] problems on [her] own.' The client admits that she feels embarrassed and ashamed that she needs professional help and that she "is not strong enough to deal with this [her]self." The therapist explains that what she is feeling is quite common and that having a mental health concern is nothing to be ashamed of. The therapist makes the following analogy to physical health: "Even bodybuilders and nutritionists—people who spend a lot of time being physically healthy—get ill and have physical health concerns, but it is by no fault of their own. Likewise, it is no one's fault if they experience mental health concerns or get mentally ill." The therapist then points out to the client that she is showing inner strength by seeking help despite the stigma.

Alvidrez et al. (2008) found that the most common attitude Black Americans used to cope with stigma was prioritizing one's health and well-being above the opinions and reactions of others. One woman stated, ". . .screw what everybody else thinks. You gotta think this [is] for yourself. You want to get better for yourself

... you can't just worry about what other people think." Thus, helping clients to realize that their well-being is paramount to the perceptions of others may effectively diminish the stigma associated with help-seeking.

Managing Anti-Psychological-Help-Seeking Beliefs

As noted, normative beliefs such as "Black people do not get mental illness," "Black people must be strong," and "Black people who seek help from a professional have less faith in God," are commonly perpetuated and endorsed by the Black community. These beliefs impede psychological help-seeking by creating a social pressure to avoid mental health services. Clinicians can promote help-seeking with Black clients by providing psychoeducation and by working with the client to critically evaluate these normative beliefs. Psychoeducation can include explaining to clients that mental illness can affect anyone, regardless of race/ethnicity. Approximately half of the Black Americans interviewed by Alvidrez et al. (2008) stated that seeking treatment was easier when they reminded themselves that mental health problems affect all types of people.

In addition to psychoeducation, should a client endorse beliefs similar to those mentioned above, clinicians can openly and gently explore with clients the evidence, logic, and suppositions behind these views by using cognitive restructuring techniques. For example, if a client discloses that it is difficult to seek help because "Black people must be strong," then the therapist might discuss with their client that such a belief implies that Black individuals can never display vulnerability or ask for help. Subsequently, a cognitive restructuring approach can be employed to explore the evidence that supports and contradicts the belief. For instance, if a client were to present this belief, the therapist might say, "Yes, it is true that people in the Black community are strong and have endured a lot of adversity. At the same time, Black people are human beings, and as human beings we all have vulnerabilities."

Regarding the belief that "seeking help from a professional shows a lack of faith in God," a therapist may similarly explore the evidence for and against the thought. In situations such as this, it would be beneficial for the therapist to

first familiarize themselves with the spiritual and religious beliefs of his or her client. For example, most Christians believe that God heals all ailments, therefore it is thought that turning to a mental health professional for help suggests a lack of faith in God. However, it is also believed that God utilizes people to fulfill his purpose, thus the therapist might ask the client, "Is it possible that God is healing people who struggle with emotional and personal difficulties by using and *working through*² people like myself?" The client will hopefully come to realize that he or she can receive help from a mental health professional while continuing to have faith in God. In short, through informative psychoeducation and the use of cognitive restructuring, Black clients might come to reconsider the validity of these culture-bound normative beliefs.

Addressing Factors That Contribute to Negative Perceptions of/Experiences With Therapy

To mitigate the barriers associated with seeking professional mental health services for Black Americans, key factors related to control beliefs for this population (reviewed in previous sections) need to be adequately addressed. Here we offer the following recommendations to tackle the negative effects of control beliefs on help-seeking for Black Americans; that is, discussing how race/ethnicity influences therapy, and managing/preventing racial microaggressions.

Mitigating Cultural Mistrust and Improving the Therapy Relationship by Addressing Race/Ethnicity in Therapy

Openly discussing the role that race/ethnicity may play in therapy can encourage psychological help-seeking in the Black community, by giving Black clients the opportunity to voice concerns they might have about being treated by someone who is not also Black. Furthermore, researchers suggest that discussing race/ethnicity and how it might influence therapy is important for promoting an environment of trust

² God "working through/in" an individual is Christian jargon for being utilized or actively engaged by God.

and understanding (Cardemil & Battle, 2003; Terrell & Terrell, 1984). Cardemil and Battle (2003) provide a graceful way for therapists to broach the topic of therapist–client racial/ethnic differences with clients:

I know that this can sometimes be a difficult topic to discuss, but I was wondering how you feel about working with someone who is from a different racial/ethnic background? I ask because although it is certainly my goal to be as helpful to you as I possibly can, I also know that there may be times when I cannot fully appreciate your experiences. I want you to know that I am always open to talking about these topics whenever they are relevant. (p. 281)

Furthermore, adopting a multicultural orientation (MCO) framework has been found to lead to strong working alliances and positive therapeutic outcomes with culturally diverse clients (Davis et al., 2018). The MCO framework describes a method of interacting with the diverse cultural identities of clients (Owen, 2013). The fundamental value of the MCO framework is *cultural humility*. Cultural humility is defined as “having an interpersonal stance that is other-oriented rather than self-focused, characterized by respect and lack of superiority toward an individual’s cultural background and experience” (Hook, Davis, Owen, Worthington, & Utsey, 2013, p. 353). The other two pillars of MCO are taking advantage of *cultural opportunities* and awareness of one’s level of *cultural comfort*. Culturally humble therapists look out for “makers or moments in therapy where the therapist and client can engage in purposeful and meaningful dialogue about the clients’ cultural identity” (Owen et al., 2016, p. 2). The MCO framework also encourages therapists to self-assess their level of cultural comfort by reflecting on the thoughts and feelings that emerge before, during, and after conversations about culture (Owen et al., 2017). A therapist’s degree of ease, openness, and calmness with diverse others can be indicators of whether or not a therapist needs to gain greater cultural perspective. MCO differs from multicultural competence (MCC) such that MCC implies a destination that can be reached whereas an “MCO helps therapists develop a way of being” (Davis et al., 2018, p. 90).

Zhang and Burkard (2008) found that when White counselors addressed race/ethnicity in session, Black clients disclosed more and had better therapeutic outcomes. However, when

the counselors seemed to avoid racial/ethnic content, clients reported greater levels of frustration. This overall attitude of openness and acceptance of cultural differences can reduce mistrust, facilitate more self-disclosure, and promote a more collaborative working alliance.

Safeguarding against microaggressions to preserve the therapeutic relationship. As discussed, microaggressions are detrimental to the development and maintenance of a working alliance with Black clients. Therefore, addressing microaggressions in therapy can increase the likelihood that Black clients will have positive therapeutic experiences and consequently be more willing to continue seeking treatment. However, microaggressions are both pervasive and insidious; they can be difficult to identify and manage because they are often perpetuated unintentionally and can often go unnoticed by the perpetrators (Sue et al., 2007). To respond to the issue of microaggressions in therapy, we suggest preventing microaggressions by continuing to practice cultural humility and treating microaggressions as alliance ruptures.

Combat microaggressions with cultural humility. As discussed, cultural humility is the overarching virtue of the MCO framework (Owen, 2013). Being culturally humble involves having an accurate view of one’s cultural self and particularly about one’s cultural limitations. Cultural humility is also marked by a lack of superiority when cultural differences occur in therapy. In essence, cultural humility stands in direct contrast to stereotype or group generalization against racial or ethnic minorities.

For example, a middle-aged, White, middle-social-class, male therapist who strongly values justice and being a law-abiding citizen may feel ambivalence about how to engage a young-adult, Black, lower-social-class, male client who sells illicit drugs to provide for himself and his family. A therapist that lacks cultural humility may assume that the client is uneducated and ignorant of the consequences of selling illicit drugs. This therapist might then start to explain to the client the risks associated with selling illicit drugs, which the client (who is fully aware of the potential dangers of illicit drug sales) interprets as condescending and patronizing. Whereas a culturally humble therapist would recognize that, as a White, middle-class male, he was likely afforded opportunities that

allowed for access to lucrative occupations—opportunities that may not have been afforded to this client for various reasons. Additionally, the therapist would also acknowledge that his values about social justice are not superior to the clients' values of providing and caring for his family. The culturally humble therapist would then be less likely to make negative assumptions or judgments about this client, and thus would be less likely to microaggress against this client.

Hook et al. (2013) have revealed that cultural humility significantly predicted frequency and impact of racial microaggressions and accounted for significant variance above and beyond variance accounted for by multicultural competence and general competence. Greater cultural humility predicted lower frequency and less impact of racial microaggressions. Overall, fostering and practicing cultural humility will help increase Black Americans' trust and receptiveness toward psychotherapy and the larger mental health system.

Treat microaggressions as alliance ruptures.

In conceptualizing microaggressions as forms of alliance ruptures, Owen et al., (2011) adapted the work of Safran, Muran, and Eubanks-Carter (2011) on alliance rupture and repair to address racial microaggressions in therapy. Safran and Muran (2000) have identified two broad types of alliance ruptures—confrontation ruptures and withdrawal ruptures. In confrontation ruptures the client directly expresses anger or dissatisfaction with the therapist or some aspect of therapy. Withdrawal ruptures are often illustrated by clients offering minimal responses, suddenly changing topics, or becoming overly compliant to therapist recommendations. A client may respond to a microaggression in the form of a confrontation. However, considering the ambiguous nature of microaggressions, clients are likely to withdraw because they may doubt the true value of their perceptions and be unsure of whether or not their negative feelings are valid (Sue et al., 2007). In withdrawal ruptures, Safran and Muran (2000) recommend exploring the factors that inhibit the expression of negative feelings, as well as allowing clients to communicate their wishes and needs.

The following example illustrates how this framework can be applied to repair an alliance rupture that was caused by an unintentional microaggression. A female client who self-

identifies as Black, mentions to her therapist that she has no one to talk to about her mental health concerns. In response, the therapist suggests that the client talk to her family and friends for social support. The therapist begins explaining the benefits of social support to the client, when the therapist notices that the client falls silent and appears disengaged. The therapist then initiates an exploration of what is currently occurring in the therapeutic relationship. The client admits to feeling misunderstood and patronized by the therapist, because discussing mental illness with family and friends is “just not something Black people do.” The therapist responds apologetically and acknowledges the inaccurate assumptions about the client and her family and social circles. The therapist then tentatively suggests that the two of them discuss how people who are important to the client perceive seeking help from a psychotherapist. The client agrees and continues to explain that mental illness is never discussed in her community, as many believe that mental illness “doesn't affect people like us.”

Research has found that resolving microaggressions and repairing alliance ruptures in an open, sensitive, and non-defensive manner, as exemplified in the case scenario above, is associated with favorable treatment outcomes (Owen et al., 2011, 2014; Safran et al., 2011). To the best of our knowledge, only one study has investigated the effects of repairing therapeutic alliances between White therapists and racial/ethnic minority clients (who were predominantly Asian American, Hispanic, and multiracial/multiethnic American adults) that were ruptured by racial microaggressions (Owen et al., 2014). Results showed that in client-therapist dyads where a microaggression occurred and was successfully resolved, the clients' alliance ratings were no different than client-therapist dyads where a microaggression did not occur. Furthermore, the client-therapist dyads that successfully resolved the microaggression had significantly better alliance ratings than dyads where a microaggression occurred but was not discussed. Therefore, while racial microaggressions are insidious in therapy and can easily go unnoticed, they can—and should—be addressed and do not have to become detrimental.

Reducing stigma, addressing race/ethnicity, and effectively managing microaggressions are

strategies that clinicians can use to help reduce Black individuals' unwillingness to seek mental health services. Still, it should be noted that these strategies are only suggestions, as there is no universally right or wrong way to interact with Black clients or members of the Black community. Furthermore, much is still unknown about how these and other factors contribute to Black individuals' decisions to use or not to use mental health services.

Future Directions and Conclusions

Professional psychological help-seeking in the Black community is a topic that is severely understudied, which means there is much left to discover. First, simply having knowledge about the help-seeking-related variables surveyed earlier in this article is insufficient for either practical or research purposes. What is needed are more sophisticated research designs that explore the intervariable relations among these culture-specific help-seeking factors for Black Americans (e.g., the relationships among help-seeking intention, mental health stigma, anti-help-seeking beliefs, cultural mistrust, etc.). Future research can examine the potential causal relationships among multiple variables by employing more sophisticated, multivariate analytical methods, such as path analysis or structural equation modeling (SEM). Furthermore, as exemplified in the present article, the TPB is a useful conceptual scheme that helps organize and comprehend existing literature and research pertaining to psychological help-seeking among Black Americans. It stands to reason, then, as a logical next step, that future research can consider employing, for example, SEM to test the TPB model's ability to explain psychological help-seeking intention and behaviors with Black American samples. This knowledge can guide how to most successfully improve psychological help-seeking intention in the Black community.

Similarly, there seems to be a consensus that addressing mental illness stigma is crucial for adequately improving attitudes toward psychological help-seeking, but there is little research about how to effectively address mental illness stigma within the Black community. Researchers have recognized that culturally informed psychoeducational interventions are more effective than generic psychoeducational interven-

tions for reducing stigma among Black Americans (Alvidrez et al., 2009). However, current mental health promotion interventions do not address how one's culture contributes to the impact of mental illness stigma on psychological help-seeking attitudes. For instance, Canada has a national antistigma campaign called *Bell Let's Talk*, which is designed to reduce mental illness stigma among Canadians by encouraging the conversation about mental health (CTV News, 2012). However, recent research by Ahmed and Dere (2017) suggests that this campaign pays little to no attention to the role culture, race, or ethnicity play in seeking help from mental health professionals. Therefore, future research can compare the efficacy of current generic mental health campaigns to the efficacy of culturally informed mental health campaigns for improving Black American attitudes toward psychological help-seeking.

Lastly, there needs to be more research on the mental health service use of Black individuals who live outside of the U.S. On the basis of our review, there is a paucity of research about the help-seeking experiences of large Black communities residing in predominantly White majority societies, such as Canada and the United Kingdom. It cannot be assumed that findings from research conducted in the U.S. are generalizable to Black communities in other countries. For example, future help-seeking research would benefit from exploring and evaluating the extent to which societal factors—such as differences in health care systems, multiculturalism/immigration policies, and/or histories of slavery across different national contexts (e.g., U.S., Canada, United Kingdom, France, etc.)—may impact the mental health conditions and help-seeking attitudes of the Black populations residing in these countries. All told, future directions can advance the study of Black psychological help-seeking intention by building on the literature reviewed in this article.

As we have attempted to demonstrate, racial/ethnic disparities in the use of mental health services is a serious concern. Thus, it is important for clinicians to understand why Black Americans have low intentions to seek mental health services, as low intention to seek help is linked to poor treatment outcomes (Shaw & Morgan, 2011). Resolving such a challenging problem is no easy task. That said, knowing why Black Americans are less willing to use

mental health services is a crucial first step for ensuring that necessary action is taken to promote psychological help-seeking in this population. It is, therefore, imperative for practitioners and researchers who are committed to improving mental health services and help-seeking intention for Black Americans to approach the issue with culturally responsive and informed perspectives. Mental illness does not discriminate; therefore, it is vital that efforts are made to ensure that all people receive the mental health services they require regardless of their race/ethnicity.

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