A PHENOMENOLOGICAL STUDY OF BLACK MALES IN THE MENTAL HEALTH PROFESSION

A dissertation presented

by

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to

The Department of Counseling and Applied Educational Psychology

In partial fulfillment of the requirements for the degree of
Doctor of Philosophy

in the field of

Counseling and School Psychology

Northeastern University
Boston, Massachusetts
August, 2014
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ABSTRACT

Using a phenomenological approach and the feminist ecological perspective, this qualitative study used individual semi-structured interviews to explore the perceptions and lived experiences of 10 Black male psychotherapists from the New England area regarding their motivation for entering the field and their perceptions about their under representation in practice. Nine themes were generated from the individual narratives with each theme containing one or more sub themes. Those themes included (a) Important Relationships with Adults who Encouraged or Supported their Pursuits; (b) Inner/Personal Qualities (c) Psychological Orientation; (d) Barriers to Entry; (e) Intersection of Culture and Oppression; (f) Masculine Identity; (g) Benefits of Increasing Culturally Aware Black Male Clinicians; (h) For Us By Us (FUBU); and (i) Intentional Recruitment and Retention. Participants through their stories revealed that Black male clinicians in the New England area have had to overcome regular exposure to systematic oppression and racism in America. The participants also highlighted their dedication to social change and social justice, which has enabled them to endure and overcome, despite enduring traumatic circumstances in their lives. The contributions of the study, limitations and future recommendations for research are also discussed.
ACKNOWLEDGEMENTS

I owe a great debt of gratitude to many people who have traveled with me along this wonderful journey. I begin by first thanking God, who has blessed me beyond measure throughout my life. I would also like to thank the 10 participants whose dedication and love for their community has inspired me to “go deeper in the trenches” while helping our community. I wish more could be done to acknowledge how much your contributions have personally meant to me. I deeply cherish the many individuals who have unwaveringly supported and mentored me during the various stages of my discovery.

For their invaluable assistance, I thank my committee members Dr. Ballou, Dr Robinson-Wood, and Dr. Sanchez. I would like to thank my committee chair Dr. Mary Ballou who supported and encouraged me through this long journey and challenged me to “explore” as opposed to “test.” She also helped me to consider the possibility that the low usage of the mental health system may be related to the incongruence between the dominant mental health system and the lives of members of Black communities. Thanks to this emphasis on discovery and exploration, I realized the importance of letting my participants share their experiences and unique perspectives. Dr. Tracy Robinson-Wood, my gratitude to you is not limited to this dissertation. You have given me invaluable professional and occupational advice at a time when it was surely needed. You also challenged me to not view Blacks as a monolith and to carefully consider the impact of culture, identity, and ethnicity. I am also truly grateful that Dr. William Sanchez was on my dissertation committee. He challenged me to explore how my findings compared with other disciplines, and his suggestions that I examine the larger societal and power
Structures enhanced my critical thinking and allowed me to examine the experiences of my participants in a larger context.

A very special thanks goes out to my friends and family who have served as the cornerstone of my very existence. To my friends, words cannot express how much you mean to me, I have known you all through the formative years of my life and I cherish every moment that has passed and that will continue. Not many people have such great friends, and I am ever grateful.

To my family who served as the foundation for my ability to learn and to love. All that I am is because of your love, dedication, and caring. My value of education and my compassion for others was learned by watching you.

I dedicate this project to my wife Fanta, my mother Marjorie, and my sister Simone. I love you all so much and I owe this all to you. You believed in me when I was unsure of myself. Your love and support has carried me through and has inspired me to be a better student, a better man, and a better human. I do not feel that a dedication can express how much you three mean to me. I am able to share with the world because of what you have shared with me.
CHAPTER 1: INTRODUCTION

The 2012 population projections for the United States indicate that there is a shift in ethnic, cultural, and racial composition, particularly for people of color. By 2043, America is projected to become a nation consisting of a greater number of minorities than Whites for the first time in history, though the non-Hispanic White population will continue to comprise the largest single group (U.S. Census Bureau, 2010). Currently, minorities account for 37% of the U.S. population, by 2060, that number is projected to increase to 57% of the population. The total minority populations will more than double, from 116.2 million to 241.3 million over the time period. According to the 2010 U.S. Bureau of the Census, the entire population of America increased by 9.7%, growing from 281.4 million in 2000 to 308.7 million in 2010. By comparison, the Black-alone population grew by 12%, from 34.7 million to 38.9 million over this same time period. In addition, 13% of Americans identified as Black-alone, while another 3.1 million, or 1% of people, self-identified as Black in combination with one or more other races.

Despite this historic increase in the Black population, marriage and family therapy (MFT), psychology, counseling, social work, and other mental health fields have been unable to grow at a rate that reflects this upward growth of ethnic minorities. This exclusion has deprived the mental health field of the added insight into the worldview, societal impacts, and concerns of racial/ethnic minorities. Various mental health fields have indicated the desire to include a more diverse workforce that is able to give voice to the concerns of a historically ignored and marginalized group (Maton, Kohut, Wicherski, Leary, & Vinokurov, 2006; Robiner, 2006). For instance, MFT training programs have cited a continued need for increased diversification of the students and faculty as a means of increasing exposure and sharing of experiences between
people of different cultures (McDowell, Fang, Bownlee, Young, & Khanna, 2007). These measures for increasing ethnic diversity may serve to empower and highlight issues of importance to marginalized student populations (Clark, Mercer, Zeigler-Hill, & Dufrene, 2012). Minority psychologists have been identified as being able to reveal new perspectives that may assist in the progression of psychological thought from a more Eurocentric standpoint, to those more relevant and reflective of the worldviews and needs of minority clients. According to Speight and Vera (2009) European, middle class conceptualizations, used as the foundation for the mental health professions, have been inadequate for addressing the needs of disenfranchised communities. Increasing racial and ethnic representation in the profession would be in accordance with psychology’s commitment to social justice (Vasquez & Jones, 2006). Speight and Vera (2009) defined the objective of social justice as the equal inclusion of all groups in the process of shaping and partaking in society. The processes that contribute and maintain the marginalization of others may be revised and transformed through the inclusion of minority groups within the field of mental health.

Specifically, in regard to mental health concerns of black people in America, an increase of black mental health practitioners could play an important role in conceptualizing theories and techniques that reflect the cultural and psychological realities of Black life, and reflect a proactive commitment towards equality and social change (Jordan, Bogat, & Smith, 2001). A proactive focus on social justice, shared power, inclusion and change requires active and deeper inquiry into the values and unique characteristics that exist for ethnic/racial minorities, whose perspectives do not originate from majority Eurocentric paradigms. The discrepancy between the growing rates of ethnic/racial minorities in the general population and the underrepresentation of racial minority practitioners in the mental health field suggests the need
for inquiry into factors that may possible reduce this disparity. Perspectives regarding issues that are of concern to ethnic minorities should be generated from the individuals, communities and cultures themselves.

The first section of this paper contains the background of the problem, statement of the problem, purpose of the study, and significance of the study. This section also contains the theoretical framework, research questions, operational definitions, assumptions, and limitations. These sections are followed by a review of the literature and a discussion of methodology.

**Background to the Problem**

Findings from Kessler et al. (2005) revealed that the annual prevalence of diagnosable mental disorders includes approximately 26.2% of the U.S. adult population, ages 18 and older, across all racial and ethnic groups. Additionally, an estimated 46.4% of Americans will develop a form of mental illness over the course of their lifetime. These findings indicate that the rate of mental disorders for ethnic and racial minorities is similar to those of the general United States population. However, there is doubt as to whether this is a true representation of the prevalence of mental illness in the multiple groups that comprise Black communities. Sue and Sue (2008) indicated that obtaining accurate accounting of mental health concerns from an ethnic minority population may be difficult due to the history of mistrust and mistreatment of African Americans by the medical profession, mental health profession, and the larger society. Additionally, disclosure norms, expressions of symptoms and distress, and recognition/acknowledgement of symptoms may be different for Blacks and other ethnic minority groups than they are for Whites, making attempts to assess their levels of health or wellness difficult using only methods and standards designed for a majority population. The general findings concerning similarities between the prevalence of mental illness between ethnic minorities and Whites also do not apply
to members of high-need vulnerable subgroups such as people who live in the inner-city, are incarcerated, are poor, and children who come to the attention of child welfare organizations and are placed in foster care (Noguera, 2003). Members of these groups that are high in social disadvantage have a higher risk for the development of mental disorders (Sampson, Morenoff, & Gannon-Rowley, 2002). According to Geronimus, Hicken, Keene, and Bound (2006), African Americans experience these disparities at a disproportionately higher rate than other groups, and are more likely to be exposed to environments that are associated with increased risk of psychiatric disorders and negative social outcomes. These disparities have numerous adverse effects such as psychological distress (Noguera, 2003; Williams & Williams-Morris, 2000), which makes it imperative that the realities of these groups be included in discussions regarding their treatment, as defined by them.

Given the aforementioned overrepresentation of African Americans in these high-need populations, African Americans have a higher likelihood of mental health needs coupled with particularly low mental health service utilization (Thompson, Bazile, & Akbar, 2004). A number of variables have been examined to explain the low usage of services by African Americans (Thurston & Phares, 2008). Low usage of mental health services has been shown to be associated with race and socioeconomic status. Studies have shown that in addition to already existing low mental health service utilization racial minorities have less access to mental health services within their communities (Mojtabai, 2005; Snowden & Yamada, 2005). Financially disadvantaged populations, such as lower socioeconomic status (SES) groups are less likely to seek health information than higher SES groups and Whites (Youman, Drapalski, Stuewig, Bagley, & Tangney, 2010). Research has indicated that racial minorities and individuals with low income and education levels receive treatment at a much lower rate than Whites and those
Another factor associated with the low participation of African Americans in mental health services is the general mistrust and long-established mistreatment of African Americans by the medical profession, the mental health profession, and the overall society. Past mistreatment of African Americans contributes to the present mistrust due to collective experiences with prejudice, victimization, exploitation, and discrimination (Sue & Sue, 2008). A cultural mistrust of Whites and White Institutions, coupled with the racial biases and stereotypes harbored by some White therapists may contribute to the mental healthcare disparities found between Black and White clients (Whaley, 1998).

African Americans are a marginalized group, with higher rates of low socioeconomic status and cultural histories of immigrating here under duress, slavery (Dana, 2002), or being victims of experimentation without their consent (Jordan et al., 2001). They have a collective history of being denied power within the overall American society and they are reminded of this constantly by their poverty and unemployment, which may render traditional tenants of psychology incongruent with their realities, and the usage of mental health services undesirable (Dana, 2002). The lack of input from minorities regarding mental health services for their communities is concerning, in light of the higher likelihood of elevated exposure to unhealthy social and interpersonal conditions, and the potential negative impact of these experiences on their mental health.

**Cultural Implications**

In response to this health concern Dr. David Satcher, the U.S. Surgeon General, produced a proposal for reducing the disparities faced by racial and ethnic minorities (U.S. Department of...
Health and Human Services, 2001). This proposal advocated for a multi-layered understanding of the roles ethnicity, race, and culture play in the reporting and acknowledgement of symptoms, help seeking ideals and behaviors, and the levels of receptiveness to mental health treatment. This plan also highlighted the societal benefits of having racial minority clinicians’ perspectives that are relevant and reflective of the views of their minority clients. The proposal emphasized increasing the understanding of the mental health field regarding the impact of culture on the lives of ethnic minorities. The U.S. Department of Health and Human Services, (2001), report highlighted the fundamental role played by society and culture in mental illness, mental health, and mental health services. The report advocates that ethnic minorities guide the mental health profession by highlighting their own cultural and societal influences. This endeavor would be undertaken in order to devise services that are more responsive to the needs of ethnic and racial minorities. The 2001 U.S. Surgeon General’s supplement explicitly acknowledged that culture “bears upon what all people bring to the clinical setting” (p. 25). The supplement validated the impact that culture often has on variations in the communication of symptoms by patients and the impact on which symptoms are acknowledged and linked with illness. Culture was cited as impacting help seeking behaviors and norms, who individuals choose to seek help from, and whether help is even sought. Societal and cultural understanding is vital for recognizing coping skills, social supports, strengths, adaptive features and resiliency. Clients will invariably bring their cultural and societal histories directly into the treatment setting.

The supplement also highlighted the importance of noting the cultures of mental health providers, as well as explicitly stating that, “every group of professionals embodies a "culture" in the sense that they too have a shared set of beliefs, norms, and values” (U.S. Department of Health and Human Services, 2001, p. 31). The culture of the mental health profession is
imbedded in the very practice, theoretical orientation, areas of emphasis, methods of inquiry, and overall viewpoints concerning the world at large. Male European American norms, values, and beliefs have historically dominated the cultural landscape of the United States. As a result of this history, which is embedded with Eurocentric and male dominant norm standards; mental health professionals may approach diagnosis and treatment in ways that are incongruent with the worldviews of their patients, particularly if the cultural backgrounds of the clinician and client are dissimilar. Thus, the historical dominance of this paradigm has resulted in behavioral health professionals and systems being inadequately equipped to meet the needs of patients from different backgrounds, and in some cases displaying bias in the delivery of care (U.S. Department of Health and Human Services, 2001). Society and culture influences both clinician and patient, therefore the foundational principles of the mental health system, which are based on White norms and ideals, must be changed in order for ethnic/racial minorities to obtain mental health care personalized to their needs.

**Under representation of Blacks in Mental Health**

The American population is diverse and composed of numerous races, cultures, heritages, and nationalities. However, racial/ethnic minorities are underrepresented at all levels of the mental health field (Vasquez & Jones, 2006). Haizlip (2012) revealed the struggles of the mental/behavioral health field in recruiting and retaining Black faculty. Furthermore, Johnson, Bradley, Knight, and Bradshaw (2007) highlighted the fact that only 3% of faculty from the Counsel for Accreditation of Counseling and Related Educational Programs (CACREP) reported being African American. The under representation of Blacks in the mental health profession is not relegated to only faculty. The 2001 Surgeon General’s Report (U.S. Department of Health and Human Services, 2001) indicated that only 2% of all psychologists in America were African American.
American. Johnson et al. (2007) reported that only 5.3% (44) out of 825 students attending CACREP accredited programs self-identified as African American males. The Center for Health Workforce Studies (2006) supplement indicated that 81% of licensed social workers were women, and only 15% of licensed social workers were Black men.

Researchers have studied and debated the reasons for the shortage of African Americans in the mental health profession and have highlighted several elements (Bowie & Hancock, 2000; Hensfield, Owens, & Witherspoon, 2011; Proctor & Truscott, 2012). The factors that contribute to this sparse representation of Black mental health professionals occur on both the individual and societal level. Johnson et al. (2007) highlighted the role that low graduation rates in high school and college play in the low number of Blacks in the mental health field. Chandler (2010) identified the following as factors that contribute to the low number of Black mental health professionals: a) inadequate recruiting, b) inadequate retention of students, practitioners, and faculty, which has implications for support, mentoring, and advising, c) a prevailing lack of awareness concerning the field in minority communities, d) a lack of connection between the field and sensitivity towards issues pertinent to Black communities, e) and inadequate funding for education and employment. Acknowledging and researching these identified multi-level factors may help reduce the impact of these barriers that contribute to the scarcity and marginalization of Blacks in the mental health field.

Recruiting, training and retaining more African American mental health professionals would help to increase the support systems for students of color. The increase in representation may also assist in decreasing the stigma associated with mental health usage. Lastly, an increase in representation may decrease the number of students who feel that the mental health field is not able to relate to or address the concerns of Black communities. Increasing the number of Black
mental health providers may provide greater contributions from Black professionals to the body of research in regards to issues of concern to Black communities, using their perspectives and not the values and research that is often generated by the dominant culture. Black mental health providers may also be able to use their knowledge of their communities to change the mental health system from one that tolerates minorities and differences, to one that respects, listens, and includes minorities as equals.

Statement of the Problem

The ineffectiveness of the prevailing mental healthcare system to adequately attend to the needs of ethnic and racial minorities has become an area of increased research and alarm. The problem associated with the current research study is the lack of Black male psychotherapists in the mental healthcare field. Another problem is the lack of input from Black male psychotherapists in regards to their thoughts and ideas concerning how the mental health field can address, identify, and respond to the needs of Black communities, while reflecting the unique social and psychological realities of their lives. Though Black clinicians do not speak for all Black people, they have the opportunity and training to uniquely bring attention to an oft-ignored perspective. Thompson et al. (2004) asserts that African American patients had concerns regarding a clinician’s ability to understand their situations, and were sensitive to the fact that a majority of psychotherapy treatment methods were developed without consideration for African Americans. The mental health field has made concerted attempts to address the shortage and under representation of ethnic/racial minorities and Black males specifically (Brooks & Steen, 2010) in an attempt to ameliorate the scarcity of non-dominate representation. However, the efforts of the behavioral health profession, based on a foundation of European male values, have been ineffective in increasing the population of minority groups and African Americans relative
to Whites in the field of mental health. Thompson et al.’s (2004) study corroborates the influence of European values on the mental health field. During a focus group, 201 African Americans respondents indicated that the image that exemplified a psychologist was that of an older, White male. Responders also explained that they had concerns regarding the depth with which psychologists would be sensitive to the societal and economical realities of their lives.

The Substance Abuse and Mental Health Administration (SAMHSA) in conjunction with mental/behavioral health experts (Annapolis Coalition, 2007) published a report for mental health practitioners citing that approximately 90% of behavioral/mental health practitioners are non-Hispanic White, while racial and ethnic minorities comprise 37% of the U.S. population (U.S. Census Bureau, 2010). The Annapolis Coalition listed the percentage of all minorities groups combined (Latino, Black, American Indian, and Asian) in the mental health profession: 6.2% for psychology, 8.7% for social work, 24.2% for psychiatry, 17.5% for psychiatric nursing, 15.4% for counseling, 5.5% for marriage and family therapists, and 5.3% for school psychology. According to the 2010 U.S. census statistics, by 2050, people of color will comprise the majority of the United States population. This anticipated population growth poses significant educational and professional implications for the practice and training of mental health professionals to meet the needs of this growing demographic (Bowie, Hall, & Johnson, 2011).

Mental health professionals and programs continue to report struggles and challenges associated with recruiting and retaining African Americans. For Instance, Curtis et al. (2004) indicated that though there were higher reported percentages of students of color enrolled in school psychology programs, corresponding percentages of school psychologists of color were not reflected in the field. These findings may indicate that students of color are not entering the mental health field despite an increase in enrollment. McDowell et al. (2007) highlighted an
over decade long struggle within the MFT field to address the lack of social and ethnic diversity that has often been prevalent throughout programs, institutes, and professional organizations. Additionally, McDowell et al. (2007) emphasized the lack of success in increasing the recruitment and retention of ethnic minorities, noting that 80% of 79 accredited MFT program students were of European American decent. Bowie & Hancock (2002), highlighted the difficulties the social work field has faced in their attempts to increase diversity in the graduate-level student body. Their study illustrated that the number of African American social workers earning MSW degrees has remained stagnant after a decline of over 25 years. The shortage or disproportionate distribution of Black therapists to patient ratio is a concern, due to the need for increased understanding of how culture and societal influences faced by Black people in American impacts the effectiveness of treatments, policies, and services intended to address their needs.

Research findings indicate that having increased numbers of Black psychotherapists may help enhance the quality and utilization of mental health resources by African Americans (Goode-Cross, 2011; Townes, Chavez-Korell, & Cunningham, 2009). Black clients may be more likely to accept therapists’ interventions and see them as useful when they work with Black therapists, who they feel may share similar worldviews (Townes et al., 2009). Being of the same racial/ethnic background does not ensure better therapeutic relationships or outcomes. However, research suggests that relationships between Black therapists and clients may possibly offer specific benefits not found in other therapeutic dyads. Cabral & Smith (2011) indicated that racial/ethnic matching may be more salient for African Americans than for White/European Americans.
Over the last 50 years, multiple sectors of the Black community have challenged the behavioral health profession to develop culturally reflective practices, policies, research, and structures that sufficiently respond to the needs of African Americans (Jordan et al., 2001). To achieve this goal of true inclusion, members of the Black community has called on Black mental health professionals to develop theories and techniques that encapsulate the complex intersection of historical, societal, economic, political, institutional, and psychological realities that constitute Black life in America (Jordan et al., 2001). Increasing the representation of ethnic/racial minority clinicians will improve understanding of the lived experiences of a vulnerable, systematically marginalized culture often overrepresented in high-needs subgroups. Additionally, the contribution of Black psychotherapists may be helpful in shaping research and treatments to reflect and assist in addressing the needs of African Americans, as defined by their standards, and not the standards of the dominant Euro-American culture.

Conducting interviews to gain insight into the reflections and motivations of Black male psychotherapists allows the mental/behavioral health community to see the profession through the perspective and interactions of African-American male clinicians. The Black population in America is not a monolith, comprising a multitude of geographical, ethnic and cultural backgrounds. However, the experiences of these Black clinicians may reveal a glimpse into the barriers and factors (such as poverty, racism, class, interactions with government agencies, school, family, peer groups, church, and communities) that they had to navigate through a myriad of historical, social, cultural, and interpersonal encounters.

**Purpose of the Study**

The purpose of this exploratory study was to gain more understanding of why Black men choose to become psychotherapists. The current qualitative study explored the perceptions and
lived experiences of Black male psychotherapists in the mental health profession and also their perceptions about the under representation of them in practice. The qualitative design allows collaboration with marginalized, previously disempowered, and silenced groups to share their narratives and worldviews in their own words (Ponte rotto, 2005). This exploration improves the understanding concerning the motivation of Black males to enter the mental health profession. There was also an examination of the views of Black males concerning the scarcity of Black male clinicians. Additional attention was given to their thoughts pertaining to the perceived benefit of Black therapists for improving the well-being of African American communities. Lastly, there was an exploration into the thoughts of Black male clinicians concerning efforts to recruit/retain racial/ethnic minorities. The present exploratory study employed a phenomenological perspective to investigate meaning and subjectivity. The phenomenological approach was ideal for this study because of its in-depth accounting from the research participants. This approach allowed for the exploration and insights from Black male practitioners regarding their lived experiences in the behavioral health profession.

The individual histories of Black clinicians and the communities that they represent are important; however, the importance of the societal, cultural, and historical contexts in which these communities are imbedded requires equal research and attention. Examining contextual factors alongside individual factors is essential for uncovering the self-identified stressors and strengths of these particular male clinicians.

Significance of the Study

This study attempts to increase the understanding of the lived experiences and perceptions of Black male clinicians related to the under representation of Black male therapists in the mental health profession. This study also attempts to explore the interplay of factors
motivating Black males to become clinicians, and attempts to document their influence through the perspective of the clinicians themselves. In Cundiff (2012), the field of psychology was described as being “womanless” and “raceless”. This was due to the lack of acknowledgement within the field concerning the influence of societal conditions and hierarchical systems of power and privilege that impact the number of women and ethnic minorities who choose to enter the profession. This failure to recognize the effect of societal realities overlooks the viewpoints of ethnic/racial minorities and women in research and presupposing that the White male experience exemplifies the model for human experience. Thus, research that includes the perspectives of non-dominant members of society is necessary for the progression of mental/behavioral health science.

The results from this study are posited to possess professional, educational, and community/societal significance. This study attempted to eschew dominant assumptions by asking Black male clinicians their motivations for becoming psychotherapists, their views on the scarcity of Black male clinicians, their views on if/how the mental health fields can better represent and meet the needs of African American communities, and their views on strategies for recruiting and retaining Black male clinicians.

**Professional.** The 2010 U.S. census projections underscore the need for all fields and academic disciplines to prepare for an increase in multicultural representation among American citizens. This shift has been difficult for the behavioral health profession due to the firm entrenchment of mores, norms, and assumptions rooted in Eurocentric practice and research (Cundiff, 2012). The need for a behavioral health workforce that promotes diversity and can reflect and incorporate the worldviews of ethnic/racial minorities into practice is essential. Unfortunately, only a small percentage of Black males choose the mental health profession as a
career (Brooks & Steen, 2010). A core concept that underlies the significance of this exploratory study was the belief that promoting and increasing diversity is beneficial to society, organizations, institutions and individuals alike. Crosby, Iyer, Clayton, and Downing (2003) describe how organizations benefit from diversity in two ways. The first benefit is the introduction of varying perspectives, which may enable an organization to respond to challenges with greater innovations. Secondly, diversity poses benefits by helping identify and provide informational marketing and service provisions and responds to the needs and desires of previously overlooked communities.

Another aspect of this study that is pertinent to the behavioral health profession is the possibility of increasing membership of the underrepresented Black communities, who may have felt unwelcome in the mental/behavioral health profession in the past. Representation of diverse groups is important because worldviews and societal realities influence the nature and content of the services afforded. Thus, changes to the profession, which may arise from racial/ethnic minorities, broadens and enhances the field’s effectiveness (Vasquez & Jones, 2006). The aforementioned census statistics illustrate the disconnect between the growth in population and the difficulties faced by the mental health field in attracting and producing a diverse workforce. For example, only 1.9% of doctoral-level psychologists in the American Psychological Association (APA) self-identified as Black (American Psychological Association, 2007), despite the overall population increase of African Americans. Statistics from the Center for Mental Health Services (2004) are similar for Black psychiatrists (1.6%), Black social workers (6.4%), and Black counseling professionals (3.8%). These findings could assist the mental health field with tailoring effort to recruit and retain more African-American in the field. Additionally, this
can also serve to increase the number of males, while achieving a racial balance in the behavioral health workforce, reflecting the ever-increasing multicultural population.

There has been growing interest in justice-centered, ecological, non-Eurocentric ecological frameworks (Flynn, Sanchez, & Harper, 2011; Greenlief & Williams, 2009; Nillson, Schale, & Khamphakdy-Brown, 2011). This changing viewpoint gives credence to the influence of the contextual dynamics that shape the lived experiences of clients. This perspective recognizes the limitations of traditional application of counseling theories solely on the individual level. Non-Eurocentric perspectives do not deny the benefits of traditional/individual level counseling, they do however illustrate the limits of individual level counseling in addressing systemic and societal issues such as oppression and poverty (Nillson et al., 2011; Vera & Speight, 2003; Zalaquett, Fuerth, Ivey, & Ivey, 2008).

This consideration of context is important due to the likelihood that predominantly White, behavioral health professionals will encounter clients or communities who differ from them in terms of culture, race, and ethnicity. The worldviews of diverse racial/ethnic clients and communities are likely to be different from these practitioners in terms of what is considered normal, what is considered abnormal, what and how helping is defined, their presentation of symptoms, and their level of trust and mistrust of a dominant society and system that has historically oppressed them, and continues to do so (Holden, McGregor, Blanks, & Mahaffey, 2012; Sue & Sue, 2008; Thompson et al., 2004; Tinsley-Jones, 2001; Watkins & Neighbors, 2007; Whaley, 1998). This research attempted to strengthen the cultural knowledge base of the mental/behavioral health profession. Specifically, the life experiences and cultural values of members of Black communities may be used to increase culturally reflective modalities and treatments, using their experiences and their perspectives.
This research attempted to promote greater diversity and inclusion in the behavioral health field by gathering information concerning the needs of Black communities, from the voices of Black males in the mental health profession. Organizations and professional bodies will benefit from diversity if they are genuinely willing to listen to the new voices and are able to actively implement changes based on these new perspectives.

The APA Task Force on Enhancing Diversity acknowledged that the psychological profession has made only modest progress in regards to creating equality (APA, Office of Ethnic Minority Affairs, 2005, 2008). The task force highlighted the stated progression of the APA in regards to the goal of increasing diversity:

The APA has been evolving as an organization that seeks to be welcoming to diversity and that there is converging interest across the association regarding the goal of enhancing diversity within APA. Attitudes have gradually changed from neglect and passive inattention in the very early years of APA, to years where such neglect represented a more active disinterest, to more recent years in which many areas of diversity have been receiving more active attention and support. As attitudes have progressed positively, actions have eventually followed, although not always rapidly or consistently. (APA, Office of Ethnic Minority Affairs, 2005, p. 10)

These findings illustrate that diversity has not always been a priority for the dominant organizations in the mental health field and that methods attempting to increase the representation of diverse communities and populations are still necessary and significant. This study aspired to contribute to the increased development of a diverse workforce that is able to work with racial minorities.
**Educational Impact.** Increasing the number of Black males in the mental health field possesses educational significance in terms of recruitment, retention, and research. In order to address the crisis of Black male scarcity in the mental health field and to improve recruitment efforts, it is critical that Black males are asked what were their motivations and influences for pursuing and completing their graduate level course in mental health. Their answers may enhance the quality and body of knowledge for recruiting Black students into the field, reflecting their different social, cultural, and political perspectives. After garnering this information, recruitment and retention approaches could be created based on the experiences and perspectives of Black members of the mental health profession.

The low percentage of ethnic minority distribution for certain psychological fields, such as school psychology, has been a long-standing problem (Chandler, 2010). For instance, approximately 90% of school psychologists identified as White, and of the remaining 7%, less than 2% identifies as Black (Curtis, Hunley, & Grier, 2004). These findings are similar to the Annapolis Coalition’s (2007) statistics regarding all behavioral/mental health practitioners. However, these findings are even more concerning because school psychologist provide most of the mental health services to students of color (Zhou, Bray, Kehle, Theodore, Clark, & Jenson, 2004) and play a predominant role in conducting evaluations that impact special education placements and eligibility (Curtis et al., 2004).

This present study may share insights into the unique issues that may be faced by Black clinicians during their academic pursuits. Presently, researchers have failed to detail the specific experiences of African American students, who, in previous studies, have expressed feelings of isolation, oppression, and marginalization (Hensfield et al., 2011; Nicholas & Tanksley, 2004; Patton, 2009). Increasing the understanding of the educational experiences of Black male
clinicians may help higher education institutions enact policies that may attract and retain a more diverse student population.

Research into the inclusion of diversity into learning environments have revealed that student learning benefits from environments that are diverse, as opposed to those that are homogeneous (Crosby et al., 2003). Higher educational institutions with a heterogeneous student population introduce students to different points of view, which provided the foundation for interactions with individuals of different cultures. Faced with new ideas and values, students experience learning that is deeper and more complex (Crosby et al., 2003). Gurin, Dey, Hurtado, and Gurin (2002) explored the educational benefits of diversity by examining longitudinal survey statistics of over 10,000 students from varying universities and colleges. Gurin et al.’s (2002) results from student interviews indicated that the diversification of higher education readies the student body for interacting with an increasingly diverse America. Gurin, Nagda, and Lopez (2004) explained the benefit of diversity further, stating that it is imperative that higher education institutions move beyond simple numerical increases of students from different racial backgrounds. The institutions must address the quality and interactions among students of diverse backgrounds in order for them to teach each other how to become culturally competent citizens and leaders in a complex and diverse democracy. Recently, research findings have indicated that higher education institutions that actively commit to diversity experience positive outcomes and benefits for their entire student body (Bowie et al., 2011; Crosby, 2003; Gurin et al., 2004). The noted benefits of this increase in diversity were the enhanced ability of all students to work with members of other racial/ethnic groups, an increase in acceptance of those from other cultural backgrounds, and an improvement in participation in community-based and other civic activities following graduation. Thus, increasing student
experiences with diverse populations in college can have a significant impact on promoting racial integration in America.

Increasing the knowledge base of learning institutions will help the mental health field attend to the interests of people from diverse needs and backgrounds, and can stimulate new approaches. The pursuit of knowledge is an undertaking that can be constructed through the lens of perception and experience. The research conducted by educational institutions is impacted by societal location, importance, and power. These factors influence which questions researchers ask, who conducts the investigation, how the results are interpreted, and what conclusions are drawn (Cundiff, 2012). Historically, these perspective or assumption were from the vantage point of a White male, producing knowledge that was limited in accurately representing and understanding the worldviews and experiences of ethnically/racially different groups.

**Community/Social.** The findings of this study could be significant for Black communities due to an increase in the cultural representation and exploration of their specific mental health needs. This study may also pose significance for encouraging social justice. Social justice advocacy in the behavioral health profession addresses societal inequalities that restrict the development of clients. Vera & Speight (2003) indicated that an active commitment to increasing diverse and multicultural representations and perspectives cannot be separated from notions of social justice. Additionally, the results of the study may highlight areas of contextual inequality and provide practitioners with a solid conceptual foundation to support advocacy and social action through the usage of an ecological framework (Greenleaf & Williams, 2009).

Presently, the mental health field is experiencing difficulty with identifying and addressing the concerns of African Americans and other historically marginalized and oppressed groups (Nilsson et al., 2011). Increasing the supply of Black mental health providers is critical
for providing competent care for African Americans in their communities. Incorporating the perspectives of Black male clinicians in the behavioral health profession may illuminate unmet needs in Black communities, spearheading new techniques based on their perspectives and worldviews.

Additionally, findings from this study may be influential in improving the effectiveness of policies designed to address the history of disadvantages that have been prevalent for minorities (Vera & Speight, 2003). The infusion of self-guided Black voices may assist African Americans with achieving equality while challenging and modifying established policies, practices, and institutional structures that were based on Eurocentric assumptions, principles, and values.

Examining the motivations of Black men may be significant from a social justice perspective and may contribute to the practice of advocating for the societal concerns of the oppressed and marginalized (Vera & Speight, 2003) while addressing issues of self-determination, equality, interdependence, and community responsibility. The surface tolerance of diversity is not acceptable if examined from the perspective of social justice and equality (Greenleaf & Williams, 2009; Nilsson et al., 2011). The individual, sociocultural, economic, and historical contexts in which racial minorities live in America are a valuable perspective that shapes their interactions with the behavioral health field and vice versa (Daniel, 2009). The vast array of overlapping realities of ethnic minorities must be examined from their perspective in order to increase their representation and participation in advancing the field to better reflect and service their needs.

The suggestions and ideas of Black clinicians, using an ecological perspective will help the identification of supports and strengths within the nested systems that are relevant to Black
communities. This perspective will also provide stakeholders with a researched perspective for incorporating environmental influences (e.g., family, church, culture, oppression, education and societal systems) into a framework highlighting both self-identified problems and solutions.

Bronfenbrenner (1979) explained that the context of participants in the research of health-related issues cannot be disregarded. As a result of the complexities within the contexts of individual experiences, inquiry into the motives and worldviews of Black male clinicians, in an increasingly diverse 21st century America requires frameworks that take these complexities into consideration (Brooks & Steen, 2010). Unfortunately, research is often concerned with an examination of individual-level factors rather than an examination of an individual or group within the sociocultural contexts and multi-levels of ecological environments (Trickett, 1997). This examination of Black male clinicians will increase the understanding of how African Americans in the mental health field maneuver through the larger social forces managing their access to power and opportunity.

**Theoretical Framework**

The feminist ecological framework (Ballou et al., 2002) was used to explore the motivations and thoughts of Black male clinicians and the contextual factors that they identify as being salient. Ballou et al., (2002) describes that this perspective was built from several theories which included Feminist therapy theory, Liberation psychology, and Transformational Multiculturalism. This framework includes foundational contributions from Bronfenbrenner’s (1979) ecological model. However, it differs from Bronfenbrenner’s model due to its integration of broader cultural and structural considerations and its explicit recognition of the value of non-dominant worldviews and meanings (Ballou et al., 2002). The notion of interconnected relationships generates important questions concerning the experiences of Black male clinicians.
These questions include aspects of Bronfenbrenner’s ecological systems, such as: what were the relationships between individual, familial, community, the larger social forces, and changes within the person and environment over time that shape the lived experiences of these clinicians? What were their support systems, what were their strengths?

The underlying principles of the Feminist ecological model allows for the examination of the multiple spheres of influence impacting Black male clinician’s motivations for becoming psychotherapists. The framework posited by (Ballou et al., 2002) expressed the view that the assumptions, norms, customs, and practices of mainstream psychology contributes to the injustice of non-dominant groups. This researcher chose the feminist ecological framework (Ballou et al., 2002) due to its commitment to exploring and articulating the worldviews of non-dominant groups from their own perspectives and the expressed rejection of oppression and social injustice.

The subsequent descriptions below are of the six ecological systems and examples of how aspects of the current study might be applicable to this framework.

**Feminist Ecological Model.** The *individual*, lies within the center of the model and encompasses the many aspects, internalized processes, representations, and genetic potentials, which interact with the other systems (Ballou et al., 2002; Berk, 2000). For example, an examination of the personal fulfillment and openness to communication of Black male clinicians are individual characteristics that spread and interact with the other levels.

The *microsystem* is the layer closest to the individual and includes the environmental elements in which the individual has direct contact and influence (Ballou et al., 2002). The micro system encompasses the reciprocal relationships and interactions an individual has with their immediate surroundings (Ballou et al., 2002; Berk, 2000). Structures in the microsystem
include family, school system, neighborhood, quality or access to resources. At this level, relationships have impact in two directions—both away from the individual and towards the individual.

The **exosystem** is the system that encompasses the regional, state, national levels that impact an individual and the environments that they are in. Ballou et al., characterize the institutions in this level as being located in positions of power and oversee public interest through a set of guidelines and structures that they have identified without soliciting information from those they purport to serve.

The **macrosystem** is the layer that may be considered the outermost layer in the individual’s environment. This layer is comprised of global distribution of resources, customs, and laws, politics, and the economy (Ballou et al., 2002). Bronfenbrenner (2005) described this layer as the social blueprints for a particular culture, subculture, or other broader social context. This explanation is applicable for this current research concerning the motivations and beliefs that are relevant to Black communities. Racism, gender roles, sexism, and socioeconomic disadvantage are other examples. This layer impacts the individual and also extends its sphere of influence across groups and communities.

Additional consideration is given to **planetary/climate conditions** which acknowledges the interconnectivity of living systems and encompasses theories, beliefs, and analysis of how humans interact with the planet.

**Research Questions**

The qualitative phenomenological research questions that guide this study of Black males clinicians are as follows: 1) What is the motivation for Black males to enter the behavioral/mental health profession? 2) What are their thoughts concerning the shortage of Black
male clinicians? 3) What are their views concerning the benefits of increasing the number of Black male clinicians, in order to identify and address concerns for Black communities? 4) In what ways can the efforts to recruit and retain Black men into the profession be strengthened?

**Operational Definitions**

During this study, the terms “African American” and “Black” have been used interchangeably. Though there are certain cultural, linguistic, and ethnic differences, these two terms was used synonymously. The interchangeability of the terms Black and African American does no assume that there is one Black collective. According to the U.S. Census (2010) the term “Black” or “African American” refers to a person having origins in any of the Black racial groups of Africa, includes people who marked “Black” on the questionnaire checkbox. This definition also includes respondents who responded-“Sub-Saharan African” (e.g., Kenyan, Nigerian), Afro-Caribbean (e.g., Haitian, Jamaican), and Afro-Latino (e.g. Brazilian, Dominican).

The terms “White,” “Caucasian,” “Euro-American” and “European” have been used interchangeably. Though there are certain cultural, linguistic, and ethnic differences, these two terms was used synonymously. According to the U.S. Census (2010), the term “White or European” refers to a person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicated their race(s) as “White” or reported entries such as Irish, German, Italian, Lebanese, Arab, Moroccan, or Caucasian.

For the purpose of this study, the terms clinician, therapist, and psychotherapist was used interchangeably. These terms will refer to practicing psychotherapists who hold masters or doctorate degrees in social work, counseling, psychology, marriage and family therapy, or related fields. The research did not focus on degree attainment; it instead focused on the
practice of psychotherapy. Psychotherapy is the formal process or interactions of two or more parties conducted with the purpose of ameliorating of distress relative to any or all of the following areas of disability or malfunction: cognitive functions (disorders of thinking), affective functions (suffering, or emotional discomforts), or behavioral functions (inadequacy of behavior). This is conducted within the framework of the therapist having some theory of personality’s origins, development, maintenance, and change along with some method of treatment logically related to the theory and professional and legal approval to act as a therapist. (Corsini & Wedding, 2000). Current Psychotherapies, sixth edition)

There were approximately 200,000 and 250,000 trained and practicing psychotherapists in the United States in 2000, ranging from doctoral level psychologists, psychiatrists, social workers, professional counselors, marriage and family therapists, and advanced practice psychiatric nurses, (Bureau of Labor Statistics, 2010).

Assumptions

The underlying assumption of this study is that the myriad of experiences that make up 21st century African American clinicians lives in America can be encapsulated and shared accurately through semi-structured interviews. Additional assumptions of this study are as follows: a) The explored experiences of Black male clinicians will differ than those of White clinicians and members of other ethnic/racial groups; b) The lived experience of Black male clinicians can be captured through purposeful recall of participants; c) The lived experiences of Black male clinicians are useful in increasing the contributions and understanding of concerns to Black communities; d) The lived experiences of Black clinicians are useful in providing information concerning the recruitment and retention of other Black male clinicians; e) There
are multiple levels and layered internal and external factors that impact the lived experiences of Black male clinicians.

**Limitations**

While qualitative methods fit precisely with the needs of this study, they do have limits as well, especially as compared to logical positivist aspirations for research. The first limitation of this study is the usage of a small sample size and purposeful sample of Black clinicians working in the New England area, which limits the application of the findings to Black male clinicians in other geographical locations. The focus on specific experiential context limits the interpretations and the ability of the findings to be generalized to the larger population. The second limitation associated with the sample selection is the focus on Black males, which limits the extrapolations that can be made to other ethnic groups and genders. Third, this study deliberately excluded other members of the African American community such as women, and other professions. The fourth limitation is the emphasis on the subjective nature of information gathering. Given that subjective recall in this study is an accounting of personal experiences, filtered through the lens of individual interpretation, the interpretation of their stories may be limited by the ability of this researcher to accurately capture the meanings of the participants.

**CHAPTER 2: REVIEW OF LITERATURE**

This section presents an overview of the literature pertaining to the factors explored in this study. Black communities have been shown to be a group that does not utilize traditional mental health services often as the dominant culture. The variables associated with historical oppression, racism, Euro-American origins and assumptions of superiority, and the exclusion of the realities of Blacks in America were explored. Additional, this literature review included factors such as: cultural mistrust, the benefit of increasing representation of ethnic/racial
minorities in the mental health field, the motivation for becoming therapists, and strategies for increasing recruitment and retention of African Americans in the field of mental health.

**Historic Overview of the Treatment of Blacks by American Systems of Power**

The historical underutilization of mental health services by members of Black communities have been consistently documented (Thompson et al., 2004; U.S. Department of Health and Human Services, 2001). The Surgeon General’s report found that the utilization of mental health services is characterized by lower availability and access, diminished quality of care, and a lack of representation in research (U.S. Department of Health and Human Services, 2001). Recent efforts to improve behavioral health services to Black communities have identified certain barriers to treatment. These barriers include socioeconomic variables that worsen or cause mental illness and a mistrust of the mental health system, based on a long history of oppression and exploitation. Other barriers interconnected with the experiences of Black people in America include: a disconnect between the principal foundations of the mental health fields and the realities of their communities, who gets treatment, who does the treating, the symptoms reported, and even why services are sought out (U.S. Department of Health and Human Services, 2001). Even the premise that the mental health field should simply increase the utilization of African Americans is loaded with foundational bias, which often assumes that treatment modalities focused primarily on individual level techniques work best for every community. This belief disregards the diverse experiences of Black communities and their ability to determine for themselves what they need. Additionally, the historic oppression, mistreatment, diminishing, and marginalizing of Blacks; their thoughts, experiences, contributions, and their worldviews must be considered when examining the low usage of dominant/traditional forms of mental health services (Carter & Forsyth, 2007; Dana, 2002).
The victimization by the dominant culture towards members of African American communities has historic and contemporary significance, influencing their social, economic, political, psychological and overall standing. The majority of the Black population in America can trace their lineage to the African slave trade (Reddie, 2007). Over a period spanning hundreds of years, millions of African Americans were kidnapped or bought as slaves to the Western Hemisphere. This continued until 1808 when the importation of slaves was banned, though domestic slave trading continued unchecked. African Americans were legally considered chattel-personal property of their owners until constitutional amendments greater legal protections for Blacks and other minority groups (Turner-Sadler, 2009). In 1868 the 14th Amendment extended citizenship to Blacks. The 15th Amendment forbade Federal and State governments from denying any citizen the right to vote, regardless of color or race. These constitutional amendments did not eliminate the oppression faced by Blacks (Turner-Sadler, 2009). For instance, the voting rights guaranteed to Blacks were systematically denied through deceitful means such as poll taxes, literacy tests, and other sanctioned methods to exclude their participation (Turner-Sadler, 2009). The dominant majority continued the systems that oppressed Blacks with the “Black codes,” or Jim Crow laws, and perpetuating the long standing tradition of economic, educational, political, economic, and social inferiority and disadvantage faced by African Americans. In 1954, the Supreme Court declared that state schools separated by race and color were unconstitutional. The 1960s saw the increased influence of the Civil Rights movement, which fought for inclusion and equal rights for all. The late 1960s saw the rise of the Black Power movement, which advocated Black self-determination and self-sufficiency. These oppressing times required immense strength and resolve to overcome.
Though there were great strides made in gaining legal protection and equal treatment, inequality is still very prevalent in American society.

The historic context of oppression and the systematic subjugation of African Americans impact their relationship with America and American systems as a whole, and the mental/behavioral health system in particular. Black communities were able to utilize a collection of individual and community strengths to surmount the litany of dehumanizing obstacles. These collective resources, values, traditions, and beliefs shaped the worldviews of many Black Americans and are still prevalent today. These adaptive beliefs and traditions are not in alignment with the foundational principles of traditional mental health services. The denigration of Black communities included slavery and raced-based restrictions from economic, political, education, social and healthcare opportunities and resources, which have contributed to the disparities that Blacks presently continue to experience. Historically, African Americans, as noted above, experienced high levels of economic and social disadvantage and inequality. Cultural and societal factors have been linked with the manifestation and exacerbation of mental illness (Carter & Forsyth, 2007; Dana, 2002).

The U.S. department of Health and Human Services (2001) reported that living in poverty had the most measurable effect on mental illness rates. These finding revealed that people in the highest strata of socioeconomic status (income, education, and occupation) were two to three times less likely than those in the lowest strata to have a mental illness. Financially disadvantaged populations, such as lower socioeconomic status (SES) groups are also less likely to seek health information than higher SES groups and Whites (Youman et al., 2010). Research has indicated that racial minorities and individuals with low income and education levels receive treatment at a much lower rate than Whites and those with middle and upper incomes (Williams
et al., 2007; Snowden, 2001, 2012; Snowden & Yamada, 2005). Racial minorities have also been reported to have less access to mental health services (Mojtabai, 2005; Snowden & Yamada, 2005). Poverty and socioeconomic status play a strong role in mental illness service access and utilization. The factors associated with socioeconomic status have been linked with having a negative influence on mental health; unfortunately, Blacks living in America belong disproportionately to high-needs populations experiencing negative socioeconomic experiences. Thus, socioeconomic status and race converge and exacerbate the difficulties with utilizing mental health services.

Researchers have also indicated that socioeconomic status is not solely responsible for the disparities in mental health. Even when health insurance coverage and socioeconomic status is controlled for, ethnic/racial minorities still experience great inequality in mental health service (Broman, 2012; Snowden & Yamada, 2005; U.S. Department of Health and Human Services, 2001; Youman et al., 2010). These findings indicate that there are other factors that impact mental health service access and use. A report by the U.S. Department of Health and Human Services (2001) identified discrimination and racism as high stress occurrences that affect mental and overall health, even when socioeconomic status was controlled.

**Euro-American Foundations of the Mental Health Field as a Barrier**

Throughout the history of the United States, the beliefs, norms, and value systems of White Europeans have dominated most aspects of American life. This includes systems, such as institutions charged with educating and preparing mental health practitioners (U.S. Department of Health and Human Services, 2001). The foundations of the behavioral health field, which purports to offer comprehensive mental health services, originated from the perspective and values of middle-class Euro-American males (Dana, 2002). These values and assumptions have
become ingrained into practitioners, who often ascribe to the beliefs that this Eurocentric model is the only therapeutic option, and that this model can be applied to all people. Gillardo, Johnson, Thomas, and Carter (2009) corroborated this sentiment by explaining that the Eurocentric model is useful in certain contexts; however, when working with racially, ethnically, or culturally diverse communities, or with communities that hold different worldviews, a modification of traditional frameworks may be needed. The exclusion of minorities is not solely relegated to the field of psychology. The educational programs, clinical training, research, and theory of the social work, marriage and family therapy, and related mental health fields were also founded on and concerned primarily with White, middle class norms (Bailey, Pryce, & Walsh, 2002; Bowie et al., 2011). This limited paradigm has not evolved to incorporate the growing diversity of race, culture, and worldviews, and may even be contrary to indigenous and collectivist beliefs systems concerning healing and health (Cervantes & Parham, 2009). Thus, mainstream behavioral health treatments may not be applicable to minority populations. This exclusion of minority perspective mirrors the history of marginalization of African Americans by the American majority and may contribute to the low utilization of services.

Additionally, the field of research, which attempts to utilize results to influence practice, also repeats a pattern of excluding the perspectives of African Americans. The U.S. Department of Health and Human Services (2001) examined a multiple efficacy treatment studies for mental disorders. The supplement highlighted the benefits of consistent scientific evidence from controlled clinical trials for improving patient outcomes. The report also illuminated the obvious omission of minority participants in the various studies. The controlled clinical trials that drive professional practices did not provide any specific investigation for any ethnic/racial minority group. The U.S. Department of Health and Human Services (2001) conducted a special
examination of controlled clinical trials (approximately 10,000 participants since 1986), citing several professional and government agencies which have relied on the scientific rigor and results of the trial outcomes to generate treatment protocols for specific disorders such as attention-deficit/hyperactivity disorder, bipolar disorder, major depression, schizophrenia. The results of this analysis indicated that only a small number of minorities were used and that none of the analyzed studies examined how effective the different treatments were by race or ethnicity. The disinclination of the behavioral health system to include racial minorities in clinical studies reinforces the notion that traditional mental health models were not concerned about the experience of minorities and continues to not be fully interested in working with the members of Black communities. Minority groups are projected to become the majority population in America, yet the mental health field has been inadequate in changing from Eurocentric paradigms to one that includes racial minorities in the development of techniques, research, training, and knowledge.

Recently, the mental health fields has attempted to consider alternative perspectives to traditional Eurocentric assumptions, as a result of the heightened focus on the changing landscape of the ethnic distribution in America (Nillson et al., 2011; Wilson & Stith, 1993). Presently 46% of students in public schools were identified as ethnic minorities, signifying a need for mental health services that are able to meet the needs of a soon to be minority-majority. The change in perspective must move away from common Euro-American therapeutic paradigms that often emphasize intrapsychic etiology models, which minorities feel may not apply to them. Instead, there must be an attempt to incorporate the spirituality, culture, family, class, diversity, and an examination of sexism, racism, and discrimination of minorities in treatment (Bailey et al., 2002; Cervantes & Parham, 2009; Dana, 2002; Kearney, Draper, &
Baron, 2005). Giving consideration to the cultural context and realities of Black communities will benefit clinicians and the mental health profession. The application of European framed mental health interventions to African American communities has not been effective in identifying or addressing their needs. The adherence of the mental health fields to Eurocentric paradigms may serve as barriers to Black communities, who may feel as if traditional forms of counseling are unable to be applied to them. It is vital that the mental health field acknowledge the realities, historical cultural contexts, and present societal conditions of African Americans and elicit their cooperation in improving the field by incorporating their diverse experience.

**Cultural Mistrust as a Barrier**

African American communities are keenly aware of the damages caused by the assumptions of European superiority and utilizes history (slavery, discrimination, racism, exclusion) to frame their understanding of how the inherent Eurocentric value system of the mental health profession views and treats Blacks (Kearney et al., 2005; Sue & Sue, 2008). Consequently, Blacks may be reticent to utilize the services of a system that purports to be helping them, yet has failed to solicit their involvement in developing, researching or representing them in treatment. Members of Black communities may be reluctant to utilize services from organizations that do not address their needs and from which the community may feel does not have their best interest in mind. For instance, African American men identified poor access to comprehensive and culturally responsive providers and a mistrust of health and mental healthcare systems as barriers to getting mental health treatment (Holden et al., 2012). Studies suggest that Black patients have a long history of receiving poor care and of being misdiagnosed by the mental health field (Holden, et al., 2012; Parham, 2002). Research also
suggests that African Americans have been over diagnosed with Schizophrenia and psychotic disorders (Kearney et al., 2005; Olejade et al., 2012).

The U.S. Department of Health and Human Services (2001) acknowledges that there is documented historical and current evidence supporting minority clients’ claims of direct and indirect bias and mistreatment. The report further states that mistrust of mental health services is an important barrier that dissuades ethnic minorities from treatment, and may account for their lower utilization rates. Watkins & Neighbors (2007) conducted a study that utilized a focus group of 46 Black men concerning their views and knowledge of mental health. The participants, citing the Tuskegee experiments as an example, expressed their fear of divulging their mental health concerns, due to the fear that they was lied to and that their information was used to harm them. Black communities are very aware of the history of abuse from White society and institutions, and have developed a sense of cultural mistrust as a means of protection.

Cultural mistrust refers to the mistrust that Black communities have developed for Whites due to the historic and present relationships of oppression and racism (Terrell & Terrell, 1981). The origins of the term arose from cultural paranoia research. However, the meaning and the usage of term cultural paranoia was changed to cultural mistrust in order to capture the adaptive nature of the concept and to highlight the cultural and behavioral context without the clinical connotations of the word “paranoia” (Whaley, 2001). The concept of cultural mistrust, which encapsulates the “paranoia-type” experience of Blacks when dealing with the dominant culture or institutions, was established using the Cultural Mistrust Inventory (Terrell & Terrell, 1981). Research concerning cultural mistrust has examined how cultural mistrust impacts the therapeutic relationship of Blacks.
Thompson et al. (2004) conducted focus groups with 201 African American participants and revealed that issues of cultural mistrust were of great debate among participants. Their study reported that participants had difficulty with trusting mental health professionals that were not connected or active in making Black communities better. Participants who had made attempts to find a therapist had a difficult time finding ethnic minority or Black therapists. Additionally, many participants indicated that they did not trust that a White therapist would be able to relate to their life experiences. The participants of the study who had no prior mental health experiences indicated that they were able to recognize the benefits of therapy, but did not trust that the majority of therapists would have enough knowledge of the Black community’s struggles and worldviews to be of service. Lastly, participants highlighted their beliefs that psychologists were preprogrammed to view Blacks negatively, would not be able to look past the stereotypes of Blacks that are prevalent in mainstream society, and thus, would be more apt to misdiagnose, mislabel, or brainwash them (Thompson et al., 2004).

This high level of mistrust may also be linked with early termination of counseling (Thompson et al., 2004). Additionally, cultural mistrust has been linked with lower treatment seeking attitudes among Black college students, and a lowered likelihood of self-disclosure to European-American counselors (Thompson et al., 2004; Youman et al., 2010; Whaley, 2001). Cultural mistrust has been show to be linked with the racial identity of Black college students. Duncan and Johnson (2007) conducted research concerning the help-seeking attitudes of 315 African American students. The results confirmed that Black college students from lower socioeconomic status had high levels of cultural mistrust and preferred Black counselors.

Holden et al. (2012) examined the mental health help-seeking experience of Black men. Their results indicated that the cultural mistrust of Whites and of mental health services with
White/European values by African Americans are not unique to interpersonal counseling and psychotherapy events. Research contends that cultural mistrust is indicative of a negative worldview of disenchantment with the entire healthcare system throughout America. Participants exhibited mistrust and disinterest in accessing mental health systems as they currently stand. This study seems to suggest that many members of Black communities have a high level of mistrust for White institutions, and will have difficulty trusting a mental health system founded on and comprised mostly of White practitioners (Cabral & Smith, 2011; Whaley, 2001).

The mistrust of the dominant culture that exists within some segments of Black communities may explain the frequent use of alternative methods of addressing mental health needs within this community. These alternate services range from informal support networks, family resources, community and church leaders, and even indigenous leaders (Cervantes & Parham, 2009; Parham, 2002; Ojelade, McCray, Ashby, & Meyers, 2012). Religious or spiritual institutions have an extensive history of providing support for members of Black communities, serving their spiritual and therapeutic needs. The spiritual resources use a holistic and communal approach that is often contrary to the individualistic tenets of traditional mental health services. Cervantes & Parham (2009) proposed that utilizing a solely intrapsychic etiology for addressing minority client distress might limit the clinicians’ understanding of salient factors that are generating and perpetuating the problems faced by their client. They highlighted the fact that many difficulties faces by Black communities are not individual in nature; they are instead adaptive responses to the societal and environmental realities of their lives such as racism, marginalization, and oppression. The community, family, and spiritual resources offer more comfortable and credible services to Blacks in their communities. These services are thought to
be able to understand the realities of Black communities and have a shared history of cooperation and trust, which is a vastly different experience than the history of cultural mistrust that African Americans have with the mental health system.

**Benefits of Increased Representation of Racial/Ethnic Minorities**

The United States of America is more diverse in ethnic, cultural, and racial composition when compared to any other time in American history (Sue & Sue, 2008; U.S. Census Bureau, 2010). The demographic growth of non-White populations necessitates an increase in the Black workforce to support and reflect the concerns of a group that previously had smaller representation (Carter & Forsyth, 2007). Consequently, there is a great need to change the mental health field towards highlighting a comprehensive view of the reality of Black people who live in America, which must be lead by members from their own Black communities. Jordan et al. (2001) concluded that the inadequate inclusion of the perspective of Black contributors hinders the applicability and effectiveness of services for members of Black communities; furthermore, they call for Black clinicians to become active agents of change in developing ethical and practical interventions for Black communities.

A benefit of increasing Black clinicians would be the greater number of clinicians who may be able to provide multicultural/cultural competency trainings to non-minority clinicians from minority perspectives. Although there have been a number of valuable trainings that have occurred by non-minority clinicians, the unique perspectives originating from minorities continues to be limited during trainings. Dana (2002) examined contemporary mental services for African Americans, framing it within the context of the historical oppression and subjugation that has been prevalent for Black communities throughout the history of the United States of America. The article explored the inadequacy of the profession in servicing Black communities
and the limitations of White clinicians at providing services to a non-White community. The article cited cultural competency evaluations that indicated that African American clinicians possess a greater level of these skills than European American clinicians. Additionally, African American clinicians providing supervision for Euro-American clinicians was cited as a possible remedy for ameliorating the modest understanding of diverse racial/cultural perspectives (Dana, 2002).

Dana (2002) reported that cultural training could be beneficial for White clinicians, citing the results from a national survey of psychologists, which revealed that more than 50 percent of psychologists did not feel confident in their ability to provide services for Black clients. Differences in race/ethnicity between client and mental health clinician do not preclude White clinicians from working with Black clients; however, increasing racial diversity and cultural competence training will heighten the awareness that White clinicians have regarding issues of discrimination and prejudice, as well as increasing their level of comfort while working with minority clients (Jayne & Dipboye, 2004). Clinicians, as previously noted, are not immune to societal bias and stereotyping (Dana, 2002). If clinicians have limited contact with Blacks as colleagues, educators, or clients this may restricts their exposure to the viewpoints of Blacks as framed by Blacks. Instead their views are shaped by messages garnered from the predominantly Euro-American perspective.

The existence of historical racial bias has resulted in predominantly negative portrayal of Blacks, and a focus on the perceived deficits of Black communities, especially in comparison to the White standards of normalcy (Cundiff, 2012; Whaley, 1998). The extraordinary individual, community, and collective strengths that Blacks are able to draw upon can be highlighted by Black clinicians when training clinicians who have less shared experiences with Black
communities. This exposure to multiple representatives from Black communities may expose non-Black clinicians to the multitude of cultures that represent Black communities. It is likely that having more experiences with representatives from African American communities that challenge bias and stereotypes will make White clinicians more effective in working with Black communities. Black communities have relied on many adaptive traits, traditions, and practices for surviving and healing through almost insurmountable circumstances. These strengths require acknowledgement, understanding, and should be incorporated into the services that are provided by the mental health field.

Though their perspectives do not represent all members of African American communities, an exploration into the experiences of Black clinicians may provide unique insights, which may eschew traditional paradigms and highlight the strengths and supportive factors that have sustained them throughout their lives. Considering the legacy of oppression and marginalization of non-White cultures, it is imperative that Black mental health workers lead the profession in identifying and addressing the needs of Black communities, while expanding the training, education, research and treatment practices of the field. Thus, the multiple worldviews that comprise Black communities must be shared and taught to the profession by actual representatives from Black cultures, which may translate into more workers who are representative and familiar with the culture of African Americans (Bowie et al., 2011; Chandler, 2010; Cundiff, 2012).

African Americans are often concentrated in poor high-need urban communities with little resources; poor African Americans often live with other poor African Americans. Poverty itself has become concentrated in urban areas, and these poor neighborhoods in turn, suffer from socioeconomic distress and disadvantage (U.S. Department of Health and Human Services,
2001). These community-level disadvantages exacerbate individual-level difficulties. However, the poverty faced in Black communities is often the result of socioeconomic, political, and economic institutions guided by racist and discriminatory practices and ideas (U.S. Department of Health and Human Services, 2001). African Americans are aware of the connection between racial discrimination and their exposure to poverty and consequently experience many stressors as a result (Wade & Rochlen, 2012). There is a need for mental health providers who possess a personal understanding of discrimination, racism, oppression, and institutional practices that adversely hinder the lives of Blacks in American. Providers from this perspective are also needed to provide community-level interventions and promote health and healing.

According to Greenleaf and Williams (2009) interventions and prevention programs have been shown to be more effective when they originate and develop with specific consideration given to the cultural and social norms and values of the population being serviced. Bowleg, Malebranche and Tschann (2012) examined the lived experiences of low socioeconomic status Black men and how they maneuvered throughout a myriad of social contexts. The results of the research revealed that the Black men displayed resilience and adaptive coping during multiple stressors. The researchers were able to highlight the importance of identifying and utilizing the existing coping and adaptive strengths of Black men, from their perspective. The acknowledgment and focus on the strengths of Black communities and the existing informal social support systems is a perspective that is often lacking in the mental health field. Not all African American communities are dysfunctional, and Black mental health workers may be instrumental in highlighting this perspective.

Research has indicated that increasing the number of Black practitioners may positively impact direct treatment of minority clients. The U.S. Department of Health and Human Services
(2001) encourages the consideration of a clinician’s worldview concerning symptoms, treatment, diagnosis, etiology and whether it is congruent with those of their clients. The clinician and the patient may harbor different assumptions about what the duties of a clinician are, how a patient should act, what causes the illness, and what treatments are available. The Department of Health and Human Services (2001) further explains that clinicians bring their own histories and beliefs to the therapeutic relationship. The potential for complications and miscommunication may increase if the clinician and client have differences that are too divergent. The U.S. Center for Mental Health Services (2001) advocates increasing the amount of Black clinicians due to the recognition that Black clients experience difficulty in finding providers who are able to deliver comprehensive services, which reflect the history, traditions, values, beliefs and realities of African American communities.

The low availability of Black mental health workers may have a negative effect on client and clinician relationships (Bowie & Hancock, 2000). The prevailing structure of the clinical relationship regularly produces some degree of distance between clinician and patient, regardless of the ethnicity of each (Burkett, 1991). In addition, clinicians also bring their own personal cultures to the therapeutic setting (Hunt, 1995; Porter, 1997). Thus, when clinician and patients do not come from the same ethnic or cultural background, there is greater potential for cultural differences to emerge (Kearney et al., 2005). Clinicians may have more difficulty recognizing symptoms that the patient deems important, or may be less likely to understand the patient’s fears, concerns, and needs. Additionally, since clinicians often mirror the beliefs, societal bias and stereotypes of the dominant society, preconceived views about Black clients may lead to misdiagnosis and mislabeling (Thompson et al., 2004). Therefore, increasing the availability of clinicians who match their clients in terms of underlying culture and beliefs may reduce bias and
decrease negative conscious or unconscious reactions/interactions based on underlying prejudice that are often imbedded in Western society concerning African Americans.

The geographical location and distribution of African American communities is another factor supported by researchers as a reason for increasing the number of Black clinicians in proportion to their distribution in the general population (U.S. Department of Health and Human Services, 2001). The geographical dispersion of African Americans pose multiple difficulties to receiving and creating self-directed mental health services. The demographic distribution of Blacks in America is still segregated. A comparatively high proportion of Blacks (53%) live in the South (U.S. Census Bureau, 2010). The population of Black-alone or Black in combination populations was highly concentrated in 106 counties in America, where Blacks represented 50% of the population. These counties were predominantly in the South, except for one (St. Louis, MI). This is in stark contrast to the rest of the country where 62% of all counties in America had a Black population of less than 5 percent. The high concentration of Blacks in specific geographic areas means that there are and will continue to be White clinicians who have very little direct experience with Blacks.

Social Justice

The expressed desire of the conventional mental health fields to increase the number of Black professionals has failed to produce results at a pace commensurate to the population (U. S. DHHS, 2001). Close inspection is needed when considering the wording and methods used to accomplish this expressed increase. The focus on merely increasing the number of ethnic minorities and on increasing multicultural tolerance is incongruent with the commitments of clinicians to social justice, equality and the equal representation of African American communities in the mental health field (Jordan et al., 2001; Vera & Speight, 2003; Williams,
2008). There has been a growing trend advocating for counseling professionals to return to the roots of utilizing social justice in theories, research, and practice (Ratts, 2009). The social justice viewpoint acknowledges dynamics of privilege, oppression, and power. The social justice paradigm approaches counseling through the lens of social activism and advocacy in order to confront unequal political, social, and economic conditions that adversely impact marginalized individuals, families, and communities (Ratts, 2009). Social justice also emphasizes the expansion of clinical roles from a traditional intrapsychic focus to broader concerns on the many extra psychic forces impacting a client’s physical and psychological well-being.

Williams (2008) chronicled the struggles of Black psychologists fighting for social justice as opposed to mere acknowledgement from the APA. The Association of Black Psychology (ABPsi) was formed as a national organization in San Francisco (1968) by a group of over 200 Black Psychologists who felt that the institutions of psychology were not meeting the challenges and needs of Black communities concerning issues as poverty and racism. The Black psychologists came together to address the grave difficulties faced by Black psychologists and Black communities. Their guiding principle was one of self-determination. The Association believed that a field that was originated by predominantly White middle class males would not be able to solve the problems faced by Black communities stemming from American/White oppression. ABPsi stated that the APA condoned White racism and the exploitation of Black communities by their continued usage of Euro-American norms and their inability to develop meaningful alternatives. The founders actively chose and maintained the organizations autonomy and independence while advocating for increasing not only the number of Black professionals, but also for a change focused on social justice to address the oft ignored political/economic/social problems affecting Black communities and other populations who’s
needs society has failed to meet (Williams, 2008). The ABPsi’s call to increase the number of Black mental health professionals was a rejection of racism and mistreatment perpetuated by the dominant mental health institutions against Blacks and was a demand for social justice and equality. It was the hope of the ABP that the social justice agenda would be furthered by practitioners who could incorporate the dynamics of race, class, and would be able to advocate and attend to issues of oppression, discrimination, institutional and political practices that adversely affect minorities (Williams, 2008). The benefits of utilizing the self-determined worldviews of Black clinicians could potentially make mental health services more reflective and accessible to minorities through active planning, program implementation, direct services, trainings, interventions, and advocacy. Although it has been a number of years since the formation of ABP, many of the issues that were initially addressed by the organization are still of concern. The Annapolis Coalition (2007) report indicated that the present mental health workforce is unprepared to meet the mental health needs of an ever-growing ethnic minority clientele.

The efforts to meet the mental/behavioral health needs of Black communities necessitate a shift from traditional paradigms to a focus on the transformation of systems of care and social justice (Nilsson et al, 2011). There is a concerted effort to increase the utilization of mental health services by African Americans. Yet, as previously cited in Williams (2008), the prevailing institutions and dominant bodies of the behavioral health professions are not able to reflect, identify or treat the myriad of concerns for many Blacks. Mays (2000) cited the need for a social justice agenda in which the health and well being of people are not hindered or negatively impacted by class, gender, ethnicity, religion, sexual orientation, or unequal distribution of resources. Goodman et al. (2004) conceptualized social justice work as:
Scholarship and professional action designed to change societal values, structures, policies, and practices, such that disadvantaged or marginalized groups gain increased access to these tools of self-determination. Drawing on an ecological model of social analysis, we propose that social justice work occurs on three different levels: the micro level, including individuals and families; the meso level, including communities and organizations; and the macro level, including social structures, ideologies, and policies. The idea that counseling psychologists interested in social justice must work to change social structures, not just individuals, is implicit in this conceptualization. (p. 795)

Jesse Jackson (2000) addressed the APA, and echoing Goodman et al.’s concept of social justice, challenged the social science disciplines to be instruments of social change. He called for the mental health profession to remember that injustice is still prevalent, and called for the rejection of injustice. He warned not to become complacent due to past accomplishments, and asked that new goals focused on ending injustice and changing paradigms reflecting new realities be championed. Jackson (2000) also advocated for the increased role of Blacks in the movement towards social justice, stating:

> We must all reject the state of health care in the U.S., unequal educational opportunity for the haves and for the have-nots, and forced choices between bad and worse that we confront every day. Today I challenge your sense of accomplishment and comfort. You must include ethnic minorities not only because it is right, but because inclusion makes you better and stronger. (p. 329)

Jackson (2000) advocated for the increase in minority representation in the social sciences in order to address concerns of racism, poverty, and oppression plaguing Black communities. He recognized that the historically changing times required eschewing purely Eurocentric/racist
perspectives and required the movement towards including diverse points of view and cultural realities, which will strengthen the behavioral health profession.

Roberts & Miller (2004) examined the important contributions that Black psychologists could make for responding to the HIV and AIDS crisis in Black communities. The authors explained that the HIV epidemic was accompanied by mental health complications related to stress and burden for the individuals infected their families, the healthcare system, and the prevailing public health system. These interactions were made even more complex due to the additional challenges of poverty, perpetual racism and racially based health care disparities. Community resources were inadequate to meet the multifaceted needs of this population. The article also examined prevention and intervention program implemented in the community. It was noted that the programs did not make any attempts to illicit information from the community in regards to whether the interventions were congruent with their cultural realities. Results of this study indicated that Black psychologists, with their unique understanding of internalized and externalized behaviors, knowledge about trauma, and the cumulative effect of poverty, oppression, discrimination, homophobia, race-based economic and social inequality, are in a powerful position to enact social change.

Kiselica and Robinson (2001) examined the roots and history of social justice advocacy and highlighted contributing scholars and clinicians who were able to make significant changes towards greater equity in the United States. The article identified multiple contributors who used social justice advocacy for the betterment of larger society, such as Bonnie Strickland, the seventh female president of the APA who advocated for the rights of marginalized groups (Blacks, women, GLBT) on multiple levels (individual, family, community). However, the article’s focus on Black contributors to social justice was explored and extrapolated onto the
debate concerning the benefits of Black mental health professionals for furthering the cause of social justice. Clement E. Vontress was a Black psychologist who pioneered cross-cultural counseling during the midst of the civil rights movement, paying close attention to the sociopolitical background of Black clients, and the difficulties faced by White clinicians in working with them. His role in directly incorporating the societal, historical, political, and cultural aspects of his clients’ lives laid the foundation for multicultural counseling skills and practice. Additionally, Vontress was cited for a variety of strategies he utilized, such as meeting with civic leaders to advocate for student rights. Maime Phips Clark and Kenneth Clark were African American psychologists and activists. Their most famous work were the experiments where they showed Black children two dolls that were identical except for in skin color. The children were then asked numerous questions including which doll was the “nice” doll, which doll was the “bad” doll, and which doll looked most like them. The researchers discovered that many children identified the Black doll as the Bad one, and almost 50 percent of children selected the White doll as looking most like them. The experiments were helpful in Brown vs. the Board of Education case, highlighting the harmful effects of segregation on children (Clark & Clark, 1947). After World War II, Maime and Kenneth Clark worked to improve mental/behavioral health services for children in Harlem, NY. Rebuffed by the social services institutions in New York, they decided to make their own clinic. Together they opened a mental health clinic with the desire to surpass services offered to Blacks by non-members of their community. The Clarks were also involved in many other advocacy and social justice related activities and illustrated the benefits of having mental health practitioners from a community develop and implement change (Kiselica & Robinson, 2001).
Increasing the representation of African American clinicians to the mental health field aligns with the social justice paradigm that advocates for groups affected by discrimination and mistreatment to take active steps in changing the multiple systems oppressing them. Black clinicians bring important new perspectives and insights to the challenges facing their Black communities. Black clinicians are in positions where they can help to explain and connect their cultural frameworks with prevention and intervention programs. Additionally, Black clinicians may be in a position to translate and reflect the realities of their Black communities and begin the process of altering the misperceptions of applied practices and theories of change to Black communities. Black clinicians, due to their membership in both the mental health fields and their respective Black communities may also be uniquely qualified for helping Black communities through the many socio-cultural difficulties impacting their lives (Jordan et al., 2001; Roberts and Miller, 2004). Vera & Speight (2003) called for the recognition that a commitment to social justice is necessary for achieving genuine multicultural competence. The comments illustrate that professional activities of clinicians go beyond the individual counseling relationships and extend into the community and policy levels, advocating for social change. Gorski (2009) also links multiculturalism with social justice. However, he makes a distinction between surface increases in the number of minority mental health professionals and true social change, stating that the focus on intercultural relationships, respecting differences, and cross-cultural education and practice falls short of fighting for the ending of injustice. Accordingly, the contemporary notions of multiculturalism is another embodiment of White privilege, in which the dominant oppressive group requires disempowered people to build relationships and resolve conflict with their oppressors on their oppressors’ terms (Gorski, 2009). The goal of social justice is to help challenge institutional and social barriers. Considering the multiple
levels of disadvantage presently faced and previously overcome by African Americans and others, it is imperative that the past contributions of Black mental health professionals and the need for increased representation be linked and explored through contributions towards equality and social justice.

**Motivation to become a Therapist**

The reasons and motivations for the selection of psychotherapy as a profession is a subject that does not often garner enough research and formal consideration (Norcross & Farber, 2005). Whenever the question of why individuals choose psychotherapy as a career has been examined within the field, research primarily uses the common-elements approach and the specific-factors approach to address this question. The common-elements approach is grounded in the notion that there are similar childhood experiences that shape most therapists and results in certain individuals choosing therapy as a profession, regardless of unique characteristics such as gender, ethnicity, and theoretical orientation (Henry, Sims, & Spray, 1973; Sussman, 1992). The common-elements approach examines motivations and influences that are common amongst therapists using both empirical and clinical literature. The specific-factors approach (Farber, Manevich, Metzger, & Saypol, 2005) is not based on the idea that there are essential commonalities amongst individuals that become therapists; rather this approach uses a multiple pathways perspective and acknowledges that career choice differs based on many factors such as gender, culture, role models, theoretical orientation and family background. For instance, the motivations of Black clinicians growing up and practicing during the Civil Rights Era will most likely differ from the motivations of Black clinicians practicing in 21st century America.

Both the common-elements approach and the specific-factors approach have aspects that are important to consider when identifying an individual’s choice to become a therapist. The
common-elements approach is necessary when attempting to initially identify general
commonalities. However, it is also necessary to use the specific-elements approach, as it allows
for the examination of the impact of societal and historical circumstances, and is not based on the
assumption that all clinicians are alike, as this would deny the reality and subjective experiences
of individuals who choose to become therapists. The motivations and histories of therapists are
important to acknowledge, in order to identify themes that are based on certain commonalities
found throughout the demographic, and the ones that are unique to specific populations, such as
ethnic minorities or women.

Norcross and Farber (2005) reviewed empirical and clinical literature to examine the
reasons individuals choose to become therapists. During their review certain themes emerged
from the literature regarding the common motivations and influences to become a clinician: a) the
therapist as “wounded healers,” b) a need for intellectual curiosity and having mentors that
inspire; c) having a disposition which views life with a focus on the dynamics of human
behavior; d) belief that being a therapist will result in future career satisfaction; e) experiencing
personal therapy before entering the field. Most of the motivational factors that impacted the
decision to become a clinician were personal in nature. Farber et al. (2005) believed that many
clinicians had a predilection towards healing and growth that enabled their various life
experiences to lead them to pursue the field. There was also acknowledgement that the
individual life experiences and worldviews of the psychotherapists and their culture influenced
their therapeutic orientation, and perceptions of the role of therapist and client.

Faber et al. (2005) reviewed the narratives of 8 contributors to a journal that was
dedicated to first-person accounts of their motives for becoming psychotherapists, exploring the
influence of family, culture, and psychological needs. Farber et al. (2005) identified 12 recurrent
themes involving therapist as a career paths: 1) experiencing cultural or social marginalization; 2) experiencing painful childhood experiences; 3) having a disposition of viewing life with a focus on the dynamics of human behavior; 4) a history of serving as a confidant to others; 5) having a mentor that validated and affirmed one’s individuality; 6) experiencing personal therapy before entering the field; 7) a desire to help others; 8) a need to understand others; 9) a need for professional autonomy; 10) an interest in the intimacy that occurs during the therapeutic relationship; 11) a need for intellectual stimulation; 12) a need for self-growth and healing. The authors noted that there appears to be no single experience or genetic factor that would explain the motivation to become psychotherapists. Multiple forces work together to motivate an individual with an existing penchant towards sensitivity and the inner experiences to become a psychotherapist. Culture, family, experiences of personal distress, reading, being a confidant, being in the presence of the suffering by others, class, gender, race/ethnicity are factors that vary from individual to individual, and were shown to influence the decision to become a psychotherapist. The study utilized the narratives of eight psychotherapists to explore the motivation to become a psychotherapist, however, the racial composition of this study excluded African Americans and included one Latina female. The findings included a consideration of culture, class, race, and family, without input and participation from more racial minorities, the applicability to minority psychotherapists is unknown.

Murphy & Halgin (1995) conducted a study to examine the motivations and experiences that influence people to become therapists. The participants in the study were 109 psychologists. 56 of the participants were psychotherapists; the other 53 were social psychologists. The psychotherapy group had a gender distribution of 30 men and 24 women. The social psychology group had a gender distribution of 25 women and 25 men. The racial/ethnic background of
participants was not noted. The results revealed that there were significant differences between social psychologists and psychotherapists on two factors that motivated them to become therapists: vocational achievement/opportunity and personal-problem resolution. There were also significant differences found in the experience of personal problems and troubled family experiences. According to the authors, psychotherapists viewed vocational achievement as more important than social psychologists on their decision to become a therapist. In this study, there was a higher likelihood that psychotherapists entered their career to resolve personal problems than social psychologists. However, only a minority of psychotherapists considered this critical to their decision to become therapists. Both psychotherapists and social psychologists endorsed the importance of interpersonal alliance. For therapists the most important interpersonal alliance was being a confidant, a psychotherapy client, or having a special teacher. For social psychologists, having a special teacher was most often cited. There were no differences on a scale of professional altruism, although psychotherapists showed a trend towards greater emphasis on altruism, while social psychologists often referred to the desire to change society. The study made no reference to the race of the clinicians, making the level of applicability to minority clinicians unknown. The stated desire of the social psychologists to engage in social change is in accord with the goals of the Association of Black Psychologists (ABPsi) and social justice paradigms that were previously discussed in this paper; examining whether Black psychotherapists endorse these ideas may illustrate an area of value for African American psychotherapists.

Racusin, Abramowitz, and Winter (1981) conducted a study on the relationship of therapists’ childhood recollections to their careers. The participants included 14 therapists, seven female and seven male. The therapists all possessed clinical psychology degrees, 5 at the
doctoral level and nine at the master’s level. The results indicated that all 14 clinicians had at least one family member with a physical or behavioral difficulty related to psychogenic factors. Despite the reported difficulties, only one of the therapists in the study, two of their siblings, and none of their parents had ever received therapy for these difficulties. The authors explained that they viewed the behavioral and physical conditions as manifestations of intimacy difficulties in their families. These chronic behavioral and physical ailments required unreciprocated nurturance from their caregivers. In these relationships the expressions of intimacy was unidirectional. The authors also characterize psychotherapy as mirroring this construct by possessing nonreciprocal relationship features, but during their role as therapists these individuals wielded the power. Additionally, the study notes that therapists may have pursued careers that provide emotional intimacy as compensation for the early family difficulties and deprivation. This study did not make mention of the ethnic/racial composition of participants, thus applicability to Black clinicians may not be possible. For instance, the authors refer to psychotherapy as a non-reciprocal relationship; however, clinicians who reject the Euro-American paradigms of traditional psychotherapy and who advocate for a feminist or minority philosophies may view these therapeutic relationships differently (Roberts & Miller, 2004; Strickland, 2000; Williams, 2008).

Elliot & Guy (1993) conducted a study to examine the prevalence of childhood trauma and family dysfunction of female mental health professionals and compared these findings to the prevalence of women in other professions. Additionally, the study examines the level of psychological distress in the adult lives of women who chose to enter the field of mental health as compared to the women who did not. The sample size was 2,963 women. Mental health practitioners accounted for 12% or 340 participants. The professional mental health composition
entailed: clinical social worker (N=214, 63%); psychologists (N=58, 17%); psychiatric nurse practitioners certified to provide individual psychotherapy (N=57, 17%); and psychiatrists (N=10, 3%). The representation of Black female clinicians was (N=88, 5.1% mental health professional, 2.7% other profession). The results of the study revealed a relatively higher prevalence of family dysfunction and trauma among mental health professionals. Female therapists reported significantly higher rates of sexual and physical abuse, parental alcoholism, hospitalization of a parent for mental illness, and death of a parent or sibling than did women of other professions. Additionally, the women in the mental health field reported greater levels of family dysfunction, less cohesion, and more conflict than women in other professions. The authors noted that the factors that motivate mental health professionals are varied, with some being related to childhood events, individual characteristics, and family dynamics. The study also suggests that due to these dysfunctions, children often play the caretaker role for ill people and may experience greater comfort with similar roles than people who had not experienced their level of dysfunction. The findings from this study also suggest that female mental health professionals experienced significantly less depression, anxiety, sleep disturbance, and impairments in interpersonal relationships than women in other professions.

Most studies do not examine the motivations for Black clinicians specifically. However, Chandler (2010) conducted a study that examined this population and asked the following questions: a) What should psychology graduate programs do to recruit more Black students? b) What were the motivating factors that influenced Black students to remain in their programs, especially since they were in the minority? The participants were 44 Black students and three Black faculty, representing three Historically Black Colleges and Universities (HBCU). The resulting themes that emerged, which related to their motivations for remaining in psychology
graduate school were: a) a desire and feeling of responsibility to help their Black communities; b) the need to create established connections between the field of psychology and Black communities; and c) an interest in increasing the Black community’s awareness of the psychology field, coupled with a heightened awareness concerning the importance of having Black psychologists in the community. The original purpose of the study was to find out information concerning recruitment and retention; however, useful information concerning the career motivations of Black psychology students in the mental health field was also garnered.

Bowie & Hancock (2000) also studied the motivation of Black students to pursue graduate learning in the mental health field. They examined the career influences and motivations for a sample of African American and other Black graduates in MSW programs. The participants were 120 MSW graduates from 2 institutions. The ages ranged from 24-72 (41.5 mean age). The gender distribution was predominantly female (N=92, 75%). The racial composition was predominantly African American born in the U.S. (N=79, 66%), the remaining were Black citizens of West Indian descent (N=38, 31.7%), most of the latter being Jamaican Americans (N=17) and Haitian Americans (N=12). The results indicated that the demographic variables of significant influence were gender, childhood SES, and pre-graduate school income. The career variables that were significant were undergraduate major, pre-graduate school job satisfaction, perceived fairness in pre-graduate school job, and type of employment setting. The authors noted that examining the motives of Black social workers from a qualitative method was unique and could contribute to institutional and professional change in the social work field.

**Recruitment**

One of the earliest articles to address the recruitment of ethnic minorities into mental health was Albee’s (1969) article, which examined ways to increase the number of minorities
entering school psychology at a graduate level. Recruitment literature has examined the individual and institutional factors that impact the recruitment of minorities into higher education in general and has found that a multitude of factors impact the likelihood of minority students entering the field, student motivation (Flowers, 2006; Zhou et al., 2004), the affordability of an advanced degree (Carter, 2006), the availability of social supports for students (Flowers, 2006) and many other individual factors. Since Albee’s (1969) article research has continued to address the enrollment of minorities into the field of mental health (Isaac, 1985; Loe & Miranda, 2005; Maton et al., 2006; Ponterro, Burkard, Yoshida, Cancelli, Mendez, Wasilewski, & Sussman, 1995; Wilson & Stith, 1993; Yoshida, Cancelli, Sowinski, & Bernhardt, 1989). Some authors have attempted to not only identify general themes related to minority recruitment, but have identified ways to increase recruitment and retention of minorities within the field (Munoz-Dunbar & Stanton, 1999; Rogers & Molina, 2006). These authors discussed factors that contributed to the successful recruitment of minority applicants such as: diversity in coursework and research, financial assistance for students, having minority faculty representation, having minority student representation, the existence of a taskforce devoted to minority recruitment, and having links to historical institutions of color. Rogers (2006; Rogers & Molina, 2006) also specifically discussed the recruitment strategies of school psychology programs, which have historically had more effective recruitment strategies for minority students.

Yoshida et al. (1989) found that successful psychology programs were twice as likely to respond to minority applicants, which coincided with their stated findings that Black and Hispanic students were more likely to rate admissions materials highly, compared to their White counterparts. The data regarding a program’s likelihood of responding to minority students included 121 clinical programs, 58 counseling programs, and 41 school psychology programs.
However, the sample of students in this study that were asked to rate admissions materials only consisted of six psychology undergraduate students, which suggests that these findings may not be an accurate reflection of students entering graduate mental health disciplines.

To date studies have attempted to examine successful methods for recruiting students of color such as the use of targeted application material (Bidell, Turner, & Casas, 2002), using techniques to identify minority students who excel academically (CEMRRAT, 1997), and the use of flexible admission criteria (Vasquez & Jones, 2006). These strategies must be carefully considered because they may be viewed by minority applicants as focusing on the perceived deficits of minority students, rather than using strength based approach (Maton & Hrabowski, 2004). Furthermore, the literature on recruiting minorities often lumps all minorities into one large group and usually does not examine the unique aspects that impact the recruitment of each minority group. The literature on recruitment also often does not incorporate the perspective of minority communities and is primarily based on the opinions of authors. The techniques used by “exemplary” psychology programs are based on findings outside the field of mental health (Chandler, 2010). A more recent study attempted to incorporate the views of one group of minorities into the research on recruitment by asking Black faculty and students at Historically Black Colleges and Universities (HBCU) to give their views regarding school psychology as a career choice (Graves & Wright, 2009). The researchers questioned 165 students and 14 faculty members at three HBCUs and found that 47% of students reported that working with children was an important factor when deciding on a graduate school. The same study also found that 78% of the faculty members believed that neither the National Association of School Psychologist nor the American Psychological Association provided their school with information about school psychology. It is important to begin asking members of specific minority groups what factors have
been most effective during their process of deciding to attend graduate school. Garnering this information from members of the community will provide more meaningful information and may help develop more useful strategies for recruiting minorities.

**Retention**

In addition to the research on recruitment, there has been increased investigation regarding the retention of minority students once they have begun graduate studies. Many of these studies are outside the field of mental health and focus primarily on attrition at a doctoral level and do not identify factors that impact attrition for minorities seeking masters or specialist degrees (Lovitts & Nelson, 2000). This may be problematic for examining the retention strategies for minority clinicians, as many behavioral health disciplines confer credentialing at the Master’s level to practice psychotherapy. There are estimates that 50% of all students who enter a doctoral program in America do not complete the degree; however, the lack of a national database makes it difficult to validate these estimates (Lovitts, 2001).

Most research regarding attrition focuses on factors that are believed to predict student completion of an advanced degree such as, undergraduate grade point average, Graduate Record Examination (GRE) scores, age, race, and gender (Hoskins & Goldberg, 2005). These findings regarding the use of the GRE as a predictor of graduate school completion have been inconclusive. Some researchers have found a connection between GRE scores and first year graduate school grades (Steinberg & Williams, 1997). However, research has also found that GRE performance is not as predictive of quality of research, teaching ability, or dissertation success (Sternberg & Williams, 1997). Additional research findings suggests that GRE is a predictor of first year graduate school grades, scores on comprehensive examinations, faculty evaluations, the amount of publications that a student will author, and overall ability to complete the graduate degree (Kuncel, Hezlett, & Ones, 2001). The aforementioned articles have examined retention related to all racial groups and were not focused on factors that may be unique to
specific minority groups, and there is little known about African American males within the field of mental health. Furthermore, it is also important to be aware that some research findings suggest that GRE and other traditional methods of evaluating performance may not be an indicator of potential and future performance (Heggins, 2005).

While reviewing the mental health recruitment literature, it appears that most studies combine the discussion of recruitment and retention. The factors related to recruitment were often given primary investigation over retention, which may indicate the difficulty in gathering or developing adequate retention strategies, especially pertaining to black males. There are some studies that discuss retention strategies for minority students which includes the following factors: the existence of minority faculty members and students (Hammond & Young, 1993; Speight, Thomas, Kennel, & Anderson, 1995; Rogers & Molina, 2006); the presence of diversity issues during coursework, (Ponterotto, Alexander, & Grieger, 1995); financial assistance (Lott & Rogers, 2011); support groups (Hammond & Young, 1993); and the use of peer mentoring programs (Hammond & Young, 1993; Rogers & Molina, 2006). More recently, Proctor and Truscott (2012) conducted a phenomenological study that included interviews with seven African American students who left doctoral level school psychology programs. The study identified misalignment between the participant’s career goals and the practice of school psychology, and poor relationships with school faculty and peers as the main factors that contributed to attrition from their graduate programs. This study reported that the issue of professional misalignment was usually related to a program’s failure to meet training expectations and the student’s perceptions about job role constraints. The issue of relatedness to faculty and peers was usually associated with interactions in which racial differences caused strained relationships with others. There was some indication that having a peer who was also considering leaving a program impacted the likelihood of these students to leave their graduate programs. The retention strategies that emerged as helpful for minority students possessed
relational aspects. The findings appear to support the conceptualization that African Americans value cooperation and collective unity (Cervantes & Parham, 2009; Dana, 2002) during their academic experiences, highlighting the need for increased input from members of the Black community concerning strategies developed to recruit and retain them in academic programs.

Summary of Literature Review

The literature review presented above explored the historical and present conditions of oppression and marginalization faced by Black communities and the inability of the current mental health system to address their needs. The history of Euro-American norms as the foundation of American institutions and the subsequent mistreatment of Blacks were explored and connected to how the paradigms and treatment modalities designed by White, middle class males might not be applicable for African Americans. The review examined and advocated for increasing the representation of Blacks, and shifting towards including the worldviews and realities of ethnic minorities in order to meet the demands of the growing diversity in America. Lastly, the importance of a social justice paradigm, in which individual-problem centered therapy was replaced by a focus on both the individual and the multiple ecological levels of interactions (discrimination, poverty, and sexism) was explored. The efforts to understand the underutilization of mental health services by Black communities has been ineffective due to biased examination through the lens of traditional mental health disciplines and values. There is growing justification for research and investigations that are initiated by members of the Black communities, developed by Black communities, for Black communities.

CHAPTER 3: METHODS

A qualitative approach was used to understand the lived experiences of Black male clinicians practicing psychotherapy. This approach was used to explore participants' lived
experiences as Black men and potential, salient experience(s) that may have influenced their choice to become clinicians. Qualitative interviewing has been described as an important tool for data collection. This method helps to assess, and/or access information that the researcher cannot otherwise observe. A qualitative design was chosen over a quantitative design due to a desire to conduct research focused on exploring and understanding the unique experiences from the perspective of the participants themselves. According to Patton (1980), individuals’ sentiments such as feelings, thoughts, and emotions may not be adequately assessed solely with quantitative approaches. Furthermore, qualitative research methods emphasize discovery as opposed to the explanatory or confirmatory goals of quantitative research (Morrow, 2007).

Quantitative research methods tend to focus on the strict quantification of observations (data) and on careful control of empirical variables. Quantitative research often incorporates large-scale sampling and the use of statistical procedures to examine group means and variances (Ponterotto, 2005). Quantitative studies have a foundation in positivism and adhere to the hypothico-deductive method, in which the focus is on verification of apriori hypothesis, which can be converted to mathematical formulas expressing functional relationships (Ponterotto, 2005). Quantitative research designs also frequently utilize a dualistic perspective on the relationship between the researcher and the study participants. The role of the researcher is to be objective and detached in an effort not to bias or influence the research results (Ponterotto, 2010). Given these factors, a quantitative method would be a different form of inquiry than the examination of narratives desired by this research.

Qualitative approaches, on the contrary, allow interpersonal interactions between interviewer and participant in an effort to access and describe their lived experiences (Ponterotto, 2005). The qualitative researcher is able to talk with participants about their experiences and
perceptions, enabling the evaluator to make firsthand observations of activities and interactions, sometimes engaging personally in those activities as a participant observer (Patton, 1980). Thus, qualitative methodology is preferred for in-depth naturalistic inquiry, data collection involving face-to-face interaction, commitment to authentic representation, and development of holistic accounts of participant’s meanings (Damianakis & Woodford, 2012). Qualitative research considers the perspective of the people themselves. Researchers use qualitative inquiry to elicit emotions and perspectives, beliefs and values, and actions and behaviors for the purpose of understanding the participants’ responses, the meanings they construct about the experience, and their subsequent actions (Morse, 2011). Qualitative research includes valuable descriptions and first-hand accounts and details. Poterrotto (2010) proposed that qualitative study allows researchers the ability to understand the worldview of participants through intensely listening to and respecting their own voice and their own interpretation of life events. This allowance for non-majority viewpoints was critical for bringing a deeper cultural understanding of Black male achievement in America.

**Research Questions**

This study explored the experiences of Black male psychotherapists. The participants’ lived experiences and the potential impact these experiences may have on their choices to become clinicians was explored using the following research questions: 1) What does it mean to you to be a black clinician? 2) I am interested in your motivation for choosing a career as a clinician, can you tell me about it? 3) What do you think about the shortage of Black male clinicians in the mental health fields? 4) Do you believe an increase in the number of black clinicians will impact the ability of the mental health field to address and meet the needs of the Black community? 5) Do you have ideas about some helpful recruitment and retention strategies
for increasing and keeping Black clinicians? 6) What is it like for you to be contributing to this research?

**Philosophical Orientation**

The phenomenological perspective was the conceptual foundation chosen for my research due to its philosophy of understanding and discovery. The phenomenological approach to investigation moves away from imposing presuppositions on the subjects being studied and entrusts the development of inquiry from the rich descriptions of the participants themselves. This approach can be described as follows:

Phenomenology does not form theories, operationalize variables, deduce or test hypotheses, or use probabilistic calculations to establish confidence as does positivist and neopositivist approaches. Phenomenology holds that psychological reality-its meanings and subjective processes-can be faithfully discovered. Psychological realities need not be constructed; they have essential features that can be intuited and described by the research scientist. “Interpretation” may be used, and may be called for, in order to contextually grasp parts within larger wholes, as long as it remains descriptively grounded. (Wertz, 2005, p. 175)

A few key element of phenomenological research were essential for this inquiry into the experiences of 21st century Black psychotherapists. The first was the suspension of scientific assumptions about the nature and causes of their experiences. The second was the use of interviews to gain descriptive access to the life-world situations within and outside of the world that they have experienced over the course of their lives. Third, there was an analysis of the meanings of situations and the psychological processes that gave rise to them. Lastly, there was no claim to universality in these findings, only descriptions that are reflective of the life-worlds
of these clinicians (Wertz, 2005). It is the wealth of the clinicians lived experiences that this study sought to understand. In order to give explicit focus to the concepts of exploration and meaning, understood through the eyes of the participants themselves, a phenomenological method was used. Phenomenology also instructs counseling researchers to “identify a phenomenon of interest and then temporarily refrain from imposing their own judgment about a phenomenon (i.e., epoche), approaching it with a fresh perspective and bracketing their expectations and assumptions” (Hays & Wood, 2011, p. 291). This perspective (bracketing of assumptions) accepts the possibility that not all research is conducted impartially and allows the researcher to later integrate their own experiences into the research process. Phenomenology entails the contextualization of phenomenon in a manner that is reflective of the experiences of the participants. Utilizing the tenets and principles of phenomenology assisted in uncovering meaning from the participants and their interviews. By highlighting the meaning making of Black male psychotherapists, this researcher hopes to gain a better understanding of the multiple salient moments in their lives.

**Sample Selection/Population**

The 10 participants for this study were drawn from a population of self-identified Black male psychotherapists from the New England area who hold masters or doctoral degrees in social work, counseling, psychology, marriage and family, or related fields. A purposive, non-random sampling strategy was used to recruit clinicians to participate in these interviews.

Purposive sampling is a non-probability sampling technique, which samples key members of a group whose information-rich cases may elucidate the questions under study. “Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry, thus the term purposeful sampling. Studying
information-rich cases yields insights and in-depth understanding rather than empirical generalizations,” (Patton, 2002, p. 242). For study participation, only three inclusion criteria were stipulated. The first was being self-identified as Black. The second was present employment as a practicing clinician. The third was a willingness to participate in one-to-one, face-to-face interview.

Ten Black male clinicians in the New England area participated in the current study. Assistance was provided through a small network of Black clinicians in the greater New England area in order to garner the appropriate sample size of Black male clinicians needed for the study. Polkinghorne (1989) indicated that a sampling size of 5-25 participants was recommended. Additionally, Wertz (2005) indicated, “the nature and number of participants cannot be mechanically determined beforehand or by formula. Rather, deliberation and critical reflection considering the research problem, the life-world position of the participant(s), the quality of the data, and the value of emergent findings with regard to research goals are required in a continuing assessment of adequacy” (Wertz, 2005, p. 171). Ten Black male clinicians from multiple ethnic backgrounds, levels of education, and experience participated in individual interview. The ages of the clinicians ranged from early thirties to early sixties [see Table 1]. By including Black male clinicians of different ethnic, age identification and at multiple levels of education and experience, the study was able to present a reflection of the attitudes, beliefs, and perceptions of a range of Black male clinicians in the New England area. This study acknowledges that the reflections provided by these clinicians do not represent all members of Black communities.

Identification codes were used to conceal the identities of participants, by using record numbers 0001 through 0010 to replace names. Throughout this report participants who were
interviewed received pseudonyms instead of identification codes. The pseudonyms (Carter, Charles, Douglas, Francis, Kenneth, Langston, Malcolm, Marcus, Martin, and Thurgood) corresponded with the ten identification codes sequentially and were assigned alphabetically. The confidentiality of all participants remained secured throughout the entirety of the study.

**Informed Consent and Confidentiality**

After the dissertation committee and the institutional review board approved the study, this researcher contacted all potential participants by email, informing them of the study. Ten participants were identified and asked to participate in face-to-face interviews by means of telephone. All participants received a letter explaining the purpose of the study and procedures (See Appendix A). All participants received and signed consent form (See Appendix B), and were informed of the background of the study, the risk and benefits of their participation, confidentiality, their rights as participants, and the voluntary nature of this study.

**Interview Methodology**

A semi-structured interview was used for data collection. This approach minimizes the potential effects of having differential wording, and/or the presentation of certain topics or issues during participants’ responses. Patton (1980) indicated that, “by controlling and standardizing the open-ended interview the evaluator obtains data that are systematic and thorough for each respondent” (Patton, 180, p.1). Consequently, this approach facilitates data analysis, including comparison of patterns across individuals (Patton, 1980).

Participants who were identified as matching the inclusion criteria were invited to participate in the study by this researcher. Upon identification, each participant was contacted by phone or in person to make arrangements for the standard interviews. Interviews took place in a location determined by the participant, at a time of their choosing. Every participant had
confidentiality procedures reviewed and explained. Participants were read and given informed consent and participation agreement forms to sign. Audio recordings from the interviews were collected by this researcher, using a personal audio recorder. Participants were informed that this researcher would create transcriptions from the interviews. Data was collected and analyzed from these verbatim transcriptions. Participants were informed about steps taken to de-identify their information in written transcripts.

**Setting.** The research was conducted in a large urban city located in the New England area. Interviews were conducted, with the participant’s permission, in settings of their own choosing, including offices in their clinics, a conference room at the public library, their offices at the schools where they worked, and an office in a group practice.

**Interview Structure.** A standard semi-structured interview was used for this inquiry. The interview questions explored the perceptions and lived experiences of Black male clinicians related to the scarcity of Black males in the mental health profession. This researcher has chosen to use “what” and “do you” questions. These questions were aimed at understanding the cognitive and interpretive processes of people and ask about opinions, values, and judgments (Patton, 1980). This line of questioning gave insight into what participants thought about their experiences, incorporating their desires, interests, expectations and goals. An identified strength of this approach was that the precise wording and sequence of the questions were developed in advance. All of the interview participants were asked the same basic questions in the same order. Lastly, the questions were worded in a completely open-ended format that allowed participants the opportunity to define phenomena for themselves (Patton, 1980). Prior to these interviews, each participant was given the research questions in order to allocate enough time for individual reflection before responses were prompted. It was this researchers’ hope that this
allotted time for reflection helped facilitate deeper thought and contemplation during the interviews.

**Understanding and Reporting the Experiences**

A phenomenological approach was used to assess participants’ responses. Phenomenological research methods are conceptualized as an analysis towards essence, resonance, and a good phenomenological description (Damianakis & Woodford, 2012). In this study, this researcher utilized data analyses that illuminated the basic structure and meaning of the participants’ lived experiences, highlighted the connections and differences in participants’ accounts. In the experiential collection phase, semi-structured interviews were used in an attempt to understand the world, meaning, and essence of the clinicians while investigating their collective perspectives across their experiences (Wertz, 2005). Four key steps have been identified as essential to phenomenological data analysis: (1) researchers bracket their experiences for each interview transcript (2) in a process known as horizontalization, they identified all nonrepetitive and nonoverlapping statements relevant to the experience under investigation (i.e., invariant meaning units); (3) researchers relate and cluster invariant meaning units to describe the textures (meaning and depth) of the experience, in what is referred to as textural description; and (4) researchers seek multiple meanings and tensions in the textural description and create a structural description. Every descriptive statement by research participants are accounted for, and its analytic treatment are available for public scrutiny (Moustakas, 1994; Wertz, 2005).

While exploring the experiences of Black male psychotherapists in 21st century America, this researcher began by bracketed personal assumptions and experiences as a Black male psychotherapist in order to set aside all prejudgments, biases, and preconceived ideas about the
phenomenon. The second step was seeking in depth information with an overarching goal of identifying the individual and shared experiences of the participants. Invariant meaning units were then identified. The third step was collapsing and thoroughly describing these units in a meaningful manner (textural description) and seeking variations in participant experiences for the units (structural description). The final step was the composition and presentation of detailed description or “essence” of the lived experiences across participants.

**Role of the researcher.** This researcher will present and discuss the assumptions, biases, and perspectives that influenced the desire to explore the lived experiences of Black male therapists in the New England area. This researcher is a Black male who was born in Jamaica and immigrated to the United States of America at seven years old. This researcher lived and grew up in a large inner city in New England comprised predominantly of people of color. Similar to the reports of the participants, this researcher has experienced discrimination, oppression, and racism since immigrating to America. This researcher’s aforementioned lived experiences influence the lens in which this study and the research participants will be perceived and interpreted.

Presently, like the participants, this researcher is also a therapist who works with a predominantly poor Black population in the inner city. This researcher has witnessed and survived through the harmful conditions and environments which beset these clients. This researcher feels a sense of purpose to work with Black communities; to empower members of Black communities as they strive to overcome a litany of obstacles, from poverty and crime, to oppressive legislation and indoctrinated practices within a system that continues to devalue and marginalize them.
Due to this researcher’s training as a therapist and experience as a Black male in America, this researcher views mental health as an important aspect of healing for Black communities that is often ignored or not explored from their perspective. This researcher views the inadequate representation from people of color in the prevailing mental health fields and classrooms as a disadvantage for the students in mental health programs and the client they will later serve. This researcher feels that it is important to seek the voices of Black males who become therapists and to enlist their perspectives in identifying ways to empower and help their Black communities. This researcher believes that an increase in representation will assist Black communities in identifying and addressing their mental health concerns and hopes that this information will result in the building of stronger individuals, families, and communities.

**Storing of Data.** All interviews were recorded by this researcher using two recording devices with computer connectivity capabilities. This allowed the researcher the ability to download and label each interview with an individualized participant identification code. The interview files were subsequently stored in a password-protected folder in the researchers’ computer. The files were also stored on an external hard drive in a locked cabinet. Lastly, the transcribed interviews contained participants' identification codes and not their names, and were stored separately from demographic information. Only researchers and personnel involved in this project had access to these files.

**Analytical Procedures.** Each interview was transcribed verbatim and line by line by this researcher using Dragon Naturally Speaking 12 Home-Windows Edition. Dragon Naturally Speaking 12 Home-Windows Edition is a speech recognition software program that converts speech into text. This allowed for the interviews to be dictated and transcribed into written text. According to Nuance (2014) the program reports to be up to three times faster than typing and up
to 99% recognition accuracy in transferring speech to text. Once each interview was transcribed it was reviewed alongside the audio recording to ensure that the written transcript precisely reflected the participants’ words. The data were read without a focus on the research questions in order to develop a deeper grasp of participants’ stories and expressions. This researcher read interview transcripts and listened to the audio recordings until clear relationships and themes developed. This deeper understanding assisted in identifying and categorizing “meaning units” of data for later analysis using NVivo 10-Windows edition. In phenomenological research, “the identification of themes and any ‘coding’ or categorization of data are merely preparatory, in that the use of themes organizes data conveniently, for the more in-depth, structural, eidetic analysis that follows,” (Wertz, 2005, p.172). Lastly, during the preparation phase, descriptive material may be reclassified in order to facilitate usefulness during later analysis. “Researchers often used a narrative that temporally reflects the original experience, but material may be ordered by themes if that better suits the research,” (Wertz, 2005, p 172).

This qualitative data was analyzed using the qualitative data analysis software package NVivo 10-Windows edition. This software platform enabled content analysis through the assessment of relationships in the text and allowed the researcher to annotate or mark sections of text(s) and/or specific items for analysis. The blending of manifest content analysis and latent content analysis were used to assess participants’ responses. The analysis identified the surface structure (frequency of elements) of what participants experienced as well as interpretive analysis of the deep structural description or symbolism underlying their experiences (Miles & Huberman, 1994). Content analysis allowed this researcher to organize the data using categories. A node or a category is reference that contains all information about a specific concept category such as a place, person or other area of interest or a theme (Bazeley & Jackson, 2013). In the
current study, as this researcher read through interview transcripts, and words, phrases or concepts were organized into nodes for analysis in NVivo 10. Ten nodes were identified during this study from which nine themes emerged. This researcher then read through each interview transcript to identify each node as they were repeated throughout the transcripts. Horizontalization of data was accomplished as the researcher worked to develop a list of “nonrepetitive, nonoverlapping statements” (Moustakas, 1994). This researcher created a printout for each individual node and coded participant statements into common themes or “meaning units” related to each specific node based on single words, incomplete sentences, complete sentences, large sections of the interviews, and paragraphs. Larger sections of the interviews were coded to provide context or clarification. For example, a participant who described the dangers of “Black” clinicians working with other Blacks required the coding of larger sections of his response to provide the context for elucidating his complete meaning of the word “Black.” During the analysis of the data nine themes or meaning units emerged: 1) Important relationships with adults who encouraged or supported their pursuits; 2) Inner/personal qualities; 3) Psychological orientation; 4) Barriers to entry; 5) The intersection of culture and oppression; 6) Masculine identity; 7) The benefits of increasing culturally aware black male clinicians; 8) For us-by-us (FUBU); and 9) Intentional recruitment and retention.

Data Trustworthiness. Trustworthiness is a central component of qualitative research, which ensures rigor, and thus minimizes limitations (Hays & Wood, 2011; Seidman, 1991). According to Morrow (2005), the researcher establishes trustworthiness by implementing several verification strategies. The strategies utilized by this researcher were prolonged engagement, reflexive journaling, informal member checks, and dependability audit trails. Audits were conducted by other outside researchers who held doctoral degrees in psychology and who were
familiar with qualitative research methods. These methods were employed to establish the
credibility of this research.

Prolonged engagement designates that the researcher immerses themselves in the
collected data over an extended period of time, which includes interviews, transcriptions, and the
development of nodes or codes. This researcher conducted all of the interviews over a one-
month period. The interview transcriptions and the development of codes were completed over
one and a half months.

This researcher conducted verbal Member checks at the beginning of each interview and
throughout the interviews, gauging and assessing the reliability of information by asking the
interviewee for clarification, or by encouraging and reminding the interviewee that his
experiences and perspectives were valuable. During the interview, this researcher asked
questions, and restated or summarizes information to participant in order to determine accuracy.
Participants were asked for clarification if the interpretation was revealed incorrect. In addition
to these steps, this researcher reassured the participants of the genuine desire and value of
hearing “your voice,” and “your point of view,” about their experiences.

Reflexive journaling allowed this researcher to document the process of the research
project from original ventures to the "arrival of final conclusions" (Bazeley & Jackson, 2013,
p.30). This researcher recorded personal thoughts, insights and strategies throughout the process,
notations concerning relevant authors and literature highlighted by the participants, development
of codes, response categories and subcategories, themes, and relationships uncovered during
analysis of the data.

The Dependability audit included informal consultation with independent experts in the
field during the decision-making process, regarding code development and methodological
approaches. This researcher consulted with two peers who earned their doctoral degrees in Clinical and Counseling Psychology who were chosen due to their familiar with the process associated with qualitative research and who worked with this researcher throughout the research process, from the beginning of this study to analysis and the interpretation of results.

**Ethical Considerations.** There were no risks, discomfort, or harm to the participants during this study. There was no deception in this study. The informed consent form explicitly stated to participants that participation in this research was completely voluntary and participants could address any concerns, refuse to answer any questions or withdraw from the study at any time without loss of any rights, benefits, or services that they would otherwise have had. Additionally, research results and findings are available to participants through written or verbal request.

**Summary of Methods**

In summary, this chapter has presented a description of the methodology used in executing this exploratory research project and the supporting rationale. Identification of participant sample selection, population, interview structure, and the ethical considerations for the study were discussed. The purpose of this qualitative study was to explore the perceptions and lived experiences of Black male psychotherapists, in addition to their inadequate representation in the mental health profession. Interview questions were developed and used as guidelines to ensure that all participants were given the same questions. Data were gathered from 10 semi-structured interviews, which revealed nine overarching themes throughout. The study provided insight into the experiences and subjective worldviews of Black male clinicians, as well as shed some light upon their views concerning their motivations for entering the field,
the shortage of Black male clinicians, as well as their suggestions for increased recruitment and retention.

CHAPTER 4: RESULTS

A closer examination into the lived experiences of Black male Clinician was facilitated by synthesizing the individual responses on an overall basis, which would eventually serve as guidelines in exploring the themes that emerged. Many of the themes overlap multiple research question areas and many common threads were interspersed throughout. Nine themes were generated from the individual narratives with each theme containing one or more sub themes. Those themes include (a) Important Relationships with Adults who Encouraged or Supported Their Pursuits; (b) Inner/Personal Qualities (c) Psychological Orientation; (d) Barriers to Entry; (e) Intersection of Culture and Oppression; (f) Masculine Identity; (g) Benefits of Increasing Culturally Aware Black Male Clinicians; (h) For Us By Us (FUBU); and (i) Intentional Recruitment and Retention.

The exploration into the experiences of Black male clinicians was facilitated by grouping responses into these themes. Due to the subjective nature of the inquiry, not every participant’s experience fit perfectly into every thematic category; however, in alignment with the coding process, these aforementioned themes were endorsed throughout the responses of a majority of the participants. The participant answers that commented on Black Male Incarceration in Table 2 demonstrated how themes for responses were developed. Response exemplars were provided for every theme and sub-theme with direct quotes and the number of participants who endorsed them provided in the text.
Theme One: Important Relationships with Adults who Encouraged or Supported Their Pursuits

For the utility of this study, this collection of themes was comprised of three sub themes that arose from the narrative of the participants: (a) family; (b) peers, co-workers, and classmates; and (c) older individuals in community.

The most common external factor that the participants identified as instrumental in becoming a therapist was the importance of critical relationships with other people who helped shape or supported their interest in the mental health field. Nine of the ten men reflected to this researcher that their parents, other family members, co-workers, classmates and older community members held great sway and influence over their pursuits. The men recounted that family, peers, and community members shaped their educational choice, their knowledge of the mental health field, and their decision to work with children. The external factors presented by participants reflect three categories identified in research as being highly influential to individual and identity development on individual and institutional levels (Gardner & Holley, 2012). Specific comments made by participants illustrated the benefits that they perceived from these interactions on their career choice.

**Family.** Five of the men gave direct recognition to their family and revealed that the desire to be acknowledged by them was an instrumental motivational piece in their completing college and choosing their profession as a clinician. The men gave testament to the significance of familial encouragement and guidance for fostering their internalized beliefs concerning personal responsibility and high educational and career standards. These quotes below serve as direct reflections of the clinicians in this study:

**Charles**
“I would say that the role models of the black men that were instrumental, whether they’ve been teachers or coaches or my uncles or my father, I’ve had fairly strong and positive role models. So I think, just from my family, it’s important to have it be acknowledged that I have a job or profession that they consider respectable.”

Douglas

“If it wasn’t for my mother-in-law, I never would have been able to finish my Masters.”

Francis

“My father is a doctor and he’s a psychologist and a real strong advocate and known member of the community so I always was motivated but he really pushed me to finish school and go back to school. I always wanted to, but he was that motivation to get me to finish it up and helping me understand that our people, black people, people of our community need us.”

Overall, family influence was explicitly endorsed by half of the men. However, two of the men highlighted the often-complicated strain between their parents’ encouragement of their educational and occupational pursuits and active attempts at dissuading the men from entering the mental health profession upon hearing of their desire to pursue a degree in the field. Carter shared his experience with this conflict:

Carter:

“I grew up within that church community, within that framework of seeing the world of seeing America, of all that. So there was, I think, ingrained in me, this sense of having purposeful work that is done because my dad and his ministry was about having a purpose and was about working with people within the religious context, for sure, but I draw parallels between of thinking between a ministry and the counseling work that we do. So I think there was that influence that wasn’t necessarily explicit as far as making
the link between that work and counseling or clinical work but it was there....Even with
the direct parallel to what my parents were doing in their work, I was very much
discouraged from going into psychology. My parents were, like, “You don’t want to
go...we don’t want you to go into psychology. We want you to do something that’s going
to help you make money and help you live comfortably so you can take care of your
family.”

Marcus’s response also showed a similar conflict between parental endorsement of
education and simultaneous denouncement of employment in the mental health field.

**Marcus:**

“That would have been my last year at (name of college has been redacted); then I would
have gone to MIT and I decided, you know, I think I want to work with these kids, stay
with these kids, work with these kids and my parents were pissed. My father was, “We
sent you to school to be a God damn therapist?” I said, “No, Dad, this is what I want to
do” because you know he was in prosthetics and I was gonna go into biomedical
engineering, and I ended up staying and graduating with a degree in sociology and
biology and then came out, came back to Boston and started working with kids in the
projects.”

The participant responses across multiple questions highlighted the value that the men
placed on receiving support, motivation, and advising throughout their journey. The men
identified familial supports and the complex push and pull between parental approval and
opposition towards their career choice, which the men identified as initially undertaking due in
part to internalizing the values instilled by their parents.

**Peers, Co-workers, and Classmates.** The men also identified advising and
encouragement from out of family sources as key factors that aided them as they navigated their educational and occupational journey. For instance, 5 of the 10 participants mentioned the influence of being supported and pushed by peers, co-workers, and classmates during their life transitions. Three out of the five embraced the assistance and spoke of the guidance as directly influencing their continued learning. For instance, Douglas recounted his initial foray into working at an inner city school as a school police officer and noted how beneficial the encouragement that he received from co-workers was to his transition into the role of a clinician. Douglas stated,

“Every day I was learning something new in it and I felt encouraged to continue my studies. So that’s how I got started. The school is a very tough school to work in, but everybody, for the most part, is on the same page, they try to help you, and that started my start.”

Thurgood:

“Somebody told me that you can actually do counseling, like, you sit down and talk to the inmates, get to know their families, talk about their families, talk about how they got there, stuff like that, not just keep track of their sentences and keep them locked up. So that’s why I ended up going back to school.”

In the case of two participants, despite acknowledging the input from others as a catalyst for piquing their interest in working in the mental health field, there appeared to be initial reticence towards embracing that route.

Marcus:

“I was horrible man. So to make a long story short, her boss called me and asked me to come down and I went down reluctantly because of my girlfriend. You know I just “aw
shit, all right I’ll go.” So I went down and I started working with the kids, the next thing you know, I start getting involved with the kids.”

Thurgood:

“And someone just told me maybe I should try to get them before they become inmates, work with kids instead. I really wasn’t interested but I kind of got pushed hard in that direction.”

“They started pushing me off that path and I fought to stay on that same path. But in the end, they pushed me towards the kids and then I figured, where could I go that I’d be able to affect, hopefully, the best change as far as working with youth that may be heading towards the courts, or to prison and stuff.”

Older Individuals in the Community. Five of the ten men made direct references to the positive influence that community members had in their choice to become clinicians. Three out of the five explicitly mentioned the positive impact older individuals in the community played in their cultivating their desire to “give back” and their overall development as a youth. For instance,

Kenneth:

“I was raised in a culture where children are not to be seen…to be seen and not be heard and I had some great people and adults in my life who, not only wanted to see me but listen to me, so I wanted to extend that opportunity to other folks and people told me I was good at it so here I am.”

Langston:

“Back when I was young, I always hung out with older individuals, it was more like, how can I get to give back like some of those older individuals who helped me out and I said this would be
“my motivation.”

Martin:

“It’s like back, that old school stuff where the seniors in the community would educate the younger kids.”

Nearly all of the participants (90%) highlighted the benefits garnered from cultivating close interpersonal relationships. Malcolm was the only clinician not to explicitly mention whether a family member/members or out of family individuals or groups had influenced him to pursue higher education or to pursue the mental health field. However, Malcolm’s comments throughout the interviews appeared to express an insightful understanding about the benefits of mentorship, support and guidance from others.

Malcolm:

“Mentorship, mentorship programs, really matching them up with seasoned professionals in the field to really guide them and introduce them to the field...”

“You take on a lot of trauma; you take on a lot of pain and seasoned clinicians can really work with newer clinicians to really teach them how to handle all that without taking it home with you.”

Most of the men who referred to their supportive relationships did not endorse having specific individuals for forming long-term enduring mentorship relationships. Familial relationships were the exception to this, often the men highlighted select moments during their life transitions in which advisors emerged influencing their individual, educational or career pathways. For example, Kenneth, Langston, Martin and Thurgood identified teachers, co-workers, classmates, and older individuals from the community without any mention of familial influence on their choices. As the men traversed throughout their lives, they were able to acquire
the benefits of mentorship relationships through non-formalized interactions. The responses from these Black clinicians illustrate the important role of support, guidance, and encouragement through critical moments and life events. Their responses also highlight the informal and casual nature of their mentor/advising relationships and the need for strengthening more formal routes for providing long-term and enduring mentorship.

**Theme Two: Inner/Personal Qualities**

All participants endorsed intrinsic traits identified as being instrumental in their decision to become clinicians. These statements reflect their inner/personal qualities and included the subthemes of: (a) need to help others; (b) natural fit; (c) personal fulfillment; (d) view self as agent of change.

The need to help others was a theme that was frequently repeated in participant responses.

**Carter:**

“I knew that I wanted to do some form of counseling and that the work of people…of working with people, helping people understand themselves and their lives a little bit differently and better.”

**Francis:**

“I chose this path because I wanted to make a difference and have individuals be able to have a different outlet to go to, see that they can seek help and not be judged.”

**Marcus:**

“And it was really emotional and I started getting these kids to do well in school, man, helping them.”

**Martin:**
“To be a black clinician is someone who is passionate about helping others, someone who is willing to go into the trenches and provide solutions, helpful interventions.”

Douglas:

“It means that I can help people figure out what’s wrong with them.”

Many of the participants framed their responses for having a need to help others within the context of helping out their Black communities and were purposeful in making connections to helping the community heal as a whole. For example,

Kenneth:

“It also helped me to provide some new information, some new learning that will help them redefine themselves, because I specialize in working with people of color right now and so it offers me an opportunity to engage people like myself, of color, in really in essence exploring their identity, exploring their history and answering some questions in terms of what’s going on in their lives and explaining what’s going on in their lives.”

Langston:

“A lot of us have valuable information based on our experiences. We overcome a lot of things and not to want to give back when you see a young person struggling or when you see a homeless person out there. It’s just not about just giving them money; it’s about giving them, again, the tools to be successful. I think it’s just a sad thing that brothers who will not want to give back and help their people out. I just think it’s sad.”

These responses highlight the importance that these men placed on not only helping others, but also specifically giving back to “their people,” or other people of color in their communities. These statements convey the message that the help being offered is not simply
about a temporary or superficial amelioration of financial hardship. The change advocated by these Black male clinicians entail deep change; a change in how Black communities define themselves, identify themselves, and develops the necessary tools for genuine success. All 10 clinicians endorsed the theme of helping others. The theme of helping their community was also reflected in the daily clinical practice of each participant, as they all noted that they work predominantly with children and families in inner city Black communities.

Natural Fit. Natural fit was another sub theme endorsed by all 10 participants. The clinicians indicated a natural affinity towards the interpersonal qualities that are the foundation of the therapeutic professions. These attributes manifested in participant responses that included, being a confidant, being someone that people have always felt comfort talking to, or regarding the field being a natural fit for them.

Charles:

“I seem to be a very patient person and it seemed that people have been or are drawn to confiding in me and talking to me about very personal things and I found that I enjoyed it and found success early on in working with people.”

Douglas:

“It’s a lot of work but I can’t really see myself doing anything else. Yeah, and I’ve always felt like people felt comfortable talking to me, even when I was a prison guard.”

Martin:

“I was always interested in different philosophies and Eastern philosophy and so it was natural for me to go in that direction.”
Further examination of participant interviews indicates that they viewed their inner/personal qualities as being useful for listening to others. They endorsed concepts of responsibility for others and conceptualized their unique attributes as placing them in positions where they must embrace social justice, citing little choice in the need to take action. Three exemplars of this are Kenneth, Malcolm and Thurgood.

Kenneth:

“I think in high school and in college, people always came to me for advice and to listen and I always tried to listen. So it was a natural fit to be able to listen to people and validate their experience. I think the profession picked me rather than I picked the profession.”

Malcolm:

“Just always being...definitely a people person, people oriented, caring about people, empathizing with people, and then also, realizing early on that I was probably a little bit more articulate in expressing my needs and getting my needs met as opposed to my peer group. So I was always kind of placed in a situation where...to advocate for the group...”

Thurgood:

“I always felt that...how would you say...it’s kind of my responsibility to make that trip

this field chose me; I didn’t choose it...”

Personal Fulfillment. The participant responses revealed further nuances within the theme of inner/personal qualities. Their responses illustrated the high levels of personal fulfillment that they derived from helping out their communities. Martin indicated that being a clinician was a second career choice for him, and that he returned due to the desire to help his community.
Martin:

“Well, my motivation, this was a second career for me although my undergraduate degree was in psych and soc but I decided not to go into the field because…quite frankly, because there wasn’t any money, they weren’t paying well. So I went and got an MPA and I was a city administrator for about 20 years and then I decided that I would come full circle and come back and do something where I could help and maybe provide the things that I learned over the years to help the folks who are struggling and even those who were not struggling but were in need of assistance.”

The unique experiences of these clinicians overlapped in many of their responses concerning their motivations for entering the field and the high level of personal fulfillment that they felt. For instance, Langston, Malcolm and Martin expressed the benefits of hope and personal fulfillment in assisting them with persevering during the difficult work of uplifting and healing their people. Their responses indicated that they are very aware of the plight of Black Americans and the need for them to serve as their voice. They also made additional statements acknowledging the lack of trust Black Americans have towards mental health providers, giving credence to the fact that despite making genuine attempts to assist them, Black clinicians will initially be looked at as an enemy. However, through their connection with their people, they solidify their commitment to helping and loving their people, with the knowledge that improvement is a slow process that happens over a long duration of time.

Langston:

“Because they have that passion and once you see change…like, it’s stressful, it’s frustrating at times but because I notice change here and there, and I’m chipping away at a hard surface that
had been developed over years of no productive behaviors, treatment, everything. I’m chipping away at it every day.”

Malcolm:

“I felt that it would be good to be able to do this and articulate the needs of those who you know don’t have the voice.”

Martin:

“It’s tough when you’re going up against a mindset that is contrary to that. So you was seen initially as the enemy, which is okay because I think why people are in this field is because they love their people and there is a passion for their people.”

Further statements by Martin emphasize both the rewards that may come from helping his people and also the gravity of circumstances facing Black people in America, literally stating that their circumstances are life and death.

“That’s the reward system for a lot of folks, is when they see someone that they’re working with, whether they can prove that or not prove that their work was a major factor, who cares, but this person has changed their life around. That’s what keeps people in the field. It’s the results, it’s those small successes stories, because some of the others…I mean, a lot of people are probably gonna die too, so it’s gonna be…, on the flip side of that, you’re going to feel for those people that continuously just…they’re committing slow suicide and some cases, very rapid suicide.”

Personal fulfillment was a sub theme that emerged from the men as they discussed how much satisfaction and personal meaning thy received from working within their community. They expressed a sincere appreciation for how their relationships with their clients did not flow one way and was highly reciprocal in nature. Personal fulfillment also connected to their
inner/personal skills and their desire to give back in the face of life and death circumstances. Statements made by Carter, Charles, Kenneth, and Langston exemplified this intersection of interpersonal reward and service.

Carter:

“I was getting just as much, if not more at times, I feel from the experience as they were. So for selfish reasons in some ways, it reinforced the kind of things that feel good to us about the individual or things that are important to someone, I think that really sealed it for me.”

Charles:

“...Being a black clinician is a jewel that’s continually being uncovered for me.”

Kenneth:

“So it was a natural fit and so if you end up doing something that you like and are getting paid for it is a win/win.”

Langston:

“I mean, working is good but giving back and seeing success, that’s even more of a reward for me. Think it’s just a sad thing that brothers who will not want to give back and help their people out. I just think it’s sad.”

Ten out of ten Black clinicians made statements testifying to their feelings of personal fulfillment from helping their community. Through participant voices, this researcher was given a glimpse into the multiple internal factors that impacted their choices to become clinicians and to help their people. These internal motivations highlight the importance of occupational congruence with internal drives and values.
View Self as Agent of Change. The last inner/personal theme reflected the men’s embracing the view that they are agents of change for their communities. This notion was endorsed by all 10 participants. What emerged from the participant responses is the high level of the personal fulfillment that the clinicians derive from not only their attempts to help and change their clients lives for the better, but also from their belief that the clients can change and improve. These glimpses into the shared experiences of 10 Black male Clinicians are highlighted through their words via five exemplars provided below.

Carter:

“There’s still people who are saying that the world is hurting and that the people in the world are hurting and that are seeing themselves as change seekers, as agents of that change and agents of that healing and are looking for ways to do that.”

Francis:

“I chose this path because I wanted to make a difference and have individuals be able to have a different outlet to go to, see that they can seek help and not be judged.”

Langston:

“I can hopefully try to instill these same kinds of practices with our people, so to speak. So, I want to be a catalyst for change.”

Marcus:

“A lot of people are really traumatized and I felt that there’s a need. That’s why I went to school to work on mental health issues that our people face.”

Thurgood:
“It’s kind of my responsibility to make that trip because there are not very many minority clinicians to start with, or minorities that at least come with some level of…a high level of education, that they can work from a position where a lot of minorities are not, and be able to hopefully, affect change with the students.”

Psychological Mindedness/Orientation and Inquisitiveness

For the purpose of this study, psychological orientation was defined as the “the disposition to reflect upon the meaning and motivation of behavior, thoughts, and feelings in oneself and others” (Farber et al., 2005). This definition speaks to the notion that there are individuals who think about the “what” and “why” of feelings, thoughts, and actions. This tendency has been described by Farber et al., (2005) as somewhat genetically programmed and is in alignment with the previous endorsed major theme of inner/personal qualities. Many of the inner/personal traits such as wanting to help others, serving as a confidant to others and viewing yourself as an agent of change are connected to psychological orientation, with psychological orientation providing the building blocks upon which these other qualities may emerge. All 10 participants endorsed this orientation during their responses to interview questions and highlighted how this unique vantage point influenced how they interpret the world and process interactions. In the following quote, Carter recounts how intertwined the concept of psychological orientation is with his very notion of self. Carter reported: “I felt like I was kind of inclined to thinking about the world around me in a way of, like, what makes a person who they are and what makes a relationship what it is? What leads us to make the choices that we make?”

For Carter, psychological orientation created a path towards majoring in psychology in undergrad and his eventual career in the mental health profession.
“So I became kind of psychologically oriented, I think, and I thought, I’m also a pretty good listener. Maybe I’ll be a psychologist so I’m going to major in psychology. So that was kind of the start of the path towards…”

Many other participants expressed their wonder and fascination with psychological processes and how it may impact self-discovery and well-being. Douglas stated:

“When I was in high school and college, I used to think about the edge, I’d think about how all these great athletes would mentally envision themselves on the court, and I started doing it and I started getting more and more into who I am.”

Statements made by Martin echoed the ethos of psychological orientation endorsed by Douglas as he identified his wonder at the burgeoning understanding of the human psyche and its potential impact. Martin stated:

“I find it extremely fascinating. I think it’s a world that is new, the human psyche and powerful, extremely powerful…and to give respect for the impact of the human psyche, whether it be valid or invalid, what folks think they’re experiencing- your perception. Perception plays a major role in our well-being.”

Martin’s sentiment connected the psychological world with meaning making and subsequent behavior. Langston made similar statements, making explicit connection between the understanding of the “what” of the human psyche and its potential for revealing core motivations, meanings, and resulting behaviors that are complicit in certain dysfunctional behaviors exhibited by members of Black communities. Langston’s statements were as follows, “you’re yelling at someone over a small dispute or where are your communication skills?” “This is about who and how you are? Oh, this is about your day-to-day practice?” “This is what
Langston’s statements revealed a core feature of these 10 clinicians, which is their desire to bolster their innate psychological orientation with clinical skill and knowledge in order to contribute to the healing of their community. Francis’ statements connect psychological orientation with his motivation for becoming a clinician. His statements also entreat providers to harness their psychological orientation when working with inner city Black individuals as a way of increasing understanding of the myriad of social injustices abound in their daily lives. Francis remarks that,

“There’s so many mis-diagnosis and that was also one of the motivational pieces that...just because you’re black and you’re from the hood, you’ve got ADHD and conduct disorder, oppositional defiant disorder, not looking at the environment but if this kid has been eating right, whether they’re biologically depressed. You’re not looking at if he’s being bullied in school; is this why he’s resorting to go look for a gun to bring to school? Do you know what I mean? There’s so many other factors that trigger it but in our mainstream society, is so quick to...”

An additional qualifier identified by the clinicians is the call to action, inspired by this orientation. The men identified a strong commitment to learning about mental health/psychological processes and then bringing this understanding back to their communities to heal and foster change. Kenneth explained through his statements the desire to teach the skills that he has learned to his community, in order to help them unlearn negative cognitions and perceptions about themselves.

Kenneth:
“I have an opportunity to sit down with...well, for me, an opportunity to help people unlearn some stereotypes and perceptions of themselves that are not true that I think impact their mental health. It also helped me to provide some new information, some new learning that will help them redefine themselves.”

This opportunity to channel their innate psychological mindedness into clinical services to their communities was a common thread shared by the participants when discussing their motivation for becoming a clinician. Charles made statements overtly referring to the plight of Black communities as a disease.

Charles:

“I think that the level of disease in the community would lessen if we had a certain level of competency of service.”

Malcolm explained that a driving force for his clinical endeavors was his belief that traumas faced by people of color needed to be understood from the perspective of someone of color.

Malcolm:

“The clinical piece came in, I guess really just wanting to learn, to really understand the trauma, to really understand the trauma from a psychological aspect and I always look at trauma from different standpoints but I always looked at it, how it affects people of color.”

The responses from Charles and Malcolm indicate that they viewed mental health as being an essential means for the uplifting and betterment of Blacks in America and subsequently worldwide. Additionally, Marcus bolsters their observations, stating “so those are the things that I know is important and with the mental health counseling piece, that’s critical to begin that
whole change of Blackness in the country, but not just here, but in the rest of the world.

American blacks can actually change the condition of blacks throughout the black Diaspora.”

Marcus’s response identifies psychological dysfunction as a prominent obstacle for African American communities. Charles’ responses are similar in their call for increased levels of psychological services in Black communities.

The 10 participants all made references to psychological orientation during their interviews. In fact, many of them made explicit statements noting the influence that these qualities had on their decision to become clinicians. The qualities revealed by these clinicians appear to be innate and serve as the men’s foundation for understanding the world. Coupled with the theme of psychological orientation was the belief that (a) Black communities were damaged, overwhelmed by multiple stressors of both environmental and biological in nature (b) clinical services/utilizing psychological orientation was necessary for maximizing the acquisition and introduction of culturally guided clinical treatment for people of color.

**Barriers to Entry**

During the exploration of the shortage of Black male clinicians, the theme of there being multiple barriers to entry into the field was mentioned. The subthemes generated from this major theme were: (a) financial (b) discouraged from entering the field/little knowledge of the field (c) shortage of black males (d) inequality in access to the profession.

**Financial.** The statements provided by the participants revealed that financial considerations were a major deterrent to pursuing a career as a clinician. Ten out of the ten men attributed the present low number of Black male clinicians to the lack of monetary compensation throughout their interviews. Charles put the importance of financial considerations into perspective and responded, “the first thing, of course, is financial.” Carter later expanded on this
initial statement and connected the difficulties attracting Black males to the field due to the high level of commitment and investment involved, with little financial reward:

“Absolutely, some form of monetary compensation that would allow that person to live and to concentrate on their chosen profession. Yeah, I think so, because if not, you’ve got to work too many hours in the actual field or in the field plus pick up something on the side just to live and that’s so difficult. The burnout is too high and the cost is just overwhelming to try to do that.”

Additional statements were made by participants, stating their dissatisfaction with the low wages of the profession. Responses from Francis, “the wages aren’t as competitive as they should be.” Martin, “When I had first came to the field after working for 20 years, I worked twice as hard and made a third of what I was making.” Thurgood, “when I realized how much money I wasn’t going to make, this is probably not the field I would have gone into.” These statements reflect the observations of individuals who were able to disregard the lack of financial compensation. Their collective responses also reflect the conflicting feelings of dismay at choosing a profession that is congruent with their worldview, yet does not afford them adequate monetary compensation.

Seventy percent cited the lack of financial incentives as a barrier for attracting more Black males into the field. Participant’s direct statements identified financial incentives. Kenneth replied, “you gotta look at incentives.” Carter indicated the need for “loan forgiveness programs,” for increasing the number of Black clinicians. Douglas expressed his feelings regarding what would attract Black men to the field, remarking, “It’s pretty simple man, do some loan forgiveness.” The incentive that Charles identified were exemplified by his statement “there has to be stipends.” Langston identified tuition assistance as an incentive, stating, “If you
say, hey, you finish this program: you’re going to get $5,000 towards your tuition, books and everything else.” Lastly, the call for full scholarships were heralded by Langston, stating “I believe if a black man was offered an opportunity to go to school where they’re going to learn something that they’re going to be passionate…if you tell these kids, Oh, you’re going to get a full scholarship:” and Thurgood, remarking that an offer of full scholarship would greatly increase the interest of Black clinicians in the profession: “say, it’s a full scholarship to work towards their Master’s in social work. They will line straight up to get here.”

These statements note the lack of financial support as key barriers and reinforced the importance of financial support for attracting Black male clinicians. Langston further noted the direct connection of poverty and financial burdens as a barrier for steering interested individuals towards the profession. Langston remarked, “a lot of poverty, a lot of financial hardships may be keeping… a lack of supports in order to push them in that direction.” Langston further details how financial considerations continue to hinder his educational progression in the profession, stating: Financial hardships because I’m still paying back for my school and it’s part of the reason why I don’t want to go for my doctorate is because I don’t have the money.”

Three of the 10 participants spoke about sexism as a financial barrier that hinders the migration of Black men into the mental health field. Statements by the men reveal their belief that the mental health field would provide greater financial wages if it were still a male dominated field. Francis’ remarks reveal his frustration regarding this occurrence, stating:

“It definitely goes back to what we already touched bases on in regards to the gender issue. Clinicians/social workers, it’s predominantly a women led field and that being the reason, the wages aren’t as competitive as they should be because I guarantee you…and
you can quote me on this…if this was a men dominated field, the wages would be a lot more and it would attract more candidates and that’s the biggest problem.”

Malcolm’s statement below offers insight into his admiration for female contributors to the field while elucidating the sexism that has hindered the pay of clinicians in the mental health field. Malcolm, a licensed clinical social worker, remarked “being that it’s a traditionally, for the most part, women have held this field down for so long, we see the gender bias reflected in the money whereas even though men control it still, it’s still on the ground level, being run by women.” Marcus’s response echoes Malcolm’s sentiments, stating how unfortunate it is that sexism is allowed to influence the compensation of women and therapists despite women working so hard (“holding down the field). Marcus’ statement paraphrased a conversation that he had concerning the earning of a female therapist: “My mother’s a psychologist. She makes $50,000 a year. She works 60 hours a week.” I said, “Well, that’s unfortunate because it’s sexism”

All of the clinician identified the lack of financial compensation as a barrier to entering the mental health field. All of the men echoed displeasure with the rate of pay, lack of financial incentives, and unhappiness at the sexist implications that underlie the low value and low income of the profession.

**Discouraged from Entering in Field/Little Knowledge of Field.** Another barrier connected to the paucity of Black male clinicians is the high number of men who are either discouraged from entering the field or the low number of men who had little knowledge pertaining to the field. Six of the 10 men interview endorsed one of these two sentiments. Marcus connected the desire of parents to see the hard work of their children rewarded financially. He noted the limited number of Black males who attend college, and illustrated how
their parents, in recognition of their accomplishment, would dissuade them from becoming a clinician. His statement was as follows,

“For young men thinking about this, his parents are going to discourage him from going into it because the rates are so low and any parent about something will say, if a young Black boy…it’s tough to get black boys to go to college, so if the parent knows anything about income, they’re going to say, ‘Listen, you ain’t going to school to be no social worker right out of college because you’ll be poor.’ And we’re paying for it, go look at some other field.”

Douglas indicated that when asked by others about the mental health field he has made attempts to discourage them from entry. He replied, “Sometimes I tell people, if they talk about getting a MSW and stuff, I say, ‘Maybe you should just get a degree in business.’”

The responses of the clinicians attest to the barriers that individuals face if they decide to become psychotherapists. The economic reimbursement from a clinician’s job is not commensurate with those of other fields with similar levels of education. For students entering a profession out of college, with student loans and increasing responsibilities, a profession that offers a high salary or financial incentives is more attractive. However, for those that choose to enter the profession, personal fulfillment was a mitigating factor for low financial compensation.

Langston’s responses illustrate the previously mentioned sentiments concerning the lack of knowledge of the profession. Langston questions why he was unaware of the field despite working as a youth counselor. He remarks, “I was a 15 and under counselor (name of organization was redacted) when I was 18, not knowing that I wanted to go into the counseling field. Why didn’t I go to college when I was 18 for counseling?” Thurgood’s response of “I just
joined the military. I was in the Reserves. I worked in the prisons,” illustrated an indirect path to
the mental health field that was shared by six of the ten men, who all identified alternate careers
or career paths before making a detour into clinical work. The path to a career as a clinician was
not readily defined to these men and served as obstacles that they had to overcome before
becoming clinicians.

**Shortage.** All 10 participants acknowledged that there was a shortage of Black male clinicians. Three of the participants made statements denoting how emotionally painful it was: Francis stated, “it’s hard,” Malcolm stated “yes it’s sad.” Charles, while commenting on the sadness of the shortage and the societal oppression and marginalization of Blacks in America, was moved to tears, stating, “I’m starting to cry because it’s so sad.” The responses provided by the participants indicate that the shortage was not surprising, considering the high level of social inequalities in America towards Blacks. Carter, when asked about the shortage exclaimed ‘it makes sense.’

Seven out of the ten clinicians identified noticing that there were only a low percentage of Black males in their classes and during their careers (sentence clarity is missing). Douglas remarked “I was one of three brothers at (name of university was redacted). There was a couple sisters there and it didn’t dawn on me what was going on until she said to me “You know, you’re one of the few brothers that even go to school here as a social work program.” The low percentage of Blacks was noticed by a majority of the participants who voiced multiple reasons for their continued lack of representation. Kenneth cited poor effort and lack of legitimate interest in increasing the number of Black clinicians. He recounted a conversation that he had with the director of a program for children with behavioral difficulties. He remarked, “I asked the director, and this program has been in existence for 20 years, what’s the diversity of the staff.
He says ‘none, totally White. We’ve been having difficulties recruiting.’ For 20 years?” Many participants shared similar stories of isolation and the resulting deleterious impact on Blacks who encounter these systems devoid of their input and representation.

**Black Male Incarceration.** Six of the ten participants cited the large scale imprisonment of Black males as a contributing factor to the shortage of Black males in the mental health profession. Marcus noted that “the bigger systemic problem is that you lose a lot of black males to incarceration and homelessness.” Francis made similar observations, recounting how his experience working with incarcerated youth inspired him to further his pursuits as a clinician, explaining:

“I worked for the ((name of organization was redacted ) for 10 years and just seeing the type of youth that came in and out of jail, waiting and just not having the knowledge, the education and just really not having a clue about what life is, what direction, whether they’re coming or going. So that 10 years in (name of organization was redacted) really opened my eyes a lot just to the reality of how bad our youth, our future are.”

The men identified prison as a contributor to the shortage of Black clinicians, which suggests a larger systemic problem facing Black communities, intertwining multiple factors such as economic viability, poverty, oppression and racism. Martin, who worked for many years in the department of corrections referred to prison “the epitome of racism.” He further expanded on his ideas, explaining the levels of abuse perpetrated upon Black inmates by White correction officers, stating “If you’re a racist, a white racist, probably one of the best places you want to work is either be a police officer or a CO because, look, you have all this power. Then you just go out and beat black people up and you don’t go to jail for it. And they’re in jail already.” Participants throughout the interviews expressed dismay at the societal sanctioned mistreatment
of Black males and cited the desire to decrease the number of Black youth and men who go to prison as a major contributor to their choice to become a clinician. Langston indicated that he hoped that his work could be effective for helping the younger generation to heal, in order to develop superlative exemplars for Black communities. He revealed this as his motivation saying, “then we’ll have less going to jail. That’s my whole philosophy and thinking of all of this.”

Low Educational Attainment and High Educational/Credential Requirements

Additional responses pertaining to the shortage of Black male clinicians suggested a convergence of factors, namely low education attainment of Black males and high educational and credential requirements for employment as a clinician. Eight of the clinicians made direct reference to this phenomenon, citing its influence on either inspiring or limiting their pursuits and the pursuits of other Black males. Thurgood commented on the lack of minorities in higher education, remarking, “there are not very many minority clinicians to start with, or minorities that at least come with some level of…a high level of education.” Marcus’ response reflected his realization that many Black men at his first job out of undergraduate school did not have high educational qualifications, which inspired him to continue. Marcus’ response stated, “I’m going back to school because even at (name of organization was redacted) all the black guys who did work there, none of them had Bachelor’s Degrees. I was the only one.”

Three out of ten participants gave responses reviewing the reasons for not obtaining a doctoral degree. Carter, Charles and Langston discussed their thoughts concerning their cost benefit analysis of obtaining a doctorate. All three men ultimately considered the cost, whether financial or non-financial, as too high to pursue. Langston remarked about a conversation he previously had with a woman inquiring why he was not in a doctoral program.
“Why are you not in a doctoral program?” and then I saw the woman who asked the question said, “You know, it’s actually not practical right now for you. You’re already basically doing it. Financially, where would you go because the money you make you still have to go back and pay the institution of which you’re learning.”

Participant statement attests to the low number of Black males who succeed academically. Due to the scarcity of Blacks in higher education, their numbers were dispersed across multiple fields and professions. Additionally, a number of participant statements give credence to the notion that the many requirements for becoming a clinician, requiring many years of schooling past the bachelor level. The confluence of these circumstances serves as another barrier contributing to the shortage of Black male clinicians.

**Inequality in Access to the Profession.** The purpose of this section is to examine the statements made by participants that refer to the inequality of access to the profession caused by institutions. Seven of the ten participants made statements that denoted inequality of access as a barrier for Black male clinicians. These statements reflect an alteration of thinking, eschewing traditional individual level thinking, and delving into larger systemic barriers that may impede the educational and occupational achievement of Black males. Francis addressed this notion, citing racism at an institution that is actively impeding the ability of Black clinicians to practice in their own clinics, despite the mainstream’s denial of its continued existence. He comments that “this is not a subject that people talk about and the reality, in our society, racism still exists. There’s so much push-back on trying to do your own business when you’re a minority, let alone being a black minority.” Further along in the interview, he remarks “you’ve sort of got to earn your keep, earn your stay because you’re a black male.” His statements reveal his thoughts that the relationship between institutions of power and Black male clinicians in business for
themselves is a strained relationship, where the path of the Black male business owner would be easier if he acquiesced to the traditional roles imposed by the racial majority. Marcus’ response alludes to the damage caused by the systemic barriers obstructing the access of Black business owners, stating, “when you look at all the major industries, there’s no blacks in the business of it. Because of that, we’re done.”

Martin and Douglas both made statements stating their beliefs that the institutions that govern the body of the mental health field unfairly control resources and access to the mental health field and are active in maintaining their power, at the exclusion of others. Martin commented that the system “it’s sort of rigged.” Douglas comments that, “I think sometimes it’s been my experience that a lot of people in the business don’t want to see people break through.”

Kenneth’s responses during the interview explains his view that incorporating the worldviews of Blacks into the mental health field poses a threat to the established institutions, who fear being put out of business. He echoes statements similar to Douglas’ saying, “from their point of view, makes sense. So why should I in essence sanction Black perspective and stuff and have them put out of my system, where would that put me? …out of business.” He goes on to further explore their perspective, saying “Yeah, so I’m going to give up my control to legitimize black people’s experience, where people of color experience, when part of psychology is to assimilate them into stuff.” Kenneth’s’ statements and Francis’ statements share common perspectives that view racism and other institutional barriers as contributing to the shortage of Black male clinicians.

Throughout 10 semi-structured interviews, the clinicians’ statements highlighted the many barriers faced by Black males on their journey to becoming clinicians. They remarked at how sad and daunting the task was, bring one of the participants to tears. However, despite
citing numerous obstacles—racism, oppression, lack of financial compensation, and isolation—they remained undeterred in their commitment to help the children and families in their Black communities rise above and heal. This sentiment was exemplified by Douglas who stated, “I am of them. So I need to give back to them and uplift us. We’re not crabs in the bucket anymore.”

**Intersection of Culture and Oppression**

During their interviews many of these Black male clinicians discussed racism, discrimination, marginalization and oppression. All 10 of the participants made multiple statements to illustrate how expansive and harmful their experiences were as men of color in America. Charles remarks that it is the most salient experience in his life, stating that, “you have to start from who you are and my predominant experience of my life has been about my race. It can be very challenging too because there’s the experience of racism, whether it be systemic and overt racism.” Statements from Marcus and Francis were analogous to Charles’ sentiment; however, their comments connect their pain with the traumas of the collective experience of Blacks and other minorities in America. Francis conveyed this message when discussing the difficulties faced by Blacks, saying they were “due to the trauma that’s been experienced for minorities and mainly black minorities.” Marcus revealed his personal connection to other Blacks, and his solidarity with their pain, stating, “I think, it’s really hard because I’m black and our people are in such bad shape, man: institutionalized racism and the trauma.” The comments by the participants reflect their beliefs that racism is a harmful yet common experience for Black and other minorities.

Statements made by Kenneth indicated that he viewed racism as embedded into American culture and informs prevailing practices and beliefs at every level of society. He
stated, “We’re in a country that promotes white supremacy.” He then expands on his observation, remarking how White society and the dominant mental health establishments have not recognized or legitimized the traumas experienced by Blacks, historically through slavery and continuing into present day racism. He directly stated:

“Our issues are not legitimized, even in the new DSM-V there’s, there’s even a struggle to recognize racism as a legit trauma issue. It’s not really...yeah, it’s not...we risk, its part of a complex trauma but it’s not PTSD because you have to have a significant event. So slavery and repeated exposure to minor aggressive and daily racism is not seen or legitimized. “

Martin also makes statements attesting to his incredulity concerning how easily the crisis of Black communities are disregarded and ignored. Martin strongly asserted:

“The thing that really gets me is that, in the African American community and Latino community, the Hispanic community, AIDS is increasing at three times the rate...three or four times the rate as in white communities amongst adolescents and women and it’s in that heterosexual population and I’m saying, where is the outcry? When it happened in the white gay community, man, you couldn’t read a newspaper, you couldn’t turn on the television, it was up on everything. This is happening in our community, silence and people are contracting this daily. I’m saying, where’s the outcry? It’s three or four times greater in the African American community amongst women and adolescents. I’m saying, where’s the outcry?“

Charles described the damage that can be inflicted on Black men through nearly insurmountable societal oppression. He remarks:
“As the pinnacle or as the top, number one targeted, ...I don’t want to say negative, but targeted scapegoat of American oppression is black men and with that being said, to have a competent or to have a clinician who’s black and male would mean he would have had to have had survived some level of that systemic and overt racism and there’s very few of us who have managed to survive into adulthood with some semblance of sanity that would allow us the capacity to be available emotionally and physically to others.”

Charles’ comments illustrate the lingering physical and emotional impairments faced by Black males and draws connections to the shortage of Black male clinicians. Malcolm also articulated a connection between oppression and the denial of the harm perpetrated on Blacks, and the limited mental health participation by Black communities. He presented his insights, stating:

“I have a theory that’s connected to the oppressive experience of black people whereas you go to a middle-class white neighborhood and if something’s bothering a person, they’re running in to see their mental health person so that they can get everything right, so that they can go on and do what they got to do, but for some reason, it’s become taboo and it could be because it’s been a disproportionate number of people of color in the field. So that could be the reason whereas people just have...not a trusting relationship that’s been established with a helping profession and the people of color because of the disproportionate number of providers. But then there’s also this other thing where, when you’re a victim of oppression, you’re usually just told to, “So what? We’ve been unjust to you; get over it.” So, the mental health piece, you kind of learn to live the injustice of it all, and just get over it, as opposed to running to someone in the helping profession to say, “Hey, help me process this so that I can move on from this.”
Malcolm’s statements also highlighted the stigma or taboo associated with the mental health field. Taboo and stigma were common concepts articulated by 6 of the 10 participants throughout their individual interviews. Remarks by Carter, acknowledged that, “the reality for a lot of communities in general, mental health, even in the predominant culture, has a stigma to it.” His statement highlighted the compounding factors associated with a field of study that is taboo for the dominant culture, juxtaposed with being Black in America and utilizing a system that has historically oppressed you. Langston alludes to this historical and present exploitation by the majority standard mental health practitioners, indicating that “other” clinicians may attempt to subvert the attempts of Black clinicians to help members of their community, stating:

“Opposed to keeping them down from the oppressive practices that some people do. I say some people. Because some people may not look like us, but try to get our kids to understand, “confide in me because I’m going to help you more than they did,” when, no, you’re not really understanding.”

Statements by Francis illustrate how the stigma towards mental health services impacts on an individual and cultural level. He explained “lot of times people, like I said before, are just reluctant to seek it out due to the stigma of mental health and not wanting to be judged and sometimes culturally, it’s not suitable to be on medication or there’s a lot of different factors that come into play with regards to mental health.”

The responses from the clinicians support the beliefs that the reluctance of Black communities to seek mental health services is at least partially impacted by individual and cultural taboo and stigma towards the mental health field.

**Ethnic/Racial Status as Non-American Black as a Protective Factor.** Among the ten participants there were many shared qualities and traits that helped them mitigate the cultural
landscape of American society. Six of the ten Black clinicians self-identified their race/ethnicity as non-American Blacks ancestry or parentage, while another identified his father as being non-American Black. Carter, Douglas, Francis, Kenneth, Marcus, and Thurgood all identified as originating from the Caribbean or Africa, while Langston identified his father as coming from the Caribbean. Given the multiple statements throughout the interviews concerning race and culture, the participants’ identification with their particular ethnic ancestry indicates its relevance to their worldviews. Researchers such as Seaton & Sellers (2010) have indicated that there may be cultural differences between Caribbean Blacks and African Americans. Their research noted that the Caribbean was created with an African-descended majority, which may have decreased the expectations that racial discrimination would significantly impair upward mobility. Conversely, the predominant experience of African Americans is being the racial minority and enduring legalized racial oppression and marginalization. Statements by Kenneth attest to his belief in the normative power of originating from a country that has a Black majority. He remarked,

“I think it’s also based on context, I’m from Trinidad, we have a lot of Black psychologists. So again, it’s the context you exist, I mean, we have a first Black president of the United States, for me it’s like, “I understand my African American brothers, I get it, but I’ve gone through Black Prime Ministers, female prime ministers so the idea of having more Black, to me in my context.”

A response by Marcus during the interview illustrated the benefit that he perceived from his Caribbean ancestry. He proudly distinguished his attitude of independence from the complacency that he felt was exhibited by other clinicians that he had encountered, stating, “all
my uncles had businesses, my grandfathers, via Barbados and here. I had a whole different attitude, so when I got into the field, I was like, I'm about to get my own thing.”

Throughout the 10 interviews, the participants were purposeful in discussing the impact of culture, ethnicity, and oppression on their lives and in the lives of members in their community. The theme of helping others and serving as agents of change were intertwined with their discussions, with some citing them as factors that were important in their clinical and non-clinical lives.

**Masculine Identity**

Another theme mentioned by the men throughout the interviews was the concept of masculinity. The participants made multiple references to participating or working in stereotypically masculine or dangerous activities or fields. Six out of the ten men made direct statements attesting to their participation in athletics or working in correctional facilities. Douglas was one of the participants that had a previous career as a school police officer, a corrections officer and a power lifter. Douglas mentioned to this researcher that he “used to power lift right, when I was in high school and college.” Langston also indicated that he participated in athletics and illustrated how he utilized his physical manifestation of masculinity to connect with clients. Langston remarked, “as a personal trainer, a lot of these young folks can’t stick up with me. So I give them motivation to say, “When I get that age, I still want to be able to do.”

Marcus in his interview discussed how his display of masculinity (before he became a clinician) allowed tough inner city gang members to connect with him, because he was a football player. He replied, “the kids were intimidated you know, I was like, 220.” He re-told the story of how his overt display of aggression and masculinity inadvertently resulted in him choosing to
work with troubled youth. Quoting remarks made by his girlfriend, Marcus stated, “so there all
down there, and a couple of black guys, but they don’t listen to them. They’re
intimidated by you and they really respected you, one of those guys was a head of a gang. One
of the kids you really jumped on was a head of the gang and he didn’t say nothing to you. He
said “I like that dude.”

Thurgood, a clinician who indicated that he has participated in sports, worked in a
correctional facility, and had been in the military, explained that he did not identify with the
stereotypical characteristics of a therapist. He went on to explain that,

“I’m not the type of... I’m not a... I guess, for lack of a better word... I’m not a tree
hugging type guy. I’ve never seen myself as a tree hugger, as a touchy-feely, as a
kumbaya, da da da da da. That’s not me. It’s just not been. I’ve played sports all my life.
I’ve been in the gym training, been in the military. Everything I did was more down the
line of; we don’t need that type of stuff.”

Thurgood’s responses highlight the conflict and eventual reconciliation between his
internalized views of masculinity with the necessary traits of a clinician He achieved this balance
by actively searching for the most severe population of youth to work with therapeutically. He
exclaimed:

“I wanted something more intense, you know what I mean. I’d be more of a (name of
correctional organization was redacted) type of person but then I found out about (name
of school was redacted) and they’re like, “Oh, (name of school was redacted) the worst.”
They said, was the worst of the worst, the hardest of the hardest and all that. I was like,
well, then, that’s where I want to go.”
The conflict between masculine identity and being a clinician was shared by many participants who had observed that the field has historically endorsed stereotypically female traits. The emphasis on female traits can be difficult for males to reconcile with due in part to socialization and may serve as another barrier for Black males. A response by Kenneth typified this notion when he mentioned,

“That’s why I think, even how the field is defined. I don’t think it attracts “males.” It’s a field that talks about feelings; it is a thing that is not manly. I think one of the reasons that “we don’t see that much males…much more black males” is because it’s the way being a clinician, a counselor, a therapist, a social worker is presented, it’s a very feely-feely type of stuff and we men have not been socialized to connect to that emotional side of ourselves.”

Carter also shared his internal struggles with integrating his masculine identity with a field that was stereotypically predicated on the discussion of feelings. He notes that,

“There was a lot of influence, for me, that suggested that being maybe someone who likes to listen to people and talk about feelings and all those kind of stereotypes about what mental health is, that’s not something that would even be remotely attractive to a real man, let alone a black man who has to kind of work twice as hard to try to earn pay, to earn respect.”

Carter further explores how larger society devalues the feminine qualities and relegates the study of thoughts, feelings, and behaviors to second-class status. He illustrates this point by stating “within academia, it’s considered a “soft science.” He then extrapolates from this concept, a connection to the difficulties faced by Black men in larger society, stating “now, pit that up against the general narrative of what it means to be a man and then, multiply that or
magnify that by what it means to be a black man in a culture such as that of the United States from an immigrant family.”

**Benefits of Increasing Number of Culturally Aware Black Male Clinicians**

When discussing whether increasing the number of Black clinicians will help get the needs of Black communities identified and addressed by the mental health profession a majority of the clinicians were in agreement. Eight of the participants endorsed a need to increase the number of Black clinicians. Carter responded positively to this question, stating,

“simply put and from an ecological standpoint or macro standpoint, I think absolutely. As we were kind of talking about a little bit before, I think, like with a lot of fields, but especially in the field of mental health, social work, psychology, whatever, it was born out of a very homogenous…it was born out of a very homogenous narrative and perspective."

Carter’s response illustrated a broad level of thinking that considered multiple areas of the mental health field that would benefit from the Black perspective. He further expands on his statement, explaining the process that traditional practitioners use for understanding populations they consider “other,” which is characterized by limited consideration of the perspectives and subjective world of these populations. He states,

“let’s go understand how these other types of people live and so there has been this kind of outside perspective of understanding the psychology of whether it’s individual psychology or family psychology or community psychology, of people and so naturally, the more diverse of a work field that you have for something, the more likely you are to have more perspectives, new questions, new theories, new research kind of come into place to reflect a broader experience. So, with more black males in the mental health
field, you are likely to have benefits for the entire field of understanding people, of really
developing this movement towards being culturally sensitive or culturally...you don’t see
the air quotes around culturally sensitive psychology.”

Participant responses revealed their belief that increasing the number of Black male
clinicians could help the mental health field in identifying the needs of African American
communities. Carter affirmed this notion, stating “I think absolutely it would help to address the
needs of the black community because everybody would understand...would be better suited at
working in the black community.” Carter and other participants endorsed Black clinicians
examining and introducing the needs of their communities without a White frame of reference.

Malcolm noted the difficulty he faced during graduate school due to the paucity of Black
contributors and perspectives being taught in mainstream classes. Malcolm’s statements reveal
his sadness at how little the contribution of Blacks were highlighted and incorporated into mental
health cannon, especially as it pertains to other Black people. However, his statements also
conveyed his active commitment to finding these perspectives. He described this as such,

“the black contributors to the psychological understanding of people, you know, so I
made a concerted effort to really read their work and it’s still unfortunate that their work,
which is so much more credible as it pertains to black people, has not been incorporated
into the formal educational process.”

He later makes comments noting the high level of surprise that his classmates would have
when he introduced them to these unique perspectives. He describes their reactions as such, “the
black perspective on psychological development of black people, it was unheard of. It was like,
“Where did that come from?” It was like that just dropped out of space.”
Statements by Charles convey a similar belief that increasing the number of Black clinicians could introduce perspectives more representative of the experiences of Black people in America into the mental health field. He identified increasing the number of Black male clinicians as an opportunity to genuinely explore issues, and to develop norms and practices guided by Black communities. When he was asked about his beliefs he responded:

“Absolutely, outlet for their ideas, outlet for their…it’s support for them sort of testing their hypothesis and then developing best practices as it relates to them because right now, they talk about they’re normed based on race and culture and then when you look at the norm, they have a sample population may be 200 and they have two to three black people as part of it and they call that normed on cultural variables and that absolutely does not speak to the actual needs of the community.”

Statements by Francis explained that Black communities are very diverse, and that by increasing representation, a greater number of Black perspectives will emerge. He notes the benefit of the increase, saying, “Yes, because it’s eclectic. One person is not going to meet all the…..not one person is going to address all the needs either. We know that for African Americans, we are so different in a lot of ways…”

A great majority of the participants endorsed a need to increase the number of Black clinicians and indicated that an increase in number would result in an increase in level of culturally competent treatments, an increase in knowledge concerning the perspectives, conditions, and increased effectiveness in resources for Black communities.

Participant interviews also revealed their belief that an increase of Black male clinicians would have direct benefits to clients. Statements by Martin attest to this sentiment, he responding to the question stating:
“I think that the increase would be extremely helpful. If nothing else, to offset the negative influence of the media; lack of parenting; putting responsibility where it doesn’t belong, and that’s where it ends up; in the schools, sometimes with the (name of juvenile correctional organization was redacted) and sometimes with the DOC. Those are not very good parenting tools but that’s what happens in our community and having positive black role models is essential and it’s tough when you’re going up against a mindset that is contrary to that.”

Statements by Thurgood also addressed how increasing the number of Black male clinicians could possibly serve to inspire more minorities towards achievement as well. Thurgood states that,

“I do believe that these minority kids and minority people need to see people in the position of power, of knowledge, of skill, of higher education to say, that “Wow, if he can do it or she can do it, then I can do it,” but if we’re not there, then…you know what I mean? Then what’s the point?”

Thurgood’s response indicates the belief that by increasing the visibility of Black male clinician amongst minorities can change the assumptions of their communities concerning potential career and educational success. This increase may serve to counteract the negative perceptions that other minorities have concerning the competency of minority clinicians. He indicated that he has witnessed multiple students saying that they prefer to get assistance from White practitioners due to believing that they are smarter, more helpful, and more competent. He states, “in the field of mental health, minorities haven’t been exposed to minority clinicians. So the assumption is that the white person is going to know. The white person has been doing this longer, the white person’s smarter. The white person has more education.”
Malcolm and Carter also advocated for an increase in representation for Black male clinicians. Malcolm indicated that increasing the number of Black male clinicians would be helpful for Black families, due to having a clinician that shares a similar cultural background. Malcolm remarked that,

“there’s a bunch of misunderstandings; misunderstandings, and misunderstanding, whereas the black provider can go in there, have a greater level of empathy, have the same amount of education, competence as any other provider, but will empower the family and move the family along more than people that don’t have that frame of reference.”

Statements made by Carter also address the notion that having a clinician of similar background is beneficial for helping engage clients into therapy. Carter bolsters his ideas by making reference to research he has read, stating

“Then there’s the obvious impact that, I think research has kind of shown that as far as getting people in the door, people are more likely to accept help from those with whom they identify as being like them in some ways or having a shared background as them. So it certainly helps get people in the door and it helps to demystify this notion of what mental health is.”

Most of the responses were in endorsement of an increase in the number of Black male clinicians; however, a few participants replied that an increase would not make a difference. While others who had voiced their approval of an increase placed caveats on their endorsement of the belief that increasing the number of Black clinicians would result in the betterment of Black communities. Douglas indicated that he was unsure if an increase in Black clinicians would work at all. He stated “I don’t know if getting more Black clinicians or whatever would
stem the tide, you still got all these people out here doing all types of crazy stuff, in (name of city was redacted) they found two people yesterday, lit on fir.” Douglas’s statements attest to the great degree of trauma and dysfunction plaguing Black communities, and expressed exasperation as to whether change could occur. Douglas indicated, “people’s diets, what they watch on TV, what their kids watch, what they drink, what’s in the water, I think all that ultimately affects …the population and I don’t think a handful of well-meaning Black clinicians is gonna stem the tides, people won’t listen.”

Kenneth also made statements expressing his uncertainty concerning an increase in the number of Black clinicians. He indicated that the larger White social system in power is not interested in true change, citing an increase in the number of practitioners, but no change in the larger government agency practices. He remarked,

“this country is not interested or ever was interested in really legitimizing the concerns of people of color. So the question is, the American Psychological Association is designed not to really recognize our issues, I think, so I’m not seeing…we know that numbers does not always represent levels of understanding and sensitivity. We have more black elected officials than ever before, we got a black president. Does that speak to their wanting to know- when we have whatever his name is from the Clippers coming up with that statement; we have Trayvon Martin and all those issues. I do not get fooled by that at all.”

Carter verbalized his viewpoint that an increase in the number of Black clinicians is not a panacea. He expressed this sentiment by saying “what it doesn’t necessarily do is guarantee that the black community or that the black clients get better mental health services. You’re not going to get better mental health services by virtue of you just being black.”
Kenneth indicated that solely an increase is not needed; what is needed is an increase in Blacks who identify strongly with their cultural identity. He states how circumstances for Blacks might change “I think if you had more Black conscious clinicians, yes.”

Kenneth and Carter’s statements highlight how important the concept and practice of having secure racial identity was for the clinicians. Racial identity refers to a person’s beliefs or attitudes about his or her own race (Parham & Helms, 1981). Their statements illuminate the concerns that some participants had regarding an increase in Black clinicians who had an assimilated or Eurocentric viewpoint. Marcus explicitly defines the qualities in a Black clinician that would cause alarm. He stated, “we have to make sure that the ones that come to the field are right, that they’re not what I call “ethnic black.” What I mean is that they’re loyal to a slave tradition and can do harm working with black folks.” Kenneth expressed the need to identify culturally competent clinicians, and cautions against viewing all Black clinicians as appropriate. He stated:

“it’s not only having black clinicians, but have black sensitive clinicians who are culturally competent. I do not want like Frantz Fanon says, Black face White mask. I don’t get tripped up in the color; I get tripped up in people who really identify with your own identity because I’ve met with black male clinicians who scared the living hell out of me and I wouldn’t refer a white man, much more a black man.”

The narratives of the 10 Black clinicians acknowledge the shortage of Black male clinicians. Their narratives also indicate the belief that an increase in Black male clinicians could help the mental health field begin to identify and address the needs of Black communities. The participant, through their replies, cautioned against believing that any Black clinician increase was helpful. Responses from the clinicians identified the dangers of Black clinicians
who identified with Eurocentric values, or who had low levels of cultural competency, and expressed the need to identify and attract clinicians who are dedicated, able, and identify with their community.

**Theme Eight: For Us By Us (FUBU)**

The theme of FUBU was a response that was repeated throughout interviews. The responses that endorsed FUBU were provided by 9 of the 10 participants. FUBU is the ethos that Black communities need to be at the forefront in bettering the living conditions of Black people. Charles indicated that he felt as if Blacks need to take the lead in helping their communities, since it is they who are the most knowledgeable about their needs. He went on to state, “I’ve always said that those who are affected are those who have to lead the way into their own recovery. It’s what we consider empowering and stemming from the mental disease of our community.”

**Self sufficiency.** At the foundation of FUBU is the principle of self-sufficiency. Kenneth expressed his belief that Blacks should not wait for the white establishment to validate their experiences. Instead, he emphasizes the importance of Black people validating their experiences with each other. Kenneth states:

“I do not look at white people to legitimize my existence or my feelings. If I have to look at them to legitimize my existence and feelings, they could choose not to legitimize it. I think it’s more important for us to legitimize our own feelings and experiences with each other. I don’t think they feel that they have to or want to. I don’t even ask them to anymore. It was a trip to ask them to legitimize my feelings.”
To further elaborate on his theme of Black self-sufficiency, Kenneth compares Black psychologists lamenting about APA giving them a grant for their Black centered research to Harriet Tubman asking her slave master for supplies for an escape, remarking:

“I think what’s her name who was running for president of the black…the American Psychological Association…I forget the black sister’s name…she always says that we need…it would be nice if the APA allowed us to have grants to do our own research and publish our own research. To me, it’s like Harriet Tubman going to the master with a grant proposal to dig the Underground Railroad. It does not make sense and if you go to the master with a proposal to dig the Underground Railroad, thinking that he’s going to give you money, to have the slaves escape, then you’re insane. So if I, as a psychologist going to a white body to validate our experience when most of the theories that is used to do counseling come from white men.”

Statements made by Kenneth exemplify FUBU and the belief that Blacks should be the catalyst for their change.

Create Jobs for Black People. Statements made by Marcus illustrate a second component of FUBU, which is gaining economic power through the creation of jobs and the employment of other Blacks. Marcus made purposeful statements, which highlighted the economic gains members of other immigrant groups have attained through job creation, indicating that,

“Blacks have been here for a long time but we’re the only group, even when you look at what happened to the Germans, the Italians, the Irish, even a lot of ethnic groups, blacks are still waiting for whites to hire them. It’s not gonna happen. You have to have those discussions with young black males and women who are going to college to create jobs.
We’re still telling our kids go to school and get an education so you can get a job. We have to change that, to say, “Listen, you need to go to school, get an education and create jobs to hire folks in our community.”

Marcus’s quote discussed what he viewed as a lack of initiative some Blacks have and what he viewed as waiting for Whites to hire them, as opposed to creating their own occupational opportunities. He was ardent in his belief that changing the mind state of Blacks from that of an employee, to that of an employer, could pose the most benefit for Black communities.

**Own Our Own Clinics.** The belief that developing Black owned clinics is a positive endeavor for uplifting and empowering Blacks was identified across multiple interview responses. Charles discussed the creation of Black mental health clinics in terms of effective resource allocation. He expressed this through his direct response, stating, “if the resources can be put in the appropriate place, I think those of us who know how to treat our community already, which we do, and those of us who can put the mental health clinics in place to do that, which we do, if we were able to access the resources to do that, I think that we could…. ” His statements also correspond with FUBU, placing Black communities at the center for their own treatment. Another clinician, Martin asserted that owning his own clinic afforded him the independence to conduct his clinical practice with his people, stating, 

“I’m in a position where I don’t have to lie about it because I own this clinic. The needs are so great that if there isn’t a great deal of help within our own, the problems are going to be recycled. It’s the people that live here that are going to make the difference, not the people that are going to say, “We’re going to give you a grant and we’re going to do this.”
Francis made it clear that having your own Black clinic is an admirable undertaking, but cautions that it may be met with resistance from the larger White establishment, he reports that "there can be a white operated mental health clinic operating the same way, but because you’re a black mental health clinic, you won’t get as much attention as the white one."

**Political Action.** The theme of FUBU encompasses a wide range of concepts and advocates for active political involvement for change. Malcolm generated responses that reflected his pleasure at being able to provide employment for and Blacks in the mental health field, while simultaneously being able to represent the people through political advocacy, remarking,

"it’s great because we have these black mental health clinics. It’s great because now, chances are, if they’re working in (name of city was redacted), they’re going to find their way hopefully to one of these black clinics, that will support their black perspectives and then they’ll be connected to the (name of organization was redacted )whereas at the policy level of things and then we can incorporate them into that as those agencies are connected to the (name of organization was redacted )and move forward to really represent the people that we’re serving and giving them that voice."

Malcolm also advocates taking advantage of the changing political climate to identify and work with legislators who are committed to similar causes. He identifies Elisabeth Warren as an ally, expressing his admiration for her, as he went on to state:

"I think the country’s changing after all the Sandy Hooks and all of the shootings, Columbine and all the other stuff. The country has changed now and you got people like Elisabeth Warren who I…man, I admire this white woman because she is starting to take the fight and I hope she runs for president in 2020. Because she’s taking the fight that
when you look at the two lowest paid fields, which are the most critical, its social work/psychology and education, but those aren’t dominated by males. If that was males, those things would be…the rates would be outrageous. So that’s about to happen, also, because folks of color, like myself are coming to the field, we ain’t going for that. So, I think that’s the biggest thing right now. So, the rates are going up, we’re going to make that happen in our generation.”

Increase Education/Supervision/Training of Our Clinicians. FUBU was not a concept that solely applied to the hiring of clinicians. Through an examination of participant statements, it was revealed to this researcher that FUBU also entailed the active education, supervision, and training of clinicians. It also encompassed providing a vessel for Black research and the pursuit of topics, theories, and professional customs relevant to Black communities, by members of the Black communities. Charles indicated his desire for such an institution, stating,

“Yeah, I think that there needs to be think tanks that are created and developed or created and their focus is in different modalities for the treatment of the black community. So we need… some modalities may be supportive around educational curriculum; some of them may be a recovery curriculum; some of them can be, like, a marriage and family practice. So there needs to be these institutes that look at best practices by black men, research by them for their communities.”

Langston described the hope that (name of organization redacted) could develop into an institution that would assist Black mental health paraprofessionals through their journey, during various educational and credentialing milestones throughout the mental health field. The development of these professionals would be overseen by experienced Black clinicians with the
hopes of developing and cultivating their interest in the mental health profession. Langston described this concept saying,

“This is what I was saying about a program, that if we had an educational institution that offered...I know the (name of organization redacted) with we’re looking at trying to, we do something...I teach at (name of college was redacted)as well...black mental health paraprofessionals, just teaching them about the mental health field. If we had programs that exposed our...not just the older individuals but our youth now in what counseling and psychology.”

FUBU is a concept that encompassed the theme of independence prevalent throughout participant statements and places the onus of treating Black communities on Black communities. FUBU advocates for the educational achievement of Blacks and advocates for the increase of Black male clinicians with strong ethnic identification, and a strong desire to inspire and help their communities. The ultimate goal of FUBU is the economic and political independence of Black communities. Nine of the participants endorsed FUBU. The lone participant who did not explicitly endorse FUBU, Thurgood, actively advocated for Blacks to increase their levels of credentials, power, and responsibility. He outlines his rationale here, stating:

“You’re in charge in here. You get to say what happens. When you step out, people respect you. People come to you for everything and in time, you’ll make more than $30. When you do your resume, you was the supervisor; you will have created; you will have done all this. As the para, you will have been supervised. You will have worked under.”

The qualities that separate Thurgood’s promotion of Black achievement from the concept of FUBU is the lack of focus on independence and self sufficiency for the betterment of Black communities. Thurgood advocated for higher education and credential, to facilitate moving up
and gaining higher authority within a particular system. FUBU also advocates for greater educational achievement and credentialing of Blacks, but this is done by a Black individual with the aspiration of creating economic and societal change for his or her Black community.

**Theme Nine: Intentional Recruitment and Retention**

**Financial.** Many of the men in the study viewed financial incentives as the key for increasing the number of Black males who become clinicians. Ten participants identified the concept of financial compensation as essential. When asked for recruitment and retention ideas, Carter’s response was “The first idea is to increase the salary. The easiest way to attract people to that, especially to attract some group that...has a history of being culturally, institutionally marginalized, is to make it more economically viable for more folks.” Carter also asserted that there should be financial supports built into the training systems for clinicians. He further states, “So, there has to be a stipend in the training and then there has to be sort of a...I don’t know what they would call...an ongoing, like a four to five year...grant that would support the ongoing training and development of that clinician outside of once he finished this program so that he could establish himself in a particular field and concentrate on making money doing that and making the money to do that. So I don’t know if that’s a stipend or grant or something else.”

Kennedy also made statements commenting on the need to “pay them well.” He further goes on to compare recruitment practices of the business world, indicating that they will pay for Black executives if they desire him. He also discussed how financial considerations were the primary factor for a young Black male who had been accepted into all of the Ivy League schools. Kennedy states:
“In corporate America they do it, if they want a Black corporate executive, they will pay for him, they will put him up, they will give him the money. Recently, it just happened with that brother who got accepted to all the white Ivy League schools. The only reason he chose Yale was because Yale gave him the better financial package. So “Harvard, Princeton, all of you all, if you really want a Black student of that caliber, you’re not willing to pay for him?” You know, if colleges worked the same way as the NBA and the NFL worked, you would have more retention. Cause money talks and B.S. walks.”

**Active Recruiting.** Participants, when answering questions pertaining to recruitment indicated that there had to be actual recruitment for Black males. Marcus indicated that he had never been recruited into the field, remarking, “I think one of the big problems, that no one recruits us. I came into the field by luck. There’s no concerted effort.” His response highlights incongruence between the stated desire of the established mental health bodies to increase the number of Black clinicians, and their statements that indicate that they are not being recruited. Thurgood indicated that during his graduate studies he was able to discern why there was a discrepancy between the stated desire of institutions to recruit Black males and the reports of the Black males that they were not targeted. Thurgood, a self-identified Black/Cape Verdean/Native American males’ responses reflect his beliefs that institutions are purposely recruiting foreign born Black males into their schools, and he believes that once the men have attained their educations, they return to their home country. He revealed a conversation that he had with the dean of his college in which he stated to her, “so basically you’re saying is, you’re not training people who are going to go back and affect change in this country. You’re not training these social workers that’s gonna go back into the city or back into this community because nobody from their community is here.” He indicated that he believed the institutions were purposefully
neglecting “home grown” candidates in order to decrease their opportunities to enact change in the Black population in America. He entreated,

“how about taking care of your home before you go abroad but you’re talking about taking care of your home but you won’t take care of...like, I don’t see these schools coming into the cities and recruiting from your home-grown, as I always say your home grown Negroes. That’s what you need to be going after but you don’t.”

Marcus, echoing the theme of FUBU in active recruitment, indicated that he has begun developing training programs for recruiting paraprofessionals into the field, training them, and supporting while they pursue higher education. Marcus explained:

“One thing is, I’m fortunate, I’m President of the (name of organization redacted). We’re actually starting...beginning putting a mental health paraprofessional training program. We recruit them, let them know that you exist but also you have an appointment. Because we are our own Black clinic, bout to open up another one, 6. Then I’ll be opening up in some other states at some other time, we can hire them as paraprofessionals. See, it’s not like they’d go to school can’t,” I ain’t got a job.” That’s what we can hire you as a Para and as long as you stay in school, we can give you support at the same time, do that and increase the numbers, then dominate. So that’s the master plan that’s already written.”

Further responses made by Thurgood indicated a new two part systematic way of conceptualizing and executing recruitment. The first component consisted of providing financial support for a youth who has been identified as having promise. He describes this process as,

“working with somebody who’s doing half decent, and say, “Hey, look, if you get from this point to this point, we’ll give you a full scholarship to go become a social worker, to
become a psychologist.” You get a kid that's in school that’s doing okay, put them on the track and say when you get here we’ll give this to you. Not just, you gotta pick the kids who are most likely going to make it. And don’t just say, hey; let me give it to some kid that you know is not going to make it. “Well, he didn’t do what he needed to do.”

He explained that by choosing a youth with promise, the likelihood of the plan coming to fruition is increased. The second component of Thurgood’s plan borrowed the military model of compensated service. He explained that once the student of promise has been identified, he or she is required to work in service of the program, as a mentor or supervisor, for a pre-determined number of years. Thurgood explained:

“I think that would be an excellent way of doing it, saying, hey, look, you know, the military does it; we’ll pay for school but you’ve got to give back so many years and you get paid for those years you work. You’re not free but you’ve got to stay committed to the program. So I’d say, all right, I’ll put you through graduate school, pay for your Master’s. In turn, you will give us four years of mentoring. For two years of school…two years for every one-year, something like that. That’s how the military contract…every two for one. You’ll give x number of hours of supervisor to somebody else, or mentoring our program. Maybe part of your mentoring might be part of the recruitment program. You’ll work with the recruitment program, recruiting and sustaining.”

Promote Profession. Another component of the recruitment process that was examined by the participants was the belief that there needs to be an increase in the promotion of the profession. Carter explained the benefits of re-defining mental health to the public, stating:

“I think the more normalized mental health as a practice becomes in the broader popular culture, then I think the easier it was to attract black males, to recruit black
males into the field because, in some ways, it’s like, once you go mainstream, there’s a side of acceptance there-across fields, for musicians to what not and so it’s like, oh, so, okay, so this is one route for me.”

Carter also endorsed promoting the mental health profession to younger students in order to increase their comfort with the profession, before they get to college. He implored recruiters to “go into the high schools and talk about this work and talk about what’s happening. So I think part of the recruiting is having folks have people learning about the field in a way that feels viable and possible.” Malcolm indicated that promoting occupational stability of the mental health field, telling potential recruits that “you’re going to start off on a nice level, so, and really getting people to understand that.” Malcolm surmised that even though practitioners in the mental health field did not receive superlative financial compensation, the starting wage was adequate and offered job security and an opportunity for upward mobility.

**Identify Eligible Candidates, Especially at a Younger Age.** Interview responses by Francis explained that effective recruitment strategies originate from early identification of people who have the desire and ability to become clinicians. He remarked that “this field isn’t for everybody and I think, during the beginning process, that’s something a person has to figure out before they move forward in this field.” Francis advocated for an early exploration of qualities that would indicate a conscious decision to become a mental health profession. He reiterated these sentiments further, saying, “I think helping people realize that from the beginning versus way in the middle or toward the end, to try to get them, so addressing that before they even enter, I think will help them with the longevity of staying.” Malcolm’s statements were parallel to Carters due to their similarities in how early they recommended introducing and recruiting individuals to the field. Marcus recommended that,
“we would have to start recruiting at an earlier age, really changing people’s perceptions of the mental health field and the benefits of doing this work. And so we’ll probably start that around the 7th, 8th grade, start when kids should be thinking about future careers or future college plans and things like that, we could start putting the plug in, start putting those plugs in there because it is a profession where, if you get your Master’s Degree, there’s a strong likelihood that you’ll be able to retain a job. “

Greater Representation of Blacks in the Profession. During his interview, Martin identified the visibility of other Blacks as a vital recruitment and retention strategy. Greater visibility would work in conjunction with early introduction and recruitment to the profession. He revealed that, “retention would be probably based on visibility because if you have folks, when they’re..., before going to school, they see that as a career option. If they’re not visible, they’re not going to see that as a career option.” Martin thought that by increasing the number of Black male clinicians, the number of Black males who were attracted to the field would increase and remain as a result.

Interview responses from Kenneth indicate his belief that institutions need to embrace diversity since it is not a new occurrence. Kenneth exclaims that:

“colleges need to really accept the fact that the world is diverse. It’s always been diverse; I don’t know where they are saying “it’s getting more diverse.” It’s like, it’s always been diverse and that they need to have courses and curriculum that’s diverse and multicultural in terms of having, when students come to your course or your college, know that you have courses and opportunity for the issues that they deal with.”

Kenneth’s statement illustrated the disconnect between what is being experienced by Black clinicians, and the institutions that purport to be making attempts to reflect a more diverse world.
Kenneth surmised that institutions would attract more Black students if they actively embraced the existing diversity and developed coursework and curriculum that reflected the perspectives and interests of Black people.

**Retention.** During his discussion on retention, Carter proposed suggestions that could retain Black male clinicians once they enter the field. He reiterated that by recruiting more Black males into the field, more Black males would remain in the field. He states:

“*The more we’re able to kind of keep black male clinicians in the field, the more likely we was able to kind of recruit more to the field. How do we keep them? I think it comes with having agencies and companies or whatever or whatever roles in mental health that sort of provide mental health services, having those agencies, those corporations be better at training in an atmosphere where everyone’s experience is, I think, validated.*”

Statements by Francis and Marcus reveal similar thoughts concerning economic independence (FUBU) and retention. Both clinicians made explicit statements extolling the benefits of encouraging clinicians to get licensed and to exercise their independence by working for themselves. Marcus identified this practice as being instrumental in retaining clinicians, saying, “*Don’t hold them back. Let them get licensed. Talk about doing stuff on their own. There’s plenty of work out here. Teach them how to take care of themselves.*” Francis made statements that mirrored Marcus’. Francis advocated preparing clinicians so that they can become independent and not have to rely on others for employment. He indicated that he often tells clinicians “*I’m here to help you grow so that you can take my job. Not all that -you can go work for somebody, so you can develop your own business, teaching them how to move forward in that aspect.*” Francis also outlined what he considers the three essential components to recruitment, which are “*empowerment, growth, and*
“I think, is huge in the recruitment process because a lot of times, people get out in the mental health field as a social worker, they’ve got their MSW, go to an agency. I’m going to motivate you to take your LICSW so you can get licensed. You make more money that way. You get more respect, helping people understand the business. You get licensed; you get your hours; you go take your LI, start your own business. You can do things on the side. It’s not all about…I think if you empower…empowerment and growth and education I think are the three key pieces in recruitment because if people are feeling empowered, they’re motivated. If you’re motivated, you’re going to bust your butt to do what you got to do. You know what I mean? So, I think those are truly the key pieces in the recruitment process.”

CHAPTER 5: DISCUSSION

This chapter will present a summary of the major findings of the study. Interpretations of data are discussed in relation to the literature review and theoretical orientation. Finally, this chapter concludes by examining the implications, limitations and recommendations for future research regarding Black male clinicians.

Summary of the Major Findings

This chapter highlights and explores the results of this study from the perspective of presently practicing Black male clinicians. The nine major themes that emerged from the individual interviews were: (a) Important Relationships with Adults who Encouraged or Supported Their Pursuits; (b) Inner/Personal Qualities; (c) Psychological Orientation; (d) Barriers to Entry; (e) Intersection of Culture and Oppression; (f) Masculine Identity; (g) Benefits
of Increasing Culturally aware Black Male Clinicians; (h) For Us By Us (FUBU); (i) Intentional Recruitment and Retention. The Feminist ecological framework was used to conceptualize the interrelated influences of individual, social, political, education, and cultural forces, allowing the men in the study to share their lived experiences through their voices. All analysis of content were based on a thematic analysis of participant experiences, voices, and subjective meanings, and literature review. To promote accuracy in the sharing of participant stories, direct quotations from the participants are provided.

Ten Black male clinicians were interviewed for this study. During the interview process, this researcher was vocal in encouraging honesty and authenticity from the participants, urging them to “tell their stories.” Each participant was asked the same six open-ended research questions: 1) What does it mean to you to be a black clinician? 2) I am interested in your motivation for choosing a career as a clinician, can you tell me about it? 3) What do you think about the shortage of Black male clinicians in the mental health fields? 4) Do you believe an increase in the number of black clinicians will impact the ability of the mental health fields to address and meet the needs of the Black community? 5) Do you have ideas about some helpful recruitment and retention strategies for increasing and keeping Black clinicians? 6) What is it like for you to be contributing to this research? Several themes and subthemes were extracted from the individual interviews.

As discussed in previous chapters, the experiences of Black male clinicians have not been investigated by the mainstream mental health field. Mainstream mental health research about Black male clinicians does not often utilize methods that reject apriori assumptions, nor does the research solicit assistance from Black males, which would reveal their worldviews. The experiences of these men encompass a wide range of ecological spheres (individual, micro, exo,
macro, planetary, and temporal). Participants disclosed their thoughts and feelings regarding their low representation of Black males in the mental health field, their motivations for becoming clinicians, and the perceived benefits that may arise from their increased contribution to the profession. The participants discussed the many intersecting factors that were prevalent throughout their lives. There were many similarities across interviews, with many participants expressing parallel interpretations and observations. However, their experiences, though comparable, were not exact duplicates, underscoring the multiple experiences of Blacks in America. The themes that were discussed illustrated the complex processes that these 10 Black males were able to identify, which compelled them into clinical service for their communities.

**Motivation**

The question of motivation is critical in the attempt to identify strategies for increasing the number of Black males into the mental health field as clinicians. Before the population of minority males can be recruited into the field, the motivations of those presently in the profession must be ascertained. Through thoughtful examination of the data, the factors that influenced the participants’ lives were extracted. The primary motivation for entry into the mental health field was “helping others,” which was reinforced through a confluence of internal and external influences and experiences. The drive of helping others was not solely a general feeling, the desire to help was directly connected to helping Black communities and social justice. Langston indicated as much when he stated “*Change is something that we have to instill and help them identify that this change is healthy and what I personally think about that, it’s sad, someone who’s not going to help another up is just selfish, to me. That’s what I feel about another…a black clinician and not wanting to help.*”
This strong desire to help was a common trait among participants and was supported by previous literature that examined the motivation of therapists. As cited in Farber et al. (2005) it was believed that many people who chose to become clinicians had an innate drive towards healing and growth, which was responsible for their life experiences and lead them to pursue the field of mental health. The responses from the participants, such as Charles, who said that he had always been “a very patient person and it seemed that people have been or are drawn to confiding in me and talking to me about very personal things and I found that I enjoyed it,” appear to confirm this. Farber et al. (2005) identified 12 recurrent themes that lead individuals to choose therapy as a career path. Of the twelve identified factors, participants directly referenced eleven of Farber’s themes. The eleven referenced factors were: experiencing cultural or social marginalization, painful childhood experiences, having a disposition of viewing life with a focus on the dynamics of human behavior, a history of serving as a confidant to others, a desire to help others, a need to understand others, having a mentor that validated and affirmed one’s individuality, a need for professional autonomy, an interest in the intimacy that occurs during the therapeutic relationship, a need for intellectual stimulation, and a need for self-growth and healing. Martin, for example indicated that he has always been psychologically oriented. He stated, “When I was an undergrad, I was always fascinated in psych. I was always fascinated in how the brain works and how it impacts our well-being.”

Though the Black clinicians endorsed a majority of the factors, there were nuanced differences between their lived experiences and the experiences of the predominantly White clinicians in the Farber et al. (2005) study. For many of the participants in this study, experiencing a painful childhood was not separate from the experiences of being from a marginalized group or the experiencing of oppression; they considered these experiences part of
the American Black experience. Additionally, the presence of influential mentors was a different occurrence for the Black clinicians. Relationships with outside-family contributors were identified as being helpful. These mentorship relationships were not formal long-term relationships where a more experienced and more knowledgeable person in the field “puts them under their wing.” Instead, their relationships were more transient, characterized by the clinicians soliciting advice from peers or coworkers when assistance was needed. The lack of formal mentor relationships available to the Black clinicians illustrated the lack of overall support that these clinicians experienced, whether in the educational or occupational realms. The difficulties that Black male clinicians may face when attempting to identify more experienced role models in the field may also hinder their knowledge of both personal and professional options available to them as they progress in the field from.

The themes identified by the participants in regards to their motivation for becoming clinicians were the desire and feeling of responsibility to help their Black communities, the need to create established connections between the field of psychology and Black communities, and an interest in increasing the Black community’s awareness of the psychology field, coupled with a heightened awareness concerning the importance of having Black psychologists in the community. Responses by Francis typified this, as he revealed “So that 10 years in (name of correctional organization was redacted) really opened my eyes a lot just to the reality of how bad our youth, our future are, and that also motivated me to want to help and play a bigger role in this ongoing battle in mental health for black people in our community.” These reasons were supported by Chandler (2010) who examined the motivations of Black graduate psychology students from HBCU and their reasons for remaining in graduate school. The themes endorsed by the participants illustrated the connection that the participants felt for improving the mental
well-being of their communities, and the benefit that these clinicians may pose for African American communities. As interest in increasing the number of Black clinicians entering the field continues, more research will need to be conducted from the perspective of the male clinicians of color to discern their nuanced motives for entering the field.

**Shortage of Black Clinicians**

The next theme was connected to the shortage of Black male clinicians and solicited the input from the clinicians themselves as to their perceptions concerning the low representation. It is hoped that by uncovering their observations and barriers to the points of entry for Black clinicians, preventative and auxiliary methods could be developed to counteract or eliminate these barriers. The results of the interviews indicated that the shortage was related to multiple barriers, which hindered Black males from becoming psychotherapists. The primary reason cited for the shortage of Black male clinicians was financial, regardless of whether this was due to low salary as a result of sexism or a lack of value. Thurgood recounted the sadness he felt at his starting salary coming out of graduate school, “*when I came back out of grad school, I was making $27,000 a year…. How did I end up with $27,000 which killed me.*” Ten of the ten participants made statements attesting to this. The men identified the high cost of undergraduate and graduate school, including college loans as a primary barrier. Multiple men indicated that they realized that they would not be adequately compensated for their work, but that their commitment to helping their people mitigated that and enabled them to pursue a career as a therapist regardless.

Participants also indicated that they had to remain undaunted, as others such as parents actively attempted to dissuade them from pursuing the field, as evidenced by Carter who echoed this sentiment, saying “*it was important to do something that I felt passionate about and*
generally interested in. So I stuck with psychology. But there was that discouraging aspect.” In addition to having to endure attempts at dissuading their decisions, participants reported selecting or considering other careers that would be more financially rewarding such as business.

The low educational attainment and high educational/credential requirements of the mental health field was also cited as contributing to the shortage of Black male clinicians. The participants indicated that due to the low number of Black males enrolled in college, combined with high academic standards of becoming a clinician (which requires a Masters degree), the scarcity of Black male clinicians was not a surprise. Three of the participants expressed their frustration at Black men for not valuing education enough to overcome their insecurity in order to increase their credentialing or education. Douglas indicated that he was dismayed by the lack of value for education possessed by Black men, saying “It lends itself to a bigger problem where, like, a lot of people don’t value education and you can argue that point.”

Another identified barrier connected to the low availability of Black men is the low number of available men due to incarceration, or due to the institutional barriers caused by oppression and racism. Prison or incarceration was cited by seven of the participants. Charles discussed the difficulties that Black communities faces with mass incarceration, stating, “It’s a continuation of sort of the problems that the community will see, which is an exodus of the men, whether they choose to check out because they don’t want to go to the hospital, don’t want to go to jail.” In regards to institutional barriers, participants cited racism, a lack of institutional value of the Black perspective, and active pushback from larger institutions against Black owned businesses as the core contributors to the shortage of Black males.
The barriers contributing to the shortage were identified by a majority of the men who verbalized their sadness and despair for the hurt being done to their communities. One participant was so saddened that he was moved to tears.

**Benefits of Increasing Culturally aware Black Male Clinicians**

When asked if they believed that increasing the number of Black clinicians would help get the needs of the Black community identified or addressed by the larger mainstream community, many of the participants agreed. Many replied that they believed that the perspectives of Black communities would be represented if more people who lived and reflected these experiences were able to share them. Clinicians like Langston indicated that an increase in Black male clinicians would increase the level of clinical interventions for Black communities. He further explained, differentiating between clinical mentorship programs and standard mentorship programs, saying, "If we had more, as they say…the Big Brother program is good and all but they weren’t really getting to the meat of the clinical necessity. They weren’t, assisting in the…like, we have a therapeutic mentor now." The desire for more clinical interventions was repeated through multiple interviews, with participants expressing the hope that more culturally specific clinical interventions could be developed and implemented through an increase in Black practitioners.

Participant interviews also reflected the scarcity of knowledge concerning the contribution of Blacks, which many clinicians noticed as they pursued their graduate studies. Participants indicated that Black contributors to the field of mental health were not highlighted by educational institutions during their coursework, and they believed that with a greater emphasis on including the Black perspective, integrating and teaching about Black contributors
to the mental health field will occur. Malcolm expressed his frustration at this, with statements such as this:

*The black contributors to the psychological understanding of people, you know, so I made a concerted effort to really read their work and it’s still unfortunate that their work, which is so much more credible as it pertains to black people, has not been incorporated into the formal educational process.*”

Connected to this theme was the notion that genuine cultural competency could be increased, as opposed to superficial cultural understandings shaped by the values and perspectives of the dominant White perspective.

The agreement that many of the participants shared concerning the benefits of increasing the number of Black male clinicians was qualified with a caveat. The caveat highlighted an ideal that was shared across interviews, which advocated for an increase in the number of Blacks with non-Eurocentric values. This ideal was directly connected to the participant’s actively separating color from racial identification. Cross (1994) presented a model of racial identity and described the transformation from Negro to Black. During this transformation, ethnic identity is cultivated and a sense of pride in being Black is developed. The participants were pointed in their rejection of assistance from Blacks who did not have strong racial identification. Malcolm expressed this as he discussed what he described as the miseducation of Blacks. He remarked, “Carter G. Woodson talks about the miseducation and he’s always indicated that one of the biggest stumbling blocks to the black community was the black professional. Dig that, and he wrote that in, what, 1930?” Marcus stated the dangers of this mentality, highlighting the potential danger of Black clinician without secure ethnic identification working with Black clients. “See, that’s the danger about these elite blacks. They can get caught up in the class and there’s not even a
white classism, okay, it’s a pseudo black elite house slave mentality and once they get caught up into that, they can do damage to the clients they work with.”

A few clinicians indicated that they did not believe that an increase in Black clinicians would bring about substantial change due to the larger socio-cultural factors that permeate American society. Overall, most of the clinicians believes that an increase in the number of Black male clinicians with secure ethnic identity would help introduce the concerns of Black communities, while spearheading research into the concerns of Black communities, and developing clinical interventions tailored for the Black community, guided by non-Eurocentric values, norm, and principles.

FUBU

The ethos of FUBU was dispersed throughout the interviews. FUBU embodied nine out of ten clinicians’ views that Black communities should take the lead in researching, legitimizing, and employing itself. Three of the Black clinicians interviewed indicated that they were the owners of their mental health clinics and private practice. Seven of the clinicians indicated that they possessed independent licensure. The participants endorsed FUBU which entreats members of the Black community to take active steps towards self-sufficiency, which will then decrease dependency on larger White institutions to employ or sanction their work with their community. Participants indicated that by creating their own clinics, they were able to exercise control in the level of care that they can provide to their community.

FUBU, as described by participants, encapsulates the economic and job creation realm. FUBU asks the members of the community to discontinue waiting for Whites to create jobs: instead, FUBU advocates for Blacks to take their skills and work with other Blacks to build each
other up. Statements by Marcus recounted a story in which he inquires to unemployed relatives who are proficient in textiles why they do not use their expertise to run their own businesses:

“Well, listen, don’t you know how to run the machines? How come you all when the white folks left, how come you didn’t decide to do business and be able to do business with Africa.” “I didn’t think about that.” I said, “That’s why embassies are here.” So, again, you waiting, the steel mill is dead unless you open it up and do your own business.”

The principles of FUBU also call for political action on the part of Black communities. Statements by clinicians highlight their awareness of the prevailing political trends. Two clinicians mentioned Sandy Hook and the sharp increased focus on mental health. Practitioners who endorse FUBU are not only aware of political trends, but they place themselves in positions to capitalize on these trends for the benefit of Black communities. They are also actively engaged in assessing the needs of their communities and brought these concerns to legislators in order to get them resolved. Charles identified the need for an increase in the number of minority male clinicians and took state wide action to develop outreach programs. He describes his endeavors thusly, “I’m actually now working with the state to try to get resources to do a local and national recruitment of licensed black and Latino men to come to (name of state redacted) to work, and to figure out what it’s going to need.”

Lastly, the creation of Black own training, supervision, and research institutions is aligned with the values of FUBU. The clinicians identified training, supervision, opportunities to conduct their own research, and mentorship as a key tool for recruitment and retention of Black male clinicians, and indicated that these institutions should be developed by Black clinicians for the benefit of Black communities. Kenneth and Marcus advocated for Blacks to become less
dependent upon Whites to legitimize them, instead Blacks should take interested in researching themselves and the concerns of their community. Additionally, these proposed institutions would not be exclusionary to Whites who’s orientations are not Eurocentric. Kenneth describes them as “someone who’s in tune and culturally competent in dealing with today’s students. So, yeah, who are willing to embrace their White privilege and their thoughts of racism.” These institutes would develop and continue the cycle of equipping Black males to become self-sufficient and then give back.

**Intentional Recruitment and Retention**

The efforts of the mental health system to recruit and retain Black male clinicians has been lackluster, as evidence by the alarmingly low number of African American social workers earning MSW degrees, which has remained flat for approximately 25 years. Other mental health fields report similar low numbers, less that 2% of school psychologists identified as Black (Curtis, Hunley, & Grier, 2004). The ideas that were cited by Black male clinicians to aid in recruitment included, institutions being intentional in their recruiting, increasing financial support, creating a pipeline where eligible Blacks are identified and introduced to the profession, providing mentorship, training, and supervision, and lastly, encouraging licensure and promoting independence. Financial considerations were identified by ten out of ten participants as barriers to entry into the mental health field. By providing financial incentives, similar to the ones provided to other fields for service, more Blacks males would be able to collect a wage commensurate to their educational level and their level of debt.

In addition to providing financial incentives, participants indicated that institutions need to be intentional in their recruiting. This intentional recruiting entails identifying where Black males are most likely to be and going there to recruit, for instance, down south, HBCU’S, and
inner cities. None of the participants indicated that they were ever recruited. Thurgood
indicated a model for recruitment in which American Blacks are given full scholarships as
opposed to foreign-born Blacks, who may have explicit plans to take their newly acquired skills
and better their country of origin. Thurgood had postulated that foreign born Blacks who do not
plan to stay in America are coveted by institutions due to the fact that they are still counted
towards the minority student quota, but they do not threaten the status quo of America, due to
their stated desires to return to their home country.

Through a combination of interviews, the concept for a pipeline system was
conceptualized. The initial stage would entail increasing awareness of the field to the general
public in order to demystify and to decrease the stigma surrounding mental health. The second
step would require the early identification of students of promise, in order to prepare them for the
pipeline towards becoming a clinician. The student would be given full scholarships throughout
his or her ongoing academic career. The student will also be required to provide mentorship and
supervision to other students in less advanced stages of their participation. This would be done in
order to allow the student to earn their financial support. The amount of service would be related
to the amount of years of support received. Participants discussed the need to incorporate social
justice. The concept of giving back was emphasized during recruitment to maintain the pipeline
through their continued service. Additionally, these students would serve as recruiters as well.

Increasing the visibility of Black clinicians in the field was cited as a tool for recruitment.
Participants indicated that the benefit to recruitment would be twofold. The first benefit would
be through inspiration and modeling. Members of Black communities would start to recognize
the mental health field as an option for them because after seeing more people who look like
them. Additionally, through an increase in Black clinicians, members of the Black communities
may begin to regard Blacks in the field as being as capable, as smart, and as clinically robust as their White counterparts.

For increasing recruitment and retention, many participants intertwined the concepts, indicating that interventions that serve to increase recruitment may simultaneously serve to retain clinicians as well. Participants mentioned increasing the visibility of Blacks in the field. The creation of pipelines for hiring paraprofessionals and supporting them through their education, and increasing mentorship was also cited as a measure that could aid retention. Though there were many overlapping concepts, participants did identify interventions specifically for increasing retention. Supervision and training were two tools posited to assist in retention. Encouraging clinicians to become licensed and supporting them as they develop into self-sufficiency was also an idea presented to assist in retention. The last intervention to aid in retention was suggested by Charles and advocated for creating or instituting regularly scheduled moments where clinicians could discuss, share, and examine their successful work in their community. He explained it thusly,

“Once they’ve gotten into the field, I think that there needs to be an ongoing Super Bowl for them, an ongoing acknowledgement on a yearly basis for the commitment that they make and the success that they have in treating our folks. So there almost should be a million man gathering of black men every year to talk about, to share, to support one another around what it’s like or what it is or how it is or let’s get folks together, you know, to acknowledge, as black men, our contributions to mental health."

Retention and recruitment ideas began with a discussion of intentionality, and indicated the incongruence between the stated desire to increase the number of Black male clinicians, and their realities, which were contrary to the stated desire for demographic representation.
The final level of interaction discussed is the intersection of race and oppression. Race and oppression was a topic that was indicated by all of the participants to be painful, enduring, and a key motivating factor for their entry into the mental health field. Six out of the ten clinicians directly referred to the stigma that impacts the availability of the mental health profession to Black communities. Historical mistreatment was mentioned, as well as present mistreatment and the misalignment of the dominant White institutions with the values of Black communities. Instances were recounted in which Black children were removed from their homes by the dominant institutions. The purpose of this recounting was to validate the historic mistreatment of Blacks by the social services system, and alluded to the fact that the children would not have been removed from commensurate White homes.

Present racism and oppression was presented in a historical context by multiple clinicians. Kenneth used the present day presidency of Barak Obama to illustrate the feelings that racism is a prevailing systemic juggernaut with little hope of improvement, he entreated “As Eric Dyson says, don’t get tied up just because we have two…., a Black couple living in public housing in Washington D.C. So, ask Obama and Michelle in terms of becoming a Black president gonna make the Black issues any better.”

The continued negative incursions on Black life were recounted, with the repeated assertion that the participants of the study cared about their community and were willing to “go in the trenches” to get them out of their negative trajectories.

When examining the impact of culture and oppression, the solidarity with other oppressed groups was noted. Multiple responses were directed in support of women and equality. On more than one occasion, the low wages of the mental health field was linked to the field being female dominated. Participants vocalized their displeasure and sadness that this was
an occurrence. The participants made comments which highlighted their views that White males were consciously not legitimizing the contributions of others in an effort to maintain control. Kenneth indicated that White women are also hindered due to the prevailing White male power systems. He stated that “they even have a hard time allowing White theorists to be legitimized.” Francis echoes Kenneth’s statement saying “it’s sad because there are so many smart, educated women clinicians out there who deserve to get paid for the hard work. This isn’t easy work.”

The comments of the Black clinicians concerning the low pay of clinicians being partially due to it being a field dominated by women (in number, not necessarily in power) is an acknowledgement of the unfairness of the oppression. The comments are not simply sadness at incorrectly choosing a field that has unfairly low wages due to having a large number of female practitioners. The intersection of gender and oppression also connected to the responses that the men made concerning their masculine identity. Seven of the men made explicit statements concerning their participation in stereotypically masculine activities such as athletics or working for the Department of Corrections. For example, Douglas, who revealed he was a power lifter and a former prison guard explained that he often dealt with more severe inmates, he explained “I was a prison guard for 10 years and I wasn’t just a regular one. I was, like, the ones that went to go get the inmates. I was on a team of like about 12 guys and we’d go in and we’d handle any problems.”

The theme of masculinity is important to consider due to the high comfort level with societal ascribed female traits that must be endorsed by clinicians. For Black males, it appears that a strong masculine identity might be needed to overcome the taboo of exploring emotions prevalent throughout present Western society. The negative messages that males receive concerning talking and helping is reinforced by the poor pay that therapists receive; which may serve to confirm the undervaluing of less masculine occupations by the larger male power
structures in control. The statements made by Douglas other participants regarding their use of physical strength or experience with a physically dangerous population left many questions as to how the role of masculinity impacts the career trajectory of Black male clinicians.

Lastly, in conjunction with examining the impact of culture, the demographic composition of the interview participants was examined. Six of the ten Black clinicians self-identified their race/ethnicity as non-American Black ancestry or parentage, while another identified his father as being non-American Black. Carter, Douglas, Francis, Kenneth, Marcus, and Thurgood all identified as originating from the Caribbean or Africa, while Langston identified his father as coming from the Caribbean. Throughout the participant interviews, race, ethnicity, culture, and community were prevalent throughout. Thus, the participants’ purposeful identification on the demographic information form indicated the salience of ethnicity and culture in shaping their experiences. Given the multiple statements throughout the interviews concerning race and culture, the participants’ identification with their particular ethnic ancestry indicates its relevance to their worldviews. As cited previously, Seaton and Sellers, (2010) noted that there were differences in culture between Caribbean Blacks and African Americans. The non-American cultural composition of the men in this study may highlight protective factors that may have served as buffers to the effects of continued exposure to American oppression. However, statements made by Thurgood concerning his beliefs that institutions were purposely excluding American born Blacks illustrate the difficulty with drawing direct conclusions.

**Contribution of This Study**

The primary aim of this phenomenological study was to explore the experiences and perceptions of Black male clinicians through their own voices. This study revealed that Black male clinicians in the New England area are a highly aware group of individuals whose heart felt
sadness and identification with their community has enabled them to overcome systematic oppression and racism in America. These results are expressed in order to illuminate the multiple obstacles that they had to navigate and overcome in order to become clinicians. Additionally, this study attempts to highlight the incredible commitment that these men have for helping Black communities heal from historic marginalization and institutional/systemic racism. It is also necessary for this researcher to highlight these clinicians’ dedication to social change and social justice, which has enabled them to endure and overcome, despite enduring traumatic circumstances in their lives. The stories shared by 10 clinicians highlight their feelings of oppression and hurting from the larger society and from the mental health field. The participants made multiple comments about feeling as if educational institutions did not view their contributions as important enough to validate or consider. Their stories highlighted their beliefs that the experiences of Black communities are legitimate irrespective of White norms and values and that their contributions are essential for increasing multicultural understanding. The purpose of this research is to present their stories to the broader public and institutions, in order to illustrate the value of integrating their perspectives into the larger context of human understanding. As noted by multiple participants, the goal is not to illicit validation from the White establishment, the goal is to develop, research, and put into action self defined and self sufficient interventions, tailored from the Black experience for the Black experience. There remains skepticism amongst participants that this brief revelation of an often-neglected perspective will result in immediate change, but this exploration may increase dialogue concerning the treatment of Blacks in the prevailing society. Lastly, this study hopes to inspire other Black males to become clinicians and to give back to their communities. By sharing their stories, these ten clinicians may inspire other man with similar innate leanings towards helping
and healing to persevere and continue when faced with adversity, with the ever present ethos of FUBU as their guide.

**Study Limitations**

There are several limitations specific to this research. The first limitation of this exploratory research study was that the primary researcher is also a Black male therapist in the New England area. The primary researcher utilized the technique of bracketing of assumptions, which required the researcher to identifying and removing his assumptions or experiences as a Black male therapist. Additional measures, which are outlined in chapter 3, detail the additional measures taken by this researcher to limit bias.

The second limitation of this study is related to the means in which the researcher attempted to explore the participants’ story. This researcher attempted to facilitate this discussion of the stories and meanings of these participants using researcher generated semi-structured interviews. The six interview questions developed by this researcher may have hindered the ability of the participants to fully reflect their subjective truth. Additionally, the research questions captured their experiences in multiple areas of their lives; perhaps a more focused inquiry would have revealed different experiences.

The third limitation is related to the specific geographical region of the New England area where this research was conducted. The unique experiences and stories shared by the participants may have been different if conducted on another Black population in America.

**Future Recommendations**

Further qualitative research that provides the opportunity for the voices, worldviews and lived experiences of Black male clinicians regarding their motivation for entering the mental health field is recommended. Further research is also recommended on Black male clinicians at
different times along their career trajectory in order to explore if their motivations and experiences are different. Lastly, research should be undertaken to get a better understanding of FUBU and the impact it may have on Black males and their ability to overcome institutional and societal racism and oppression.

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Appendix A

Institutional Review Board

Northeastern

Notification of IRB Action

Date: April 2, 2014	IRB #: 14-02-14
Principal Investigator(s): Mary Ballou
Richard Booth
Department: Counseling and Applied Educational Psychology
Address: 404 INV
Northeastern University
Title of Project: A Phenomenological Study of Black Males in the Mental Health Professions
Participating Sites: Academic and Behavioral Clinic – approval received
Pyramid Builders – approval received
Informed Consent: One (1) signed consent
DHHS Review Category: Expedited #6, #7
Monitoring Interval: 12 months
Approval Expiration Date: APRIL 1, 2015

Investigator’s Responsibilities:

1. Informed consent form bearing the IRB approval stamp must be used when recruiting participants into the study.
2. The investigator must notify IRB immediately of unexpected adverse reactions, or new information that may alter our perception of the benefit-risk ratio.
3. Study procedures and files are subject to audit any time.
4. Any modifications of the protocol or the informed consent as the study progresses must be reviewed and approved by this committee prior to being instituted.
5. Continuing Review Approval for the proposal should be requested at least one month prior to the expiration date above.
6. This approval applies to the protection of human subjects only. It does not apply to any other university approvals that may be necessary.

C. Randall Colvin, Ph.D., Chair
Northeastern University Institutional Review Board

Nan C. Regina, Director
Human Subject Research Protection

Northeastern University FWA #: 4630
Appendix B

Letter to Participants

Dear

We are inviting you to participate in a research study to explore the perceptions and lived experiences of Black male clinicians practicing psychotherapy and their views concerning the underrepresentation of Black males in the mental health profession. This phenomenological research will attempt to explore the motivation of Black males to become clinicians, their views concerning the shortage of Black males in the mental health profession, their views concerning whether increasing the number of Black male clinicians may have a positive impact on the well being of the Black community, and their views on what strategies and techniques may be used to increase and retain Black male clinicians.

Participation may be used to provide valuable information for increasing and retaining Black male clinicians. If you know of any other Black male clinicians in the New England area, please feel free to forward this email to them. Participation would involve a single semi-structured interview that will be conducted by doctoral student Richard Booth. Richard Booth will contact you within the next week for this interview. The interview completion time is approximately 1-1 ½ hours and will be audio taped by this researcher.

If you have any questions or concerns about the study, please feel free to contact Richard Booth 617.479-1876 or r.booth@neu.edu. By taking part in this study, you are contributing to important research that may help others in your community. Thank you in advance for helping us.

Sincerely,

Richard Booth, MS.
Student Investigator

Mary Ballou, Ph.D.
Principal Investigator

Approved
Appendix C

Participant Content Letter and Consent Form

CONSENT FORM
Northeastern University, Bouvé College of Health Sciences

Name of Investigator(s):  Dr. Mary Ballew, Richard Booth
Title of Project:  A Phenomenological Study of Black Males in the Mental Health Profession

We are inviting you to take part in a research study because you are a Black male clinician. This form will tell you about the study, but the researcher will explain it to you first. You may ask this person any questions that you have. When you are ready to make a decision, you may tell the researcher if you want to participate or not. You do not have to participate if you do not want to. If you decide to participate, the researcher will ask you to sign this statement and will give you a copy to keep.

Background Information
If you decide to take part in this study, we will ask you to participate in a confidential face-to-face semi-structured interview with the researcher. The semi-structured interview will allow for you to express your perceptions on Black male clinicians in the mental health profession. The purpose of the study is to explore the perceptions and lived experiences of African-American male clinicians practicing psychotherapy and their views concerning the underrepresentation of Black males in the mental health profession. This research will attempt to explore the motivation of Black males to become clinicians, their views concerning the shortage of Black males in the mental health profession, their views concerning whether increasing the number of Black male clinicians may have a positive impact on the well being of the Black community, and their views on what strategies and techniques may be used to increase and retain Black male clinicians.

Risks and Benefits of being in the Study
There are no foreseeable risks or discomfort associated with being in the study. You will be interviewed at a time and place that is convenient for you. The interview questionnaire with 19 questions will take approximately 1-1 ½ hours of time to complete. There will be no direct benefits to you for taking part in this study. However, information learned from this study may contribute to the understanding of Black male clinicians and the salient experiences that may have influenced their choice to become clinicians.

Confidentiality
Your part in this study will be confidential. Participants will be given identification codes instead of using real names. All data and files related to the researcher study will be secured in a locked file cabinet in the home office of the researcher with only the researcher having access for three years then destroyed. Each respondents' transcripts will be electronically filed and will be password-protected. Responses will also be printed and stored in a locked cabinet. Upon completion of the study, the researcher will make all results and findings available to participants. This researcher will audio record interview and the audio tape will be destroyed after being transcribed. In the published reports, there will not be any information provided which would assist in identifying any participants.
Voluntary Nature of the Study

Your participation in this research is completely voluntary. You do not have to participate if you do not want to and you can refuse to answer any question. Even if you begin the study, you may quit at any time. If you do not participate or if you decide to quit, you will not lose any rights, benefits, or services that you would otherwise have. If you decide to participate in the study, you are free to address any concerns or to withdraw at any time.

Contacts and Questions

If you have any questions about this study, please feel free to contact Richard Booth, Tel: 617.479.1876, Email: r.booth@neu.edu. You can also contact Dr. Mary Ballou, Department of Counseling and Applied Educational Psychology, 404 International Village, Boston, MA. 02115. Tel: 617.373.5937, Email: m.ballou@neu.edu 617.373.5937. If you have any questions about your rights in this research, you may contact Nan C. Regina, Director, Human Subject Research Protection, 960 Renaissance Park, Northeastern University, Boston, MA 02115. Tel: 617.373.4588, Email: n.regina@neu.edu. You may call anonymously if you wish.

Statement of Consent

I agree to take part in this research.

______________________________________________
Signature of person agreeing to take part/ Date

______________________________________________
Printed name of person above

______________________________________________
Signature of person who explained the study to the participant above and obtained consent/ Date

______________________________________________
Printed name of person above

APPROVED

HU 1590
VALID 1/1/14
THROUGH 1/4/15
Appendix D

Demographic Questionnaire

1. Identification Code

2. Age

3. How do you describe your race/ethnicity?

4. What was field of mental health?

5. How many years have you been a practicing clinician
Appendix E

Interview Questions: Administrator

Do an introduction that not only includes good day but also thanks them for agreeing to talk with you and tells them what you are interested in exploring.

1. What does it means to you to be a black clinician?
2. I am interested in your motivation for choosing a career as a clinician, can you tell me about it?
3. What do you think about the shortage of Black male clinicians in the mental health fields?
4. Do you believe an increase in the number of black clinicians will impact the ability of the mental health fields to address and meet the needs of the Black community?
5. Do you have ideas about some helpful recruitment and retention strategies for increasing and keeping Black clinicians?
6. What is it like for you to be contributing to this research?
Table 1.

Demographic Information of Participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Level of Education</th>
<th>Age Range</th>
<th>Self-Identified Race/Ethnicity</th>
<th>Years of Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carter</td>
<td>Masters</td>
<td>29-34</td>
<td>Black/Haitian</td>
<td>5-10</td>
</tr>
<tr>
<td>Charles</td>
<td>Masters</td>
<td>47-52</td>
<td>Black</td>
<td>29-34</td>
</tr>
<tr>
<td>Douglas</td>
<td>Masters</td>
<td>41-46</td>
<td>West Indian</td>
<td>5-10</td>
</tr>
<tr>
<td>Francis</td>
<td>Masters</td>
<td>29-34</td>
<td>Black/African</td>
<td>5-10</td>
</tr>
<tr>
<td>Kenneth</td>
<td>Doctoral</td>
<td>53-58</td>
<td>West Indian</td>
<td>11-16</td>
</tr>
<tr>
<td>Langston</td>
<td>Masters</td>
<td>41-46</td>
<td>Black</td>
<td>5-10</td>
</tr>
<tr>
<td>Malcolm</td>
<td>Masters</td>
<td>41-46</td>
<td>Black</td>
<td>11-16</td>
</tr>
<tr>
<td>Marcus</td>
<td>Doctoral</td>
<td>53-58</td>
<td>Black</td>
<td>35-40</td>
</tr>
<tr>
<td>Martin</td>
<td>Masters</td>
<td>59-64</td>
<td>West Indian</td>
<td>5-10</td>
</tr>
<tr>
<td>Thurgood</td>
<td>Masters</td>
<td>47-52</td>
<td>Black/African</td>
<td>17-22</td>
</tr>
</tbody>
</table>
Table 2.

Black Male Incarceration

<table>
<thead>
<tr>
<th>Prison/Prisoners (n=4)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Marcus:</td>
<td>They understand it too, that’s why they’re shocked to see a Black president because we’re done as a group. Pick a city, pick a town, go to Gnome Alaska, the Black population is 1% but we make up 80% of the prison population.</td>
</tr>
<tr>
<td>Martin:</td>
<td>I worked at the Department of Correction. Before, I went there, I used to think... there was this allure or this...”Oh, man, people are going to prison and then when they come out, they’re cool; they’ve got that rite of passage.</td>
</tr>
<tr>
<td>Thurgood:</td>
<td>When I first started out my goal was to work in a prison. There’s always black people right there.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Jail (n=4)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Charles:</td>
<td>Jail is not an effective treatment and it’s just expensive and it’s continuation of sort of the problems that the community will see, which is an exodus of the men.</td>
</tr>
<tr>
<td>Francis:</td>
<td>I’ve always had a passion for working with youth, particularly at risk youth in my community. Just seeing the type of youth that came in and out of jail, waiting and just not having the knowledge, the education and just really not having a clue about what life is, what direction, whether they’re coming or going.</td>
</tr>
<tr>
<td>Langston:</td>
<td>Continue the cycle of, now, instead of making jail birds, we’re going to make more clinicians and doctors. Instead of making individuals or...pardon me, not making but...or developing prisoners or burial plots or what is it, wheelchair-bound.</td>
</tr>
<tr>
<td>Martin:</td>
<td>You just go out and beat black people up and you don’t go to jail for it. And they’re in jail already.</td>
</tr>
</tbody>
</table>