MENTAL HEALTH COUNSELING: A PHENOMENOLOGICAL STUDY OF

AFRO-CARIBBEAN CHRISTIAN'S HELP-SEEKING TENDENCIES

by

Heather G. Lewis

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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APPROVED BY:

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ABSTRACT

The purpose of this phenomenological study is to understand the help-seeking tendencies of

Afro-Caribbean Christians. The use of social support systems and the impact of generational

status on asking for and seeking help is the central phenomenon of the study. Study participants

include 10 members selected from a Philadelphia church. The theory guiding this study is social

support as it explains the relationship between social support and the use of professional mental

health services. Study participants were interviewed using a semistructured interview process,

transcribed interviews were analyzed in NVivo a qualitative data analysis software used for data

management and analysis. Through NVivo themes and common concepts are developed from the

interviews as well as addressing the central research questions.

     Keywords: Afro-Caribbean, mental health, counseling, help-seeking, Caribbean, social

support

Dedication

This research is dedicated to my husband, Byron Lewis Sr., my children Brianna Lewis, Byron Lewis Jr., and Renee Lewis. Thank you for allowing me the space and time to complete school and write this dissertation. Thank you for being my silent partners in this endeavor.

Acknowledgments

Jeremiah 29:11 states, "For I know the plans I have for you, declares the Lord, plans to prosper you and not to harm you, plans to give you hope and a future." First and foremost, I want to acknowledge God as the director, author and finisher of my life. This journey began with an a firm understanding that God has the final say and that He makes no mistake! This has been an awesome, inspiring and faith filled journey, and I thank God for guiding me every step of the way.

I thank everyone who supported me along the way and encouraged every aspect of this journey, my husband Byron, my biggest supporter, my family, my parents, my friends and everyone who spoke into my life by calling me "Doc"! Thank you for reminding me every day to keep pressing on.

I thank my Chair, Dr. June Tyson for keeping me on task and encouraging me to take my research to the next level. When I thought to myself, its summer and I am going to chill, Dr. Tyson was right there requesting a status update and pushing me on. In addition, thank you for helping me sort through the theory chapter, by far the most difficult concept to hone in. Thank you to my reader, Dr. Melvin Pride. I still remember meeting you on my first day of school when you stopped in our Statistics class to introduce yourself to us. I am so pleased that the journey has come full circle where you are able to pour into my life and my work in a meaningful and wonderful way by sharing your qualitative skills and knowledge. Thank you to my pastor, Dr. Bishop Shawn D. Bartley for his support and guidance. Thank you to everyone who showed interest in participating in my study and to the 10 participants, thank you for being vulnerable and open to discussing this topic with me.

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Diagnostic and Statistical Manual (*DSM–IV*)

Medical Expenditure Panel Survey (MEPS)

National Survey of American Life (NSAL)

CHAPTER ONE: INTRODUCTION

Overview

Even with years of research and advances in mental health treatment and care, mental illness still carries some degree of stigma and shame. Those who have mental illness can often feel ashamed to ask for help, ashamed of their sickness and see themselves as a burden to family and friends. Particularly in very close-knit families, mental illness is the family's secret, one that is managed within the family. In this dynamic, psychologist and mental health counselors are often viewed as outsiders. One such example of closeness, secrecy, pride, and shame exist in the Afro-Caribbean Christian community. For this study, *Afro-Caribbean* will be used to refer to those from Caribbean countries. Caribbean countries are a group of islands between North and South America.

This study focuses on the Christian community because Caribbean culture has a rich history in Christianity (Chierici, 2004). Therefore, not only is pride a factor, but faith and scripture are amongst some of the most influential guiding forces against asking for professional help. Instead of seeking professional support, many will put faith into action believing that prayer and intercession are all that is needed to overcome any issues. Many scriptures and even gospel music reinforce the belief that prayer is the ultimate healing force. It is not uncommon for those in this community to seek God for help by calling upon prayer groups, pastors or seeking God for themselves. This alternative method of asking for help requires placing all belief and hope in the healing power of prayer. Altar calls, prayer and deliverance services are often used as support methods against seeking professional help.

Additionally, with a history linked to African culture and customs, some Caribbean cultures subscribe to the practice of voodoo or Obeah. Voodoo or Obeah is the belief that some

power, often demonic may be the cause of physical and mental ailments, and likewise, the same source is sought to remove the curse of such mental illness. For example, Handler (2000) writes that Barbados slaves believed in evil magic and spells and would often display psychogenic symptoms. Even with the knowledge that medical treatment can be helpful Pusey-Murray and Miller (2013) writes that Jamaicans still chose Obeah for reasons such as the idea that mental illness is under the control of Obeah workers. Obeah workers are also cheaper than medical professionals are and so their services were sought first. These spiritual charlatans can be seen as both the cause of mental illness and the hope for curing mental illness (Handler, 2000). In her fieldwork in Trinidad examining the role of devilish spirits in illness and the relationships between spirits and bodies, Lynch (2015) found that illness was commonly attributed to devilish spirits and linked to Pentecostal belief that the body is the home of the Holy Spirit and if left unclean can lead to exposure of other unhealthy and demonic spirits. These ideologies are deep-rooted part of the rich history and culture of being Caribbean.

For those who do seek help for mental illness, another drawback is the lack of connection with mental health counselors. Many counselors are not connected socially, mentally or physically with the communities that they serve. The African American experience is as unique as the Afro-Caribbean experience as is the White experience. Counselors need to be culturally competent and savvy enough to recognize and appreciate the difference between cultural groups. Cultural sensitivity is key to working with the Afro-Caribbean population. Most notably, counselors must recognize the difference between Afro-Caribbean and African American including the rich culture and history of belief in systems such as Obeah, curses, demonic forces and the importance of keeping family issues private, and viewing the counselor as an outsider.

In addition to these cultural barriers, other factors prevent Afro-Caribbeans from seeking psychological support. These factors include immigration and generation status. Immigration places a level of stress on families that includes feelings of alienation and starting over. For those without legal immigration status seeking professional help can jeopardize their ability to stay in the United States. Using the data sets from the Medical Expenditure Panel Survey (MEPS) and National Health Interview Survey Chen and Vargas-Bustamante (2011) examined the effect of immigration status on mental health care utilization and found that immigrants were 3 times more likely to be uninsured and 15% less likely to have a regular source of care. Additionally, the data showed that disparities in mental health care and utilization would reduce by 20–30% if non-U.S. immigrants had the same access to care as U.S.-born citizens (Chen & Vargas-Bustamante, 2011). Generation status may impact the level of acculturation, and for example, older generations hold fast to ideas of their home countries more so than younger generations or those that have lived in the United States longer. Through analysis of the National Survey of American Life (NSAL) data, J. S. Jackson et al. (2007) found that there were significant relationships between age at immigration and mental health use, specifically that the third generation and later were much more likely to utilize mental health services than second- and even first-generation immigrants.

Mental illness is a debilitating disease that can have a long-reaching impact on the family unit. Proper care and treatment are essential. Social support and spiritual connectedness are essential. However, professional treatment plans through psychological services are essential. Counselors play an essential role in bridging this gap. A means of bridging this gap begins with understanding the cultural barriers that exist in care and treatment in various cultures such as the Afro-Caribbean community. Counselors must work towards understanding these cultural

differences and making strategic steps to breaking down these barriers. For example, it is essential that counselors understand the culture of the community that a counselor will serve. Cultural sensitivity includes understanding the history and how that impacts effort towards moving forward and asking for help. In the Afro-Caribbean community, there exist a phenomena of not asking for or seeking professional help for mental illness. As a result of the cultural history of stigma and shame in addition to the lack of cohesion with mental health counselors, Afro-Caribbean mental health patients continue to experience a disparity in help-seeking.

Background

The most commonly associated words with mental illness in the Afro-Caribbean community dialect are: *mental*, *mad*, *sick*, *head nuh good*, *madman/madwoman* and *crazy*. These words present a negative connotation of mental illness. It portrays someone with mental illness as unwell and unfit to be around. In their study of the stigma around mental illness and health-seeking utilization, Arthur et al. (2010) found that there are several themes present amongst this community. Those include the definition of *stigma*, emotional and behavioral response to mental illness, and understanding the distinction between madness and mental illness. To understand these concepts requires understanding the history and culture within which Afro-Caribbeans live.

Historical

Jamaica's mental health history is steeped in a culture of shame beginning with slavery and the imprisonment of the mentally ill, including in 1862 when the first psychiatric hospital the Lunatic Asylum was built (Hickling, Robertson-Hickling, & Paisley, 2011). Mental illness became synonymous with hospitalization and being committed to this custodial institution for treatment. Those who could not afford the care and treatment of a counselor, much less a mental institution fell into poverty. Family shame and poverty resulted in many mentally ill patients

falling into homelessness and wandering the streets. This public display of the mentally ill as unkempt, dirty and homeless also contributes to the narrative of fear and stigma about mental illness.

Social

Migration is a stressful process, compounded with the fact that those from the Caribbean are very private and prideful, this issue becomes even more important for counselors to address a method and means by which to help this community seek, and stay in counseling. Counseling offers a wealth of emotional and behavioral support that can help those in the Afro-Caribbean community enjoy a more fulfilled life in America. Studies have shown that counseling is often helpful (Vogel, Wester, & Larson, 2007). Immigration plays a vital role in understanding mental illness within the Afro-Caribbean community in the U.S. immigration, and the redefinition of one's identity can impact mental well-being. According to D. R. Williams et al. (2007), Black Caribbean immigrants can suffer increased mental health risk due to the exposure of ethnic diversity in the United States and being associated with minority status. It is difficult moving from majority status to minority, navigating the cultural shock and stress that comes with migration can be difficult.

The age or generation of immigrants and the rate of acculturation can also impact help-seeking tendencies for those that have a mental illness. Through analysis of the NSAL data, the most extensive study on mental illness amongst Blacks in the United States. D. R. Williams et al. (2007) was able to glean that disparity does exist amongst Black Caribbean immigrants and is associated with generational status, foreign birth, age at immigration and years in the United States. The data indicate there is much researchers can glean from immigration status and how to

treat mental illness. For example, counselors may have a more significant impact and reach with younger generations and those who have strong acculturation.

Theoretical

Some of the many constructs around Afro-Caribbean help-seeking tendencies and mental health disparities include: negative attributions about mental health, devaluation–discrimination about mental illness (stigma), use of social support from family friends, religious coping, resilience (the idea of I can overcome this myself), accessible care, generational (first generation vs. second generation), qualified counselors, gender scripts around asking for help, attitudes towards counseling, willingness to seek counseling, and migration in particular the role of assimilation and degree of distress. In a study of pathways to care for psychosis within the African, Caribbean and European community it was found that Caribbean young people held firmly to cultural beliefs in mental illness as a sin and therefore sought religious coping as a solution. Furthermore, the internalized stigma and need to protect one's family was essential to Caribbean youth, who in turn view the family as a private space to deal with issues of mental illness (Ferrari et al., 2015).

<div align="center">Situation to Self</div>

My motivation for conducting this study is my identification as a member of this population. As a Jamaican, I see daily the struggles with seeking out professional mental health services. Even in my family it is difficult to ask for help or admit the fact that professional help may be necessary. The philosophical assumptions of this study are epistemological in that I believe that many younger Afro-Caribbean immigrants are more likely to use mental health services than their parents or even older generations. The reception to mental health and understanding of the illness may be changing for younger generations. However, there is still

some old world thinking that asking for help is invasive to the private nature of the family. The constructivism paradigm will guide this study, particularly social constructivism which postulates that knowledge and reality are linked to relationships and interactions. Heppner, Wampold, Owen, Wang, and Thompson (2015) define *constructivism* as the abandonment of truth and reality in favor of the idea that the social world is one constructed in the minds of the individual. This research will examine the social world as constructed by Afro-Caribbeans and what impact that may have on what is the truth and reality about mental illness.

Additionally, according to Heppner et al. (2015), social constructions are developed through the investigator's interaction with the participant and their environment. Through the use of hermeneutics and dialectics, the researcher can facilitate an understanding of the participant's construction. According to Cauce et al. (2002), it is crucial to acknowledge that human beings exist within complex environmental systems that impact one's psychological well-being. Understanding that the Afro-Caribbean community is tight-knit, prideful and private my connection with this community will help to foster this dialectic exploration. Social interactions and image are significant. The idea of mental illness and asking for help is very isolative and disrupts the idea that relationships are healthy and working.

Problem Statement

A review of the literature demonstrates that the research does not entirely address the issue of getting Afro-Caribbeans to seek and stay in counseling. The gap demonstrates that the stigma and help-seeking propensity in the Afro-Caribbean community is partly a result of the homogenous treatment of African Americans and Afro-Caribbean in current research. The NSAL dataset is an example of the homogenous treatment of African Americans and people of Caribbean descent. Few researchers such as D. R. Williams et al. (2007) used the data to

examine intragroup differences. Clinicians and counselors must consider the role of immigration and other cultural norms and their impact on asking for help. Counselors must also respect the very different nature that is Afro-Caribbean and that while Afro-Caribbeans share some commonalities with African Americans, the two groups are still very different. Agyemang, Bhopal, and Bruijnzeels (2005) assert that researchers should be careful about using specifically defined terms for specific ethnicities, for example, *African Caribbean* should be restricted solely for persons originating from the Caribbean. The implications of the homogenous categorization can be misleading because as noted by Agyemang et al. ethnicity includes cultural, behavioral and environmental factors are crucial in epidemiology and public health.

Another problem that as demonstrated in the literature is the slow pace at which modern psychology and psychotherapy have kept up with the impact of culture and migration in counseling. Western psychology discounts the fact that certain cultures, particularly the Afro-Caribbean cultures subscribe to a collectivist viewpoint and will miss the benefit of soliciting support from social networks within this community. Additionally, when counselors treat African American and Afro-Caribbeans as one group thereby neglecting the culture and history that comes with migration and Afro-Caribbean culture this exacerbates help-seeking.

Purpose Statement

The purpose of this phenomenological study is to understand the help-seeking tendencies of Afro-Caribbean millennials and older generations at local Philadelphia churches. At this stage in the research, *help-seeking* will be generally defined as rates of mental health treatment or service utilization (Cauce et al., 2002). The theory guiding this study is social support, first developed by Drs. John Cassel and Sidney Cobb (Turner & Brown, 2010). Social support is one of two types of psychosocial process that is important in disease etiology. What Nguyen,

Chatters, and Taylor (2016) found in their research is that networks such as social support are vital to a treatment plan for families. In the Afro-Caribbean community, it is critical to connect with strong social support networks that can positively impact the healing process by way of encouraging the use of professional mental health services.

The purpose of this study is to understand the importance of culture to human identity, its impact on change and how to leverage the support systems within cultures to motivate change and encourage seeking help in counseling. Through qualitative investigation, the research will examine Afro-Caribbeans concerns around professional counseling, the impact of migration and generation gap differences in asking for help. Through exploration of the lived experiences of Afro-Caribbeans, counselors will be better positioned to understand the experience of Afro-Caribbean and how to get this population to appreciate the benefits of counseling without viewing counseling as an intrusion. The research will further solidify the many benefits of counseling while providing counselors with the tools to help Afro-Caribbean clients seek help and stay in counseling longer.

Significance of the Study

African Americans and Afro-Caribbeans have very similar but different lived experiences in the United States. These differences must be acknowledged and understood for those in counseling and helping profession to be able to effectuate change and serve this population. Appreciation of the nuances serves to not only help the counselor understand this population but can foster trust in Afro-Caribbeans that will move this population towards utilizing the professional help services such as counseling, psychotherapy, and more.

The research presents hope for the future of mental illness treatment and care in the Afro-Caribbean community in the United States of America. Most notably, Palmer, Palmer, and

Payne-Borden (2012) calls for Caribbean born counselors to leverage the research and support that they have gained in their host countries and to use that information to improve counseling practices and treatment plans in their native countries or in working with Caribbean clients in their host countries. This cross-training and exposure will help to break down the traditional walls of stigma and shame that surrounds counseling and asking for help. When the person from whom you seek help identifies with you, it is easier to be more receptive to that help.

<div align="center">**Research Questions**</div>

This study will examine the following research questions to help counselors understand how to leverage social support network and better understand the generation gap as a mediator for seeking help and staying in counseling. A conceptual model of the hypothesis is that there exists a relationship between generation, social support networks and one's attitude and willingness to seek help. Do stigma and cultural ideologies from the country of origin impact the use of mental health services? Alternatively, does acculturation and generation status impact the use of mental health services?

Research Question 1: Does social support impede or facilitate the help-seeking attitude of those in the Afro-Caribbean community?

Research Question 2: Does generation play a role in help-seeking attitudes and if so how to leverage generational gap as a mediator for seeking support?

Through a qualitative design, interviews will be conducted to determine whether social support plays a role in reaching Afro-Caribbean immigrants and whether there is a notable contrast between first- and second-generation immigrants as a result of acculturation.

Definitions

1. *African American* - Refers to a person of African descent brought to America as slaves between the 17th and 19th century (Agyemang et al., 2005).

2. *Afro-Caribbean* - Black Caribbean immigrant that has migrated to the United States.

3. *Black church* - Common name for the church consisting of mostly Black people. Through its connection to slavery the Black church is seen as not only a spiritual institution but one that manages other aspects of Black culture such as, education, politics, counseling, community outreach and more (Floyd-Thomas, Floyd-Thomas, Duncan, Ray, & Westfield, 2007).

4. *Millennial* - Generation born in or after 1980.

5. *Obeah* - A type of sorcery or witchcraft that used to deliberately harm another (Bilby & Handler, 2004).

6. *Stigma* - defined as a sign of disgrace or discredit, which sets a person apart from others. Some examples include shame, blame, secrecy, isolation, social exclusion, stereotypes and discrimination (Byrne, 2000).

7. *Voodoo* - A religion based on black magic and witchcraft, superstitious beliefs used for deceptive purposes (Bartkowski, 1998).

Summary

Counseling provides a plethora of benefits to those who seek and need professional help. The alternative can be a life filled with struggles and void of the tools to cope with daily issues of life. While some may not need counseling consistently, a session or two can provide some relief and tools on coping. Life itself is full of struggles, add to it migration, separation of family and rebuilding in a foreign country. These are some of the unique struggles of immigrants. This

study will examine the experiences of Caribbean immigrants in the United States and how to better get this population to see counseling as a tool. Additionally, Afro-Caribbean will hopefully be encouraged to seek counseling and stay in counseling.

In addition to migration issues, Caribbean immigrants have a history and culture of viewing mental illness as a shameful disease, and as a prideful community mental illness is a sign of weakness that embarrasses the family. Mental illness is left to the will of God to correct and is the family secret. This position no longer benefits a community that struggles with mental illness suffer needlessly. Competent multicultural counselors are needed to examine the root cause of help-seeking tendencies and how to approach Caribbean Americans in a sensitive, meaningful way where they feel connected to the process of seeking and asking for help. Chapter Two examines the state of research on this topic including, current research findings, next steps as proposed by researchers in the field and any gaps.

CHAPTER TWO: LITERATURE REVIEW

Overview

The systemic issues surrounding the underutilization of professional mental health services in the Christian Afro-Caribbean community presents a significant health and welfare problem that warrants further research. Disparities in underutilization exist due to lack of access to and use of mental health services, cultural norms such as the stigma associated with a diagnosis, the accompanying shame, immigration status and access to alternative support services. For example, in the Afro-Caribbean community pride and independence are treasured attribute and an indication of mental illness as a sign of weakness. Family members hold the mentally ill in secret for fear of embarrassment. Additionally, asking for help assumes the family does not have the skills to care for, support and nurture the one who has a mental illness. For the Christian subset population, asking for help means that God is not a healer and all-sufficient.

This chapter will address the current state of the research on Afro-Caribbean Christian community help-seeking tendencies for mental illness including the importance of understanding the generation gaps in seeking help, and the role of the church. An in-depth review of the research examined coping strategies available and how Christian counselors should be trained to help this population by understanding cultural barriers and moving towards improving access and care for those in the Christian Afro-Caribbean community.

The disparity in mental health care within the Christian Afro-Caribbean community poses significant health concerns for that community and warrants further research. Not only do these disparities negatively impact the lives of the individual inflicted but it also impacts the family and the overall Afro-Caribbean community. A literature search in PsycINFO, APA PsycNET, ProQuest Psychology Journals, PsycARTICLES, Wiley online library and other databases for the

years 2011–2018, keywords search: *mental health*, *health disparity*, and *Afro-Caribbean* revealed that there are many studies conducted on mental health issues in the African American community but not many specific to the Afro-Caribbean community. The literature describes African Americans and Afro-Caribbeans as a homogenous group. Interestingly, much of the research on Caribbean descendants and mental illness is based in the United Kingdom and Canada. One reason for country differences can be attributed to research efforts being ramped up after large-scale Caribbean migration to the United Kingdom in the early 1950s to mid-1960s when there was a noticeable elevated rate of schizophrenia among the Caribbean population (J. S. Jackson et al., 2007). It is also likely that the research in these countries is more prevalent in the literature because in these countries they do not suffer from the same homogenous problems as the United States. The research in the United Kingdom and Canada is promising and is a roadmap on how to move forward in the United States.

The Caribbean community constitutes the largest subgroup of the Black immigrant diaspora. Despite this fact, not many studies have been conducted to address the mental health issues and the within-group ethnic variations (J. S. Jackson et al., 2007). It is estimated that Afro-Caribbean make up 15% of the Black population (J. S. Jackson et al., 2007). According to Ellis (2012), *Afro-Caribbean* is defined as those born in the Caribbean, namely the West Indies and islands such as Cuba, Jamaica, Haiti, Dominican Republic, Puerto Rico, Greater Antilles, St. Lucia, St. Vincent, Barbados, Trinidad, Guyana, and, some countries in Central and South America. Most of the literature on mental illness tend to treat Afro-Caribbean and African Americans as a homogenous group. This classification fails to take into account the cultural differences and how that impacts help-seeking tendencies and informs a counselor on how to treat clients.

Culture

Culture is an integral part of how people identify and define themselves. While many in the Afro-Caribbean community share overlapping cultural norms, there are distinct behaviors and characteristics. These and other cultural influences and values can ungird one's view on mental health issues and whether to seek help for mental illness. For example, in her fieldwork on mental illness Lynch (2015) found that in the Trinidadian culture illness and misfortunes was often attributed to the devil and some demonic spirit. Counselors who do not understand this cultural norm will be at a disadvantage when trying to work with those in this community. Discrediting these beliefs leaves a service gap and introduces the mistrust of the counselor.

Some cultures like Jamaicans believe in the practice of Obeah. Obeah is the belief that some person with mystical power can put a curse on someone causing illness or misfortune. Obeah can account for the misinformation about the cause of mental illness and contributes to the resistance towards asking for professional help. Belief in Obeah calls for nonclinical practices to cure the Obeah curse (Fernandez-Olmos & Paravisini-Gebert, 2003). Understanding these differing beliefs can help guide clinicians in helping clients understand the need for seeking professional help. Another area of contention for those in the Afro-Caribbean community is acculturation and the stress associated with this.

Acculturation

Immigration is a stressful activity that includes a transition period into a culture into which one may have little or no insight. Immigrants often face many barriers in the transition to a new culture and way of life. First and foremost, through migration, the adjustment to another culture can often take an emotional toll. Like any other immigrant population, Afro-Caribbeans struggle to adapt to a new culture, social structure, financial reality, housing, emotional isolation

and issues related to prejudice and fundamental cultural differences. Pezzini (2011) states that migration is a stressor that often results in psychological trauma due to adjusting to a new culture; this includes feelings of isolation and disconnection. Counselors must appreciate the experience of migration which can include leaving family, and children included behind to start a new life. Many migrate with no home of their own and must share common space with family and friends until they can make it on their own. There is also a constant connection with the country of origin and trying to maintain dual households.

Social Support

According to the 2017 National Alliance on Mental Illness fact sheet, in addition to acculturation, some examples of barriers include stigma, access to care, inferior quality of care, misdiagnosis, lack of cohesion with practitioners because of cultural differences and prematurely ending care. In addition to institutional barriers, underutilization stems from structural and cultural barriers such as a desire to deal with problems on one's own or within the family for fear of stigmatization. One's value systems and cultural beliefs can also influence what type of help one seeks and coping strategies. Those that lean towards family as social support network will look within that network for help.

The gaps identified in this population can help counselors to look closer at the culturally derived values that Afro-Caribbean assign to mental disorder as well as understanding how to leverage the support of family and other support systems such as the church. It is essential to examine these issues in order to address the challenges within the Afro-Caribbean community adequately. For example, neglecting to address mental illness is not only physically debilitating, but it can also lead to other unintended consequences such as incarceration, suicide and other issues that should concern the human population as a whole.

In their research on incarceration, Skeem, Manchak, and Peterson (2011), found that the prison system is the gatekeeper of those with mental illness. More often those who have mental illness are being incarcerated for minor crimes. In addition to the disproportionate representation in the criminal justice system, incarcerating those with mental illness will likely lead to their illness becoming worst. Finally, their research notes that the goal for the incarcerated population is to reduce recidivism, however, efforts must be broader than this, and psychiatric treatment is the best first goal. This one example of the unintended result of the lack of appropriate mental health support demonstrates the importance of researching and addressing the issues of mental health disparities in the Afro-Caribbean community. Every opportunity must be taken to provide this population with the resources to help them live a healthy life.

The articles presented synthesizes of some of the research available on mental health help-seeking tendencies in the Afro-Caribbean community. Most notably, the gaps in the research demonstrate the lack of acknowledgment that Afro-Caribbeans migrate to the United States and face a unique set of cultural issues than those of African Americans. Failure to take into account these cultural differences and how that impacts help-seeking tendencies will limit a counselor's ability to treat Afro-Caribbean clients effectively. The limitations in the literature highlight the importance of future research in understanding the differing beliefs of the Afro-Caribbean community and the need for targeted resources to help guide clinicians in understanding help-seeking tendencies.

Theoretical Framework

Social support is one theoretical framework that undergirds the mental health and well-being of those in the Afro-Caribbean community. This community is a tight-knit network, and social support is an essential component for them. Clinicians and counselors should work to

understand this connection and how to leverage it in working with this population. According to Turner and Brown (2010), social support along with stress and coping techniques form the standard and most essential constructs in understanding mental illness. Social support became the prominent focus in mental health research in the late 1970s with the work of Drs. John Cassel and Sidney Cobb whose primary hypothesis states that social support acts as a buffer against life stress and protects one's mental health (Turner & Brown, 2010). In their work on the effectiveness of group work, the American Psychological Association (n.d.) states that collaboration with family members, community members, and one another provide active ethical, mental, behavioral health and education support for immigrant adults.

Dr. John Cassel made one of the first attempts to conceptualize social support in the biomedical research field. In his paper on social support and its impact on health, Kaplan, Cassel, and Gore (1977) postulated that adequate social support could act as a buffer from harmful stimuli including psychosocial stress factors. Dr. Cassel was able to identify social support as one of two types of psychosocial process that is important in disease etiology. It is important to note further that these protective factors were associated with nature, strength, and availability of social supports (Kaplan et al., 1977). Citing a study on psychiatric utilization among college students Kaplan et al. noted that without adequate support these students experience psychologic and physiologic strain. Dr. Sidney Cobb supplements this idea in his research on social support as a moderator of life stress. Cobb (1976) found that social support falls into three classes: (a) feeling cared for and loved, (b) feeling esteemed and valued and (c) belonging to a network. Through an examination of life circumstances such as hospitalization, stress, employment termination, and bereavement Cobb found that social support acts as a protective source that helps to facilitate coping and adaption.

Another lens into social support states that social support is the ability to offer cognitive guidance, tangible resources and aid, and emotional sustenance in times of need (Sarason, 2013). Most notable in this aspect of social support is that there needs to be congruence between what Sarason calls adaptational demands and support resources, this congruence works to mitigate the adverse effects of stress. Recognizing that stressors vary in the adaptational demand Sarason (2013) surmises that the type of social support will be dependent on the adaptational demands they can moderate. Citing the work of Lazarus and Launier, Sarason further noted that the appraisal of these resources is the most crucial part of social support. This appraisal represents the first stage in stress and coping. In a study on the perception of belongingness and social support in attenuating posttraumatic stress disorder among firefighters Stanley et al. (2018) found that if support is consistent people will use it and if not, they will likely shut down.

According to Nguyen et al. (2016), the extended networks and institutions that provide emotional, social and psychological support should not be assumed homogeneous in that they operate the same for all groups. They state that these social networks operate on a person-centered approach and that it is heterogeneous in that the participants of these networks derive their meaning out of these groups. This idea of approaching social networks with caution allows the clinician to practice with a questioning attitude and not assume that these networks can fully support the health and well-being of an individual. What Nguyen et al. found in their research is that these networks are a vital part of the treatment plan for families. In the Afro-Caribbean community, it is vital to connect strong social support networks that can positively impact the healing process.

Additionally, these networks can prove to be a hindrance to the healing process particularly if the network subscribes to the negative help-seeking behaviors. Networks can

represent risk profiles, be used to assess clients' social environment and resources, identify

vulnerable areas and facilitate more specific treatment such as social disengagement, problematic

interaction and inadequate support. For example, younger generations in the Afro-Caribbean

network are more open to psychological counseling and support. Also, their inner circle is more

accepting and less critical of this means of help.

On the other hand, older generations may be part of a network that sees mental health

counseling as an unnecessary, invasion of private space and family issues. The latter group may

believe that their network is all the support and guidance that they need. Some would even say

the Bible and church are all they need.

A Biblical View of Mental Illness

The Bible offers many accounts of *mental illness* albeit often referred to as *madness* and

lunacy. The Christian religion itself offers believers the ability to seek God for peace of mind.

The Bible makes references and provides tools for believers to seek peace and salvation in

Christ. The Bible also provides many examples of mental illness including God's compassion for

the ill.

Some examples include the Old Testament Deuteronomy 28:28, "The Lord shall smite

thee with madness, and blindness and astonishment of heart." Another example, David acting

mad to escape capture (1 Samuel 21:13–15) "And he changed his behaviour before them, and

feigned himself mad in their hands, and scrabbled on the doors of the gate, and let his spittle fall

down upon his beard." Likewise, in the New Testament, there is an example of Jesus healing a

lunatic (Matthew 17:15), "Lord have mercy on my son: for he is lunatic, and sore vexed: for

ofttimes he falleth into fire and oft into the water." These examples show that mental illness has

been prevalent since the beginning of time. However, most importantly the scriptures show that

Jesus' ministry on earth included caring for the ill. The scriptures also provide support and guidance for coping with life and caring for others. Therefore, it is crucial for Christian counselors to help believers understand the importance of acknowledging mental illness and seeking professional help.

Furthermore, the Bible is full of scriptures that illustrates that God intends for us to live healthy lives in Him. However, the Black church has a long-standing history in demonizing mental illness. According to Sullivan et al. (2014), the history of religion and mental health is one of mistrust and conflict between mental health professionals and clergy. When religion demonizes medicine, it impedes help-seeking tendencies. The lack of support for the benefits of mental health counseling results in a negative association with seeking professional help and supports the narrative that prayer alone is the only option. This notion can also set counselors up as the outsiders while putting the church at the forefront of support.

Mental Illness and the Black Church

Afro-Caribbeans have firm religious and spiritual beliefs. Faith-based institutions can offer valuable resources for combatting mental illness. The Black church has a history rooted in social change. These services date back to slavery when the church was an integral part of survival (K. Hays, 2015). There is tons of research and literature on the impact of spirituality on behavioral health outcomes. In their work on religiosity and African American women, Reed and Neville (2014) write that Black women see religious institutions as a necessary space for them. To further examine this idea Rosmarin, Bigda-Peyton, Öngur, Pargament, and Björgvinsson (2013) conducted a prospective study to assess religious coping as predictors of pretreatment symptoms and subsequent treatment outcome. They found that almost 85% of their sample reported some use of religious coping strategies which suggests that even nonreligious patients

within their sample used religion to cope. This information supports the idea that the church can serve as another avenue for reaching those with mental illness as well as those connected to them. However, these same institutions can enable a negative viewpoint on seeking professional mental health care.

In trying to merge the efforts of the church and psychologist Stanford and Philpott (2011) notes that the relationship between clergy and psychologist tends to be strained because of lack of understanding of each other's role. Clergy will often cite inadequate education about the causes and treatment of mental illness while psychologist report not having the training to deal with faith and religious dynamics. This disconnect results in "clergy being unable to speak the language of psychology and psychiatry, [and] most in the mental health community [being] unable to [speak] with clergy on their terms" (Stanford & Philpott, 2011, p. 282). Additionally, clergy and mental health professional tend to have a mutual distrust due to the lack of shared values between the two. To examine this phenomenon Stanford and Philpott focused on referral patterns, education of pastors and counseling pattern primarily within the Baptist General Convention of Texas (BGCT). The study found that BGCT pastors report a moderate level of contact with the mentally ill, are likely to refer to Christian mental health professional, understand the importance of biological causes over psychosocial and spiritual and, a shared appreciation for medical intervention. The most hopeful part of this research is that it demonstrated that clergy is open to collaborating with professional counselors, albeit predicated on whether they share values.

On the far extreme is the demonizing of mental illness, relegating the sickness to a demonic attack that only through prayer or laying of hands can it be healed. This minimal point of view discounts the medical and professional support services that can bring a person to full

healing. For those who may seek help, it is also vital that clergy and church leaders are trained to be sensitive and practice confidentiality. The act of shaming and naming people as demon possessed is counterproductive.

<div align="center">**Related Literature**</div>

Mental Health Disparities in the Afro-Caribbean Community

Furthermore, given that the literature is sparse on the disparities in the Afro-Caribbean community, the contributing factors to those disparities will be addressed. There are several mental health disparities in the Afro-Caribbean community, which can hinder this population from seeking help from mental health professionals. Some of the many constructs around Afro-Caribbean help-seeking tendencies and mental health disparities include: negative attributions about mental health, devaluation–discrimination about mental illness (stigma), use of social support from family friends, religious coping, resilience (the idea of I can overcome this myself), accessible care, generational (first generation vs. second generation), demonizing mental illness within the church, qualified counselors, gender scripts around asking for help, attitudes towards counseling, willingness to seek counseling, migration—role of assimilation and degree of distress.

The Lunatic Asylum

In many developing countries, mental health services are custodial, inpatient hospital treatment. For example, in Jamaica, the first hospital dedicated to inpatient hospitalization treatment and care of those who have a mental disorder was built in 1862 and was called the Lunatic Asylum. Lerner (2002) writes about Ann Goldberg's research on institutions like the Lunatic Asylum. These institutions highlight the history and trend of isolating people who did not fit into society. Goldberg's research also emphasized the systemic issues with these

institutions including the fact that psychiatric care is structured by gender, class, and race. The

negative history of these institutions has long-lasting implications. Many of Afro-Caribbean's

associations with these hospitals contributed to the stigma around mental disorder. Being

committed to these institutions for care was synonymous with unalterable madness. According to

the research by J. S. Jackson et al. (2007), these patterns of care and lack of resources in

countries of origin may also affect behaviors and attitudes about mental health service use among

immigrants in general. This disparity contributes to the difference in help-seeking tendencies

amongst first and second-generation immigrants.

In their examination of the use of mental health services and satisfaction with treatment

in the Black Caribbean community, J. S. Jackson et al. (2007) examined the data from the

NSAL, a sample which includes 1621 Blacks of Caribbean descent and 891 non-Hispanic

Whites. A modified version of the World Mental Health Composite International Interview was

used to assess mental disorder as defined in the *Diagnostic and Statistical Manual* (*DSM–IV*).

Additional constructs include migration status, formal treatment, and measures of satisfaction.

The results showed that Afro-Caribbean's use mental health care services at low rates, also, of

those who meet the criteria for a disorder as defined by the *DSM–IV* about one third used formal

mental health care services.

Stigma

The stigma of a psychiatric diagnosis is also detrimental to the patient and family. Many

in the Afro-Caribbean community treat mental disorder as a family issue and hide the diagnosis

and the person diagnosed within the family. Some of the negative associations of being

diagnosed with a mental disorder include the idea that the illness is due to a moral or character

flaw. The research further suggests that these negative labels are detrimental and do not reinforce

the idea of seeking help or staying in a program. D. J. Williams (2014) study suggest that in the

Jamaican community the determination to seek help is closely linked to the symptom origins. For

the most part, there is a negative connotation with mental disorders and seeking help is

stigmatizing. Mental illness is harmful and a result of one's wrongdoing. The study consisted of

a sample of 339 Jamaicans; various scales were used to assess attitudes toward seeking

professional psychological help, opinions about mental illness, somatization and demographic

information and beliefs about mental health etiology. The results show that predisposing factors

often predict attitudes toward seeking professional mental health care. For example, older

generations and those with increased benevolence demonstrated positive attitudes toward seeking

help. Most notable was the fact that adolescents did not believe that seeking help would provide

any relief from symptoms which speaks to the lack of trust in the mental health support systems.

Immigration Issues

In addition to the issues surrounding stigma, the research shows that effort must be

geared towards understanding and removing the barriers to mental health services for those in the

Afro-Caribbean community. For the immigrant population, some of those barriers may include,

language barriers, cultural competence of the clinician, and poor prior experience with mental

health service. Of importance is understanding the role of immigration and culture and its impact

on the well-being of those in the Afro-Caribbean community. For instance, J. S. Jackson et al.

(2007) found that there was a meaningful relationship between the age at immigration and the

likelihood that one would use mental health services. The research found that Afro-Caribbean

third generation or later reported significantly lower satisfaction with services and care received

from any mental health services than did those who were the first or second generation, including

African Americans. D. R. Williams et al. (2007) drew the same conclusion that the first

generation had lower rates of mental illness as compared to the second or third generation. Jackson et al. review of the NSAL dataset also revealed the existence of racial and ethnic differences in informal and formal mental health service use within the African American and Afro-Caribbean community. Williams et al. also found that roughly 22% of Afro-Caribbean seek mental health support, Afro-Caribbean males have higher risk rates for psychiatric disorders while Afro-Caribbean females presented at lower risk rates. Through further analysis, Jackson et al. surmised that it is essential for clinicians to consider the importance of ethnicity, immigration, and other migration-related factors when working with the Afro-Caribbean population. These factors in addition to generation status all contribute to the rate of use, satisfaction, and perception of helpfulness. A culturally competent and sensitive mental health provider would need to consider these factors in working with clients and developing treatment plans.

Jamaican immigrants are amongst the largest immigrant population in the United States (Yorke, Voisin, & Baptiste, 2016). Not unlike any other immigrant population, Jamaican immigrants experience many personal, emotional and mental challenges around immigration and assimilation. Using survey data collected from 115 first-generation immigrants residing in New York, Yorke et al. (2016) measured attitudes towards professional mental health care and psychological distress, social support from family and friends amongst other demographic factors. Through SPSS analyses they looked at factors associated with help-seeking attitudes. What they found was that more often those with mental illness initially sought help from within the family and from friends. The research further supports the idea that having strong social support was positively correlated with sustained emotional and mental issues. In addition to the fact that Jamaicans were less likely to ask for help and more likely to use their social support systems including their pastor.

According to D. Jackson and Heatherington (2006), Jamaicans value responsibility, ambition, and independence. Their study included 1,223 Jamaican students sampled from secondary schools. Students watched a videotaped interview of two job applicants where one applicant exhibited signs of mental illness. Students were asked to complete a Social Contact Scale and Opinions about Mental Illness Scale. These scales were used to assess the candidates' capabilities and likeability as well as a measure of the student's comfort in interacting with the candidate. Jackson and Heatherington found that opinions about what mental illness is, what it looks like impacted the students' willingness to accept the candidate with signs of mental illness. As a result of high self-values, Jamaicans hold the view of mental disorder as a sign of weakness and failure. As a result, there remains a reluctance to seek professional counseling and a tendency to conceal negative information about one's self and family. Asking for or seeking help implies owning the diagnosis which equals to admitting to being a failure. Adding to the stigma is the idea that mental disorders are self-inflicted, or resolvable through self-soothing activities such as relaxing, accepting life as is, exercising, hope and prayer (D. J. Williams, 2012).

Counselor Congruence

Another point of view on the lack of use of mental health services is the idea that clients may take issue with the lack of cultural congruence between therapist and clients. The Afro-Caribbean experience in America is a unique one. Families that seek help will look to others that they can connect and relate to, which often is family, other kinfolk and church members. Cabral and Smith (2011) state that matching therapist to clients can lead to a stronger therapeutic alliance because there is a level of trust when the client perceives the therapist to be more similar to them. They do however caution that "match is neither a necessary nor a sufficient condition for positive treatment outcomes" (Cabral & Smith, 2011, p. 544). A meta-analytic review of

preferences, perceptions, and outcomes indicated that there was a substantial effect size in all three categories when there was a racial/ethnic matching of client and therapist. These results offer hope for getting Afro-Caribbean families into the therapist office.

Marrast, Himmelstein, and Woolhandler (2016) found that in Black and Hispanic communities, children and young adolescents were less likely to receive help for mental help because of the stigma about mental health care, lack of trust in doctors, in addition to the shortage of culturally competent child psychiatrist. They examined racial and ethnic disparities in children and young adults' receipt of mental health and substance abuse care through a review of 2006–2012 MEPS. The MEPS is an annual survey conducted by the National Center for Health Statistics, it is a collection of data on medical care, and utilization in the U.S. disparities as found for young adults. Black and Latino children receive less outpatient mental health care than their counterparts. The research by Marrast et al. brings this gap to the forefront and stresses the need for targeted intervention. These disparities often exacerbated psychiatric and behavioral problems for many young minority adolescents, which often resulted in more in school punishment or incarceration, but rarely results in increased service and care for this underserved population.

In addition to the impact on young adolescents, Ellis (2012) reviewed the literature around the disparities in mental health care for older Afro-Caribbean groups living in the United States. His literature review found that 20% of Afro-Caribbean elderly experience some mental condition as defined by the *DSM–IV*. The mental illness that this population experience is often comorbid with other chronic conditions and further exacerbated by sociocultural stigma. As this population tends to hold on to their cultural beliefs, Ellis found that in older Afro-Caribbean populations they have a higher lifetime rate of psychiatric disorders. Furthermore, as this

population continues to age, a gap will begin to form in the utilization of mental health support service. The research highlights the need for more research to identify trends and to mitigate factors in reducing mental health disparities in the elderly population.

The literature further shows that more research is needed to examine the race-related stressors that may contribute to the high rate of mental disorders within the Afro-Caribbean community. D. R. Williams et al. (2007) examined levels and correlates of mental disorder among Black Caribbean immigrants and found a prevalence of psychiatric disorder in the Afro-Caribbean community attributed to increased societal stress and downward social mobility. In addition to ethnicity, immigration history, and generation status played a role in increased psychiatric distress. The study also looked at the length of time in the United States and its impact on mental health diagnosis. Using four measures of immigration (a) generation status, (b) length of time living in the United States, (c) age of migration and (d) U.S.-born or naturalized citizen status, the researchers looked to see if there was an association with mental disorders and these demographic factors. The result was indicative that generation status mattered as it pertains to seeking help. Also, the first-generation men exhibited higher levels of mental disorder in comparison to other generations.

Also noted in the study was the critical distinction between Afro-Americans and Afro-Caribbeans. These results stress the importance of understanding cultural context, the therapeutic relationship and that the delivery of mental health services should integrate cultural and contextual factors associated with immigration. Finally, this literature also adds to the conclusion that future research needs to focus on aspects of the immigrant experience with health status.

Chronic Stress

Mental health disparities in the Afro-Caribbean community can contribute to morbidity and mortality disparities. J. S. Jackson, Knight, and Rafferty (2010) discussed these consequences. Through analysis of the data from the Americans; Changing Lives Study conducted by the Survey Research Center, Institute for Social Research at the University of Michigan, researchers found that those who live in stressful environments cope with stress by engaging in unhealthy behaviors. They also found that there was a positive association between stressors and chronic health conditions.

Additionally, they noted that among African Americans there was an additional positive association between many unhealthy behaviors and number of chronic conditions. They surmise that unhealthy behaviors may mask the physiological and psychological experiences of poor mental health because they live in chronically stressful environments and cope with stress by engaging in unhealthy behaviors. Their research highlights the need for alleviating stressors linked to one's environment. These conditions contribute to the morbidity and mortality disparities among certain groups of people, including but not limited to the Afro-Caribbean population.

In an examination of social factors and its impact on mental health recovery, Tew et al. (2012) delved into the literature and found that some of the social factors that contribute to mental health difficulties include powerlessness, injustice, abuse or social defeat. Among other issues, social oppression was substantially higher incidences of mental health difficulties. Their research further notes that mental health crises result in not only a feeling of powerlessness but a disconnection with one's sense of who they are as well as how others perceive them. This

internalization, they found can be a barrier to recovery as it undermines self-esteem, hope, self-efficacy, and confidence.

Their review of the research supports the idea of social intervention to combat the internalized stigma within the Afro-Caribbean community. The impact of this research is the highlight of the importance of social support networks in the management and care of mental health challenges. Tew et al. (2012) suggest that treatment plan should include connecting Afro-Caribbeans with their social worlds such as family and friends and promoting social inclusion. This theory calls for helping Afro-Caribbeans to maintain as much of their regular life and identity as possible by minimizing the negative associations and impacts of hospitalization. As noted, because many immigrants associate hospitalization with their country of birth it is important to think of novel approaches to helping this population get the help and support they need. J. S. Jackson et al. (2007) found that there is a link between willingness to seek help, perceived dissatisfaction in measures of helpfulness, stereotyped attitudes and lack of value in formal mental health care. Through focus group interviews Keating and Robertson (2004) found what they refer to as a "circle of fear" (p. 440) defined as community mistrust of services and staff at community health centers. The circle includes service providers who themselves are fearful of the members of the community where they serve. Sixteen focus groups interviews were conducted highlighting a significant source of the fear for users was related to negative experiences, the thought that services are discriminatory, and a form of control and oppression.

Additionally, mental health service providers feared the weight and gravity of their responsibility and the outcomes of their interventions. This circle of fear limits trust and engagement with services. Understanding that the relationship between the Afro-Caribbean community and service providers can be difficult and troubling, Keating and Robertson (2004)

recommended that the community and service providers form a partnership and safe space to address broader issues of inequality in care and treatment.

Summary

The literature highlights the challenges in seeking help and providing service for those in the Afro-Caribbean community. The data demonstrate a need to reach children, adolescents, adults and the elderly. Each one with their unique challenges and opposition to seeking and asking for help. What makes this population unique are the cultural barriers that often seem to impede the care and treatment processes. The research in the United Kingdom demonstrates that some techniques are working well. For example, Knifton et al. (2010) analyzed community engagement as a method of addressing mental illness. Through a pre- and postevaluation process they found that community conversation workshops help to reduce stigma in reporting mental health distress and seeking help. The workshops revealed that mental health was a shared concern and the openness to discuss the issue contributed to the reduction in secrecy and shame.

D. J. Williams (2012) found that Jamaican adolescents will often turn to friends, family first, followed by pastor and teachers when looking for psychological support. Using the work on research of Shin who examined help-seeking tendencies in Korean immigrants, Williams cited the four states of help-seeking behavior (a) self-soothing coping, (b) reliance on family and friends, (c) formal services and stage (d) professional specialized mental health services. Therefore, the ultimate goal of the counselor is to move clients to stage four, professional specialized mental health services preferably with a culturally competent counselor who understand the nuances of the Afro-Caribbean community and the challenges they face.

Abel, Richards-Henry, Wright, and Eldemire-Shearer (2011) researched the benefits of integrating mental health into primary care. Using data from the World Health Organization

Assessment Instrument for Mental Health Systems, demonstrated that in addition to trained medical staff, community-level health workers should be trained as gatekeepers. These gatekeepers can help to identify mental health concerns and refer patients for additional care and treatment. Integration of these services would promote collaboration between community health counselors as well as the reduction in stigma. Additionally, it is important to note that Afro-Caribbeans should not be categorized with African Americans. Afro-Caribbean clients expect counselors to understand and respect their differences.

CHAPTER THREE: METHODS

Overview

This study examines the role of social support and generation in the attitudes towards seeking professional help and counseling in the Afro-Caribbean immigrant community. Through the deconstruction of the stigma commonly associated with asking for help, counselors can learn how to leverage the support of social networks and the position of younger generations to get the Afro-Caribbean population to see counseling as beneficial. The goal of the research as discussed in the work of D. J. Williams (2012), is to move Afro-Caribbean clients to stage of help-seeking behavior where they feel comfortable, supported and encouraged to utilize the services of specialized mental health care providers. Utilization can improve through the deconstruction of the myths and stigmas around mental health. This chapter will provide the rationale for using a qualitative research design, steps for data collection and analysis will be discussed.

Through qualitative analysis the following research questions will be explored: what is the association between stigma and help-seeking tendencies in the Afro-Caribbean community, what are some of the impediments to use of service, is the usefulness of treatment related to the source of help and what are the training needs of clinicians and other mental health professionals. The qualitative analysis will be accomplished by way of interviews from a convenience sample drawn from the Afro-Caribbean population in local churches in the Philadelphia area.

Design

This study will be a qualitative interview procedure from convenience sampling. By nature of being a phenomenological investigation, the lived experiences of Caribbean immigrants living in the United States. Participants will be divided into two groups based on age. The participants will come from congregations of predominantly Afro-Caribbean churches in the

Philadelphia area. *Qualitative research* is defined as a method of inquiry that emphasizes the

importance of context in helping to understand the phenomenon of interest (Heppner et al.,

2015). Through this process, the research examines the phenomenon of interest through the use

of research tools included but not limited to the interactive process of interviews, personal

history, ethnicity and biography (Heppner et al., 2015). According to Weiss (1995), interviews

can give access to observations of others, perception, and interpretation of perceptions, and a

window on the past. Because this study focuses on the role of stigma, help-seeking propensity

and the importance of perceived social support it is essential to understand the lived experiences

of those in the Afro-Caribbean community. This information will be gleaned through responses

from the semistructured interviews. By nature of being a phenomenological study looking at

lived experiences through interviewing the study data will be more experiential rather than

statistical.

Research Questions

This study will examine the following research questions to help counselors understand

how to leverage social support network and better understand the generation gap as a mediator

for seeking help and staying in counseling.

Research Question 1: Does social support impede or facilitate the help-seeking attitude of

those in the Afro-Caribbean community?

Research Question 2: Does generation play a role in help-seeking attitudes and if so how

to leverage generational gap as a mediator for seeking support?

Setting

All participants will be members of the Christian church community in the Philadelphia

area. The focus will be on predominantly Afro-Caribbean churches. This setting is important

because the research focuses not only on the cultural impact of asking for help but also on the impact of religion. Most of the churches have a bishop or senior pastor from whom permission will be sought to introduce the study to the congregation.

Participants

For this study, a member of the Afro-Caribbean community is persons who trace their ethnic heritage to a Caribbean country, but who now reside in the United States, and are racially classified as Black. According to research by Logan and Deane (2003) in the northeast corridor of the United States Afro-Caribbeans mostly reside in cities such as New York, Boston, Philadelphia, Miami and Ft. Lauderdale in urban neighborhoods and within ethnic enclaves. Study participants will be drawn from a convenience sample of local churchgoers in the Philadelphia area from a predominantly Caribbean community. All participants must meet the definition of *Afro-Caribbean* or identify as born in the United States to Afro-Caribbean parent. Additionally, first-generation immigrants are individuals who were born in another country of citizenship and moved to the United States. Second-generation immigrants are those individuals who were born in the United States to immigrant parents. The sample size for this study will be 10 participants.

Procedures

Afro-Caribbean parishioners will be solicited from a local church in predominantly Afro-Caribbean community. Study approval will be sought from the Institutional Review Board (IRB) of Liberty University as well as from the pastor. Following receipt of approval, a brief introduction to the study will be done during a Sunday morning church service. The data collection procedures including but not limited to confidentiality of data and informed consent process will be discussed at this meeting. Qualified participants will complete a screening

questionnaire to determine eligibility, the questionnaire will ask for name and phone number for contact purposes. Eligible participants will review and sign the informed consent form (Appendix B). Upon completion of the informed consent, interviews will be administered in person. All interviews will be recorded for transcription purposes. As the primary researcher for this study all data will be collected personally.

Participation in the study will be voluntary. Consistent with IRB approval participants will be required to read and sign the inform consent form before being able to participate in the study and completing any questionnaires. Given the very private nature of this community and the cultural sensitivity to the issues being discussed the highest consideration will be given to the anonymity of responses and storage of data. All participants will be given the flexibility to withdraw from the study.

The Researcher's Role

By nature, phenomenological research includes the researcher as the human instrument in the study (D. G. Hays & Singh, 2012). Assumptions and biases must be managed, particularly in this instance where I have a cultural connection with the participants. Heppner et al. (2015) cautions that self-awareness and reflexivity are essential for the researcher to understand. It is important to acknowledge my position in this culture and how this can influence the research. My perspective and background will be checked by having the data from the interviews coded.

Data Collection

Research participants will be sampled from a local church in the Philadelphia area. Participants will include those that meet the definition of *Afro-Caribbean*, including consideration of *first-generation immigrants* defined as those individuals who were born in another country of citizenship and moved to the United States. Second-generation immigrants

are individuals who were born in the United States to immigrant parents. Participants will be interviewed consistently with the questions found in Appendix E. All interviews will be recorded, note taking will be to capture any thoughts during and after the interviews.

Each participant will complete a brief screening questionnaire (Appendix D). Questions will include age, and whether the participant was born in the Caribbean or born in the United States to Caribbean parent. Administering this questionnaire will serve to determine participant eligibility.

Interviews

Semistructured interviews (Appendix E) will be conducted. Semistructured interviews are a balance between structured and unstructured interviews in that it offers a set of defined questions but still allow the participants to offer personalized responses (Heppner et al., 2015). Interviews will be conducted respectfully to protect the confidentiality of the participants (Weiss, 1995). The interviews will solicit feedback and dialogue with study participants. However, some key points of discussion include if the individual was born abroad, the age of arrival to the United States, if the individual was born in the United States, the background of the parents would be ascertained.

Data Analysis

Data analysis of the transcribed interviews will be done by way of coding through qualitative data analysis software NVivo. NVivo is a computer-assisted qualitative software for data management and analysis. Emerging themes and constructs will be further analyzed and explored. This information will be used to determine if there are common themes from the interviews and whether these themes demonstrate areas for improvement of services within the

Afro-Caribbean community. This information will be used to create intervention and training

programs for the community and counselors.

　　　Additionally, as a member of this community, it is essential to avoid the appearance of

bias. Therefore, it is essential to hone in on my feelings about the topic as well as personal

opinions and observations. Heppner et al. (2015) refer to this self-awareness and reflexivity as

part of the interactive process that occurs between the researcher and the participants. It is crucial

to explicitly acknowledge that the phenomena being explored are filtered through the

researcher's knowledge, language, values, and worldviews. Triangulation is essential for

validity; therefore, an additional safeguard would be to use others to cross-check the data and

emerging themes. One way to accomplish this validity is to use the participants as a cross-check

for the data. D. G. Hays and Singh (2012) referred to this process as the opportunity to check in

with the participants to see if the data truly reflects their expressions and experiences. This

triangulation process will be accomplished through follow-up discussions with participants.

Trustworthiness

　　　Trustworthiness of the data and results is essential. Therefore it is necessary to addresses

credibility, dependability, transferability, and confirmability. Methods for increasing

trustworthiness include, but are not limited to, triangulation, member checks, peer/expert review

and, external audit. Additionally, Heppner et al. (2015) note that trustworthiness is a measure of

the richness and complexity of the findings. The data must be rich enough to capture the nuances

of the lived experiences of Afro-Caribbean and mental health utilization. This richness, Heppner

et al. notes, is captured by way of sample size, quality and depth of interview data and a

deliberate act of the researcher to look for and seek out the unexpected.

Credibility

Credibility refers to the extent to which the findings accurately describe reality. Credibility depends on the richness of the information gathered and on the analytical abilities of the researcher. According to Heppner et al. (2015), qualitative research is thought-provoking and should inspire the researcher to think about the meanings behind field notes or transcripts including examining intrinsically ambiguous data.

Dependability and Confirmability

Dependability and confirmability deal with consistency, which is addressed through the provision of rich detail about the context and setting of the study. Dependability and confirmability can be achieved through transparently describing the steps of the research and keeping good records (Korstjens & Moser, 2018). This detailed description ensures that the findings are supported by the data and are not simply the researcher's thoughts about the phenomena.

Transferability

Transferability is another aspect of qualitative research that should be considered; it refers to the possibility that what was found in one context is applicable to another context. Transferability is best accomplished through a thick description of the findings. A description of the phenomena in context can provide meaningful information to an outsider trying to understand the experiences of Afro-Caribbeans.

Ethical Considerations

The risk to study participants is less than minimal. However, ethical considerations will be addressed in the informed consent form and reassuring participants that their responses will be anonymized in the study. The confidentiality of participants and their home churches will be

protected in the written report by way of use of pseudonyms. Other ethical considerations include data storage. All data will be stored on a secured computer, notes and transcription will be stored in locked filing cabinets. Data will be destroyed following the approved record retention period.

Summary

This chapter concludes a high-level overview of the phases of qualitative research method and the benefits of a phenomenological approach. These include examining the role of the researcher including one's assumption and biases and its impact on the research, theoretical paradigms, and strategies, the method of data collection and analysis and finally interpretation and evaluation of the data. The recruitment and interview process is detailed including the process for coding and analyzing the interview data. As this research looks to explore the lived experience of Afro-Caribbean with mental health counselors, a qualitative approach seems suitable to help "bridge the science and practice gap" (Heppner et al., 2015, p. 361). All study participants will contribute to this study by way of sharing their lived experiences. In Chapter Four the study results will be discussed in light of the methodology as described in Chapter Three.

CHAPTER FOUR: FINDINGS

Overview

The purpose of this phenomenological study is to understand the help-seeking behavior of Afro-Caribbeans living in the United States, mental health utilization and the impact of social support networks on asking for or seeking help. Participants for the study were solicited from a local Philadelphia church to also measure for the effect of faith on asking for help. Eligible participants were those who were born to Caribbean parents or born in the Caribbean and currently living in the United States. The eligible participants were consented via completion of an informed consent form and subsequently interviewed for the study. Semistructured interviews were conducted to learn of the lived experiences of Afro-Caribbeans in the United States and their experience with mental health services. Interviews were also a way to initiate a dialogue about the general knowledge of mental illness, the role of immigration, generation, and spirituality in help-seeking. *Help-seeking* is defined as rates of mental health treatment or service utilization (Cauce et al., 2002). This study is essential to help counselors understand the nuances that exist in Afro-Caribbean history and their lived experiences in the United States. These differences are essential to those in counseling and helping professionals to understand serving this population. Appreciation of the nuances can help counselors understand this population and can also foster trust of counselors. These factors can help move this population towards utilizing the professional help services such as counseling, psychotherapy, and more. This research presents a roadmap for counselors to understand how to engage with Afro-Caribbeans when they seek mental illness treatment and care. Additionally, the discussions of the results will enlighten other Afro-Caribbeans to see that counseling is appropriate mental health care preventative

measure. The importance of social support networks such as friends, family and clergy are also examined to gain an understanding of social networks impact on mental health help-seeking.

This chapter details the description of the participants, analysis of the results, and the research questions. Through the interviews, study participants shared their lived experience in the United States with mental health counseling and asking for help. Some of the participants' responses are shared verbatim to highlight their perspective on using professional mental health services in the United States. Finally, through analysis of the interview data in NVivo, in-depth analysis and synthesis of the themes that emerged are presented in this chapter. These themes are used to address the main research questions, does social support impede or facilitate asking for help and does age or generation play a role in help-seeking attitudes.

Participants

A phenomenological approach was utilized through one-on-one interviews to gain insight into the lived experience of Afro-Caribbeans. Criteria for study eligibility includes being 18–65 years of age, born in the United States to Caribbean parents or a Caribbean immigrant. The study was announced during a Sunday morning church service at a church in the Philadelphia area. Following the announcement, 18 participants were identified. Of the 18, 10 agreed to participate in the study because of meeting the study criteria. After being consented interviews were scheduled. The interviews happened at the church in a small conference room. Interviews with all participants was conducted over a two-week period. Each participant was assigned a pseudonym to maintain his or her confidentiality. The name of the church is also not used or referred to for confidentiality purposes. All participants resided in the immediate Philadelphia area. The study cohort consisted of seven females and three males; this was indicative of the opinion that women are more likely to seek and use professional help (Mackenzie, Gekoski, &

Knox, 2006). Additionally, it could be representative of the church body as most of the congregants are female. The participants were mostly born in the Caribbean island of Jamaica or born to Jamaican parents. One participant identified as being Cuban American. Following is a detailed description of each participant. Pseudonyms and age ranges are used to protect the identities of the participants.

Angela is in the 40–50 age range. Angela is an immigrant to the United States and was born in Jamaica. Angela has lived in the United States for 19 years. Angela has extensive experience with mental health use and support. There is a family history of mental illness. Angela indicated that she has also sought professional support for her struggles with mental illness, particularly depression and anxiety. She understands the importance of having and seeking professional support. While Angela believes in prayer, she also supports the use of professional counselors and psychologist.

Gregory is in the 40–50 age range. Gregory is an immigrant to the United States and was born in Jamaica. Gregory has lived in the United States for much of his life, 40 years. Gregory has had extensive experience with mental health support services. There is a family history of mental illness, and Gregory currently works with those that suffer from trauma. He understands the importance of mental health support services and has used the services of a counselor.

Yvonne is in the 50–60 age range. Yvonne is an immigrant to the United States and was born in Jamaica. Yvonne has been living in the United States for 18 years. Yvonne works with the mentally ill as a caretaker. However, she has no family experience with mental health services use or illness.

Maggie is in the 50–60 age range and has little or no experience with mental health support or use. Maggie is an immigrant to the United States and was born in Jamaica. Maggie

has been living in the United States for 33 years. Maggie strongly believes that prayer is the key and that while professional services are excellent, nothing beats prayer.

Gayle is in the 40–50 age range and has little or no experience with mental health support or use. Gayle is an immigrant to the United States and was born in Jamaica. Gayle has been living in the United States for little under a year.

Mark is in the 30–40 age range and has little or no experience with mental health support or use. Mark is an immigrant to the United States and was born in Jamaica. Mark has been living in the United States for most of his life, 29 years. Mark believes that professional support is excellent, but the support of friends and family is critical as they have an invested outcome in your well-being.

Monica is in the 60–65 age range and has some experience with mental health support and use. There is a family history of mental illness, and Monica understands the impact of mental illness on the family and the importance of seeking professional help. Monica is born to Afro-Caribbean parents. Monica's father immigrated to the United States in the 1950s from Cuba. Monica has often used the support of professional counselors and believes in the integration of spiritual and professional support.

Jasmine is in the 20–30 age range and has little or no experience with mental health support and use. Jasmine was born in Jamaica. Jasmine has been living in the United States for 13 years.

Tiffany is in the 20–30 age range and has little or no experience with mental health support and use. Tiffany was born in Jamaica. Tiffany has been living in the United States for 25 years.

George is in the 20–30 age range and has some experience with mental health support and use. There is a family history of mental illness, and George has an understanding of mental health support. George is born in the United States to Caribbean parents.

Table 1 describes the limited data on the participants.

Table 1

Profile of Participants

Name	Age	American-born?	Caribbean-born?	Highest education	Experience mental illness/support
Angela	40–50	No	Yes	High school	Yes
Gregory	40–50	No	Yes	Associate's degree	Yes
Yvonne	50–60	No	Yes	High school	Yes
Maggie	50–60	No	Yes	High school	No
Gayle	40–50	No	Yes	High school	No
Mark	30–40	No	Yes	Master's degree	No
Monica	60–65	Yes	No	Bachelor's degree	Yes
Jasmine	20–30	No	Yes	Bachelor's degree	No
Tiffany	20–30	No	Yes	High school	No
George	20–30	Yes	No	High school	Yes

Results

Interviews were recorded and then transcribed verbatim in a word file. The transcribed interviews were then uploaded to the NVivo 12 plus software for coding. Codes and select nodes were identified by analysis of the interview questions and responses. As noted by Rubin and

Rubin (2011) there can be many themes and concepts that emerge from interviews, however, it is impossible to code them all. Themes were reviewed against the research questions. Cross-analysis of the data was completed across all participants to test for themes.

Theme Development

According to Rubin and Rubin (2011) themes describe an occurrence in the research and represents the interviewees' summary about what is happening. The themes show a relationship between one or more concepts and add support for the research questions. The themes developed in this research will guide the research questions and add context and framework to any developing ideas around mental health utilization in the Afro-Caribbean community. Themes are important to guide policy, future research development and identify any gaps in the research. The following themes were developed from the interviewees responses.

Understanding of Mental Illness

One emergent and unexpected theme that developed from the interviews was the varying responses from interviewees about their depth or knowledge of what mental illness is. Participants who had firsthand knowledge such as family experience with mental illness or personal use of mental health services were more likely to define and articulate their understanding of what mental illness is, even naming a specific diagnosed disorder. Participants who did not have a direct or indirect experience with mental illness whether in family or through personal usage of counselors demonstrated a difficult time in giving a clear and concise definition of their understanding of mental illness. For example, Angela and Gregory, whom both work with the mentally ill used words like *depression* and *borderline personality disorder* in giving examples of mental illness. Monica's mother suffered from manic depression schizophrenia, her brother-in-law also has depression, and she was able to define what mental

illness looks like. For others who did not have a personal connection to mental illness it was difficult for them to articulate what mental illness is.

When asked about their understanding or knowledge of mental illness, some responses from those without firsthand knowledge or experience include: Jasmine stated, "It is some sort of sickness, people say or do certain things, people go off in a rage." Mark defined *mental illness* as a learning impairment, "From what I heard about it or understood, it is kind of a learning impairment." Finally, Tiffany defined *mental illness* as,

> Like when you see certain people that don't function the same way as you function, so it's like they don't have the same or some of their brain cells have not developed or they might be autistic and different stuff like that.

Age and education had no impact on the understanding of mental illness. Personal experience and exposure to mental illness was a clear indicator of one's understanding of mental illness as a disease. This was an important theme development as it presents some gaps in the research and provides support for increased training on the etiology of mental illness.

Family Openness to Accepting and Discussing Mental Illness

Afro-Caribbean culture is one of pride and strength. Mental illness is a sign of weakness and therefore is not openly discussed in families (Arthur et al., 2010). However, four participants discussed seeing mental illness in their own families growing up and shared examples of how mental illness was managed and discussed within their families. Table 2 is a breakdown of the participants and relationship to a family member that had a mental illness.

Table 2

Participants' Relatives With Mental Illness

Name	Relationship to person with mental illness
Angela	Mother diagnosed with schizophrenia
Gregory	Uncle (undiagnosed)
Monica	Mother diagnosed with manic depression and schizophrenia; brother-in-law diagnosed with depression
George	Aunt (undiagnosed)

Gregory talked about as a child seeing his uncle living under the house and that the family would care for him and bring food to him outdoors. His uncle's mental illness was not a secret and everyone in the family knew he was ill. However, Gregory's mother would often refer to his uncle as a "madman" and attributed his illness to smoking weed. Gregory recounts that he later grew up to associate smoking weed to causation of mental illness, and that it was one of the reasons why he never smoked weed in college. Monica recalled being subject to her mother's schizophrenic episodes. She also talked about the shock treatments her mother received to help manage her episodes. However, being the baby in the family, her older siblings tried to protect her as much as possible from her mother's illness. Angela also openly discussed her mother's diagnosis with schizophrenia.

George's story is the most telling and gives insight and evidence of a difference in generation openness. George is related to another study participant. However, George was the only one that openly discussed his aunt's struggles with mental illness. As he recalls it, "she was literally going mad." George talked about the many trips to the hospital, the doctors they spoke

with and even turning to prayer. When asked about a family history of mental illness, George's family member, also a study participant answered negatively. At no point during our interview did George's family member discussed the mental health sufferings of her family member.

These stories indicate that within the Afro-Caribbean community there is an openness to discussing and managing mental illness within the family. This tight-knit private community is growing more comfortable with addressing mental illness in the family. Participants did not address whether people outside of the family had knowledge of any issues. Additionally, there is some remnant of shame and cover-up, as seen in Gregory's and George's case. Gregory's mother attributed the illness to a substance abuse while George's family member refused to acknowledge that there was an issue within the family.

Impact of Culture on Asking for Help

Almost half of the study participants have used professional mental health support services such as a marriage counselor, grief counselor, and psychiatrist. The data shows that those with a family history or connection to mental illness were more often the ones that admitted to using professional helping services. Concurrently about a third of the participants admit that Afro-Caribbean culture supports the idea of being quiet about mental illness and encourages trying to work issues out by oneself. Gregory stated that he feels that Afro-Caribbeans are taught to be silent about mental illness even more so than African Americans. Mark affirms that his Caribbean-ness is a contributing factor in not asking for help. When asked to clarify what is meant by his Caribbean-ness, Mark speaks about being raised to be tough, not crying or showing any emotions and handling problems on your own. For most of her life, Jasmine did not see mental illness as something serious. She grew up hearing people define *mental illness* as someone not being in their right state of mind, mad, or being under the

influence of a spirit or witchcraft. Jasmine is in the 20–30 age range, and she admits that it was only recently that she began to understand what mental illness is and its actual impact. Therefore, while most participants are actively seeking help or have used professional help many still hold on to the idea that it is ok to work things out by yourself. Asking for help is seen as a last resort once all personal avenues of help have been exhausted.

Importance of Cultural Congruence With Counselor

For those who did seek professional counseling, the preference for a counselor of the same background, whether race or culture was mixed. Angela did not have a strong preference and stated that she just wanted to get better. For Gregory, in hindsight, he would have preferred someone with the same skin color but is open to not necessarily being so connected to a counselor that the counselor is telling him what he wants to hear. For Mark, the race was essential to an extent, but the most important criteria was age. Mark believes that with age comes wisdom and experience. Therefore, if he must go to counselor he would prefer someone older and more seasoned in life. Monica stated that it would be difficult for a counselor of other races to truly understand what Caribbean people experience because they would have nothing to relate to the lived experiences of Afro-Caribbeans.

For those who have never had direct experience with a counselor, the response was mixed as well. For Yvonne and Jasmine race did not matter. For Gayle and Tiffany, the race of the counselor did matter. In general, the responses indicate that cultural congruence may be necessary but not required for the selection of a counselor. Gregory gives an excellent example of an encounter with his counselor where she was encouraging him not to support his mother in the purchase of a house and to stand his ground. Gregory felt that his counselor did not understand the collective nature of Caribbean culture and that in many immigrant communities

money and resources are pooled to help each other. Perhaps knowing more about the Caribbean culture would have been useful to Gregory's counselor, or maybe having a Caribbean or Afro-Caribbean born counselor would have helped Gregory not to feel frustrated. Therefore, the responses to this question suggest that cultural congruence to the counselor has a mild impact on the counseling relationship.

Research Question Responses

Research Question 1: Does social support impede or facilitate the help-seeking attitude of those in the Afro-Caribbean community? Social support is one theoretical framework that undergirds the mental health use and well-being of those in the Afro-Caribbean community. According to Drs. John Cassel and Sidney Cobb social support acts as a buffer against life stress and protects one's mental health (Turner & Brown, 2010). These networks can prove to be a hindrance to the healing process, mainly if the network subscribes to the negative help-seeking behaviors. Networks can represent risk profiles, used to assess clients' social environment and resources, identify vulnerable areas, and facilitate more specific treatment plans. A strong social network can help guide counselors in assessing social disengagement, problematic interaction, and inadequate support.

For Mark, he placed more emphasis on social support and saw the advice of his friends as a more profound connection than one on one professional counseling. Mark sees the social support of friends as a personal connection that he believes he would not receive from a professional counselor. For example, when asked about seeking or asking for help Mark notes that men in the Afro-Caribbean culture see asking for help as a sign of failure and are more likely to indirectly ask for help by seeking advice from fellow men or other close friends.

Most of the participants view social support as complementary to seeking professional help.

- George talks about friends being important but agrees that only a counselor can listen to you and "properly dispose of what you just dumped on them and keep going on about their day."

- Monica sees social support of friends and family as stabilizing place where

  We take the information that the counselor gives us and what our family and friends say to us and what ministers and pastors could do for us. If we don't have all those choices we usually pick the wrong thing to do.

- Gregory feels that his friendships provide for a great exchange of therapeutic conversations where they can be transparent, and that these connections are important.

- Angela also agrees that social support is complementary to professional help. According to Angela, "I use everybody in the church; I feel like they deal with me better; they are more understanding. Not only for my mental illness, I not only need professional, but I need spiritual help. I lean on both sides."

Research Question 2: Does generation play a role in help-seeking attitudes and if so, how to leverage generational gap as a mediator for seeking support? Participants who have all used mental help support services all range from the age 30 and older. It is not clear why younger generations are not using professional services. Some reasons for underutilization could be there is no present need, a lack of understanding, and result of fear or shame. All but one participant did support the use of professional mental health support services and would recommend counseling to a friend or family member. Maggie, the only participant that opposed counseling, is in the 50–60 range and states that she prefers praying. For those who were likely to

recommend counseling, the qualifying event was whether they or the person could cope on their own without professional help. Table 3 shows participants response to the question of would they recommend counseling.

Table 3

Would Participants Recommend Counseling?

Name	Age	Recommend counseling?
Angela	40–50	Very likely
Gregory	40–50	Very likely
Yvonne	50–60	Very likely
Maggie	50–60	Unlikely
Gayle	40–50	Likely
Mark	30–40	Likely
Monica	60–65	Very likely
Jasmine	20–30	Likely
Tiffany	20–30	Very likely
George	20–30	Very likely

Summary

A qualitative approach was taken to understand the lived experiences of Afro-Caribbeans in the United States and their likelihood of asking for help and using professional mental health support. Volunteers for the study were initially reluctant to sign up. This was attributed to a misunderstanding of the request for participants. Some heard "if you have mental illness" when in fact the solicitation was a request to discuss what the Afro-Caribbean population knows about

mental illness. Even after confirming and consenting to do the study many of the participants still seemed hesitant to be interviewed, and it was hard to pin down interview time and dates. Those who had some experience with mental illness, whether through the use of professional help services or connection to a family/friend were far more eager to share their story.

Interview responses demonstrated common themes that point to the importance of mental health utilization. Those themes include (a) an understanding of mental illness, the research demonstrated that between younger and older generations there are varying degrees of understanding of mental illness, (b) family openness to accepting and discussing mental illness, almost half of the study participants discussed seeing mental illness in their own families growing up and shared examples of how mental illness was managed in the family. This openness is indicative of a willingness to discussing mental illness within the family, (c) impact of culture on asking for help, while most participants are actively seeking help or have used professional help, many still hold on to the idea that it is ok to work things out by yourself, and (d) importance of cultural congruence with counselor, cultural congruence to the counselor has a mild impact on the counseling relationship. This supports the literature that "counselor match is neither a necessary nor a sufficient condition for positive treatment outcomes" (Cabral & Smith, 2011, p. 544). Finally, the research showed that those with a desire for mental help support were utilizing the professional resources as needed. Even those who have not had the support of professional counselors were likely to use counseling and support services. One out of 10 participants would prefer to use spiritual support instead of professional support. Social support was complementary to professional support; except for one participant who believed that social support was a stronger connection than a counselor could ever be.

CHAPTER FIVE: CONCLUSION

Overview

The purpose of this phenomenological study is to understand the mental health help-seeking behavior of Afro-Caribbean millennials and older generations in the United States. This chapter will discuss the summary of the findings from the interviews of the 10 study participants. The implications of the findings are addressed in light of the literature review as presented in Chapter Two, implications of the methodology, delimitations, and limitations of the study, and recommendations for future research on the impact of Afro-Caribbean culture on counseling.

Summary of Findings

The research study was designed to examine the following research questions:

Research Question 1: Does social support impede or facilitate the help-seeking attitude of those in the Afro-Caribbean community?

Research Question 2: Does generation play a role in help-seeking attitudes and if so how to leverage generational gap as a mediator for seeking support?

Semistructured interviews were conducted to gain a response to direct questions about mental health knowledge and utilization. However, through conversations that follow the questions, participants discussed their lived experiences with mental health support in the United States.

Research Question 1 is aimed at understanding the role of social support systems such as friendships, family, and pastoral support in the context of its impact on asking for help. The Afro-Caribbean community is a tight-knit, collective network wherein social support is an essential component. According to Turner and Brown (2010), social support, along with stress and coping techniques, form essential constructs in managing mental illness. However, if social

support is available, does this facilitate asking for professional help, or does it impede asking for

help?

Most participants in the interview cohort agreed that asking close friends and family for

help was essential and that the relationships with family and friends were a natural part of their

day-to-day well-being. However, professional help was acknowledged as the best option.

Participants who did not agree on utilizing professional care or friendship believed in either

spiritual support or a combination of spiritual and professional support. On a Likert scale of *very*

likely, *likely*, *neutral*, *not likely*, and *very unlikely* most participants were *likely* or *very likely* to

refer others to counseling if needed. Therefore, social support does not impede help-seeking or

referral patterns. Social support is likely used to complement and facilitate moving towards

professional counseling. These results support the research in the literature review that highlights

the importance of social networks. In their study, Nguyen et al. (2016) found in their research

that social networks are a vital part of the treatment plan for families in counseling. In the Afro-

Caribbean community, it is vital to connect strong social support networks that can positively

affect the healing process.

Research Question 2 was directed at finding out whether one generation was more open

and amenable to counseling than the other. The hypothesis was that millennials were more likely

to use counseling, as they would be less connected to the historical and cultural stigma of mental

illness. The stigma of psychiatric diagnosis is often detrimental to the patient and family. Many

in the Afro-Caribbean community treat the mental disorder as a family issue and hide the

diagnosis and the person diagnosed within the family. Some of the negative associations of being

diagnosed with a mental disorder include the idea that the illness is due to a moral or character

flaw. However, the research results show that participants that have utilized counseling are older

and most tend to have a family history of mental illness. D. J. Williams (2014) attributed this phenomenon to increase in age, decreased authoritarian beliefs, increased benevolence, and more positive attitude towards asking for help. Millennials, on the other hand, had little or no experience with professional counseling services beyond school counseling. As a result of the lack of exposure to mental illness, most millennials could not sufficiently define *mental illness*. However, if needed millennials were still likely to use counseling and recommend counseling to others. Therefore, there is no generation difference in utilizing mental health services. The only limitation in use identified was whether there was a presenting condition that required professional counseling.

Discussion

The research findings offer mix support for the literature review. The themes addressed in the literature review include counselor congruence, culture, and social. The findings that support or otherwise do not confirm these themes will be discussed.

Counselor congruence was discussed in the literature as a limiting factor in seeking help. While it was useful, it was not necessary that counselors be of the same ethnicity for counseling to be effective. Some participants did think it would be helpful for a counselor to identify with the nuances of being from a Caribbean family. Some participants were looking for counselors that could identify with their experience in the United States. Others did not care whether they were culturally connected to a counselor. Therefore, counselor congruence was not exclusively necessary for counseling to be effective. The participants who did participate in counseling all met with counselors of a race and culture different from their own. As noted by Cabral and Smith (2011), counselor congruence is neither a necessary nor a sufficient condition for positive treatment outcomes.

The recognition of Afro-Caribbean culture was critical to many of the participants. The differences between African Americans and Afro-Caribbeans were discussed, and it was apparent that these differences do impact ones lived experience in the United States. For example, Gregory spoke about the abandonment that he felt due to his mother leaving him with family members in Jamaica when she immigrated to the United States for a better life. He still struggles with these abandonment issues, and even now, when his mother visits, he becomes anxious when she is about to leave and go back home. These abandonment issues were only recently brought to light in his counseling sessions. Mark talked about how his Caribbean parents taught him to hide his emotions and deal with his issues on his own. Mark struggles with asking for help but would prefer to share his concerns with close, select friends or family.

D. J. Williams (2012) found that Jamaican adolescents often turn to friends, family, followed by pastor and teachers when looking for psychological support. The research confirms this as many participants used support systems such as friends and clergy. These support systems did prove to be useful and supportive in counseling. Only two participants had varying views on friends as support. One participant valued friends over counselors for the personal touch and connection. While another participant thought it was difficult to expect, friends to bear the emotional weight that comes with sharing problems. Trust did not appear to be an issue for this participant. The concern was with friends and family be able to manage the burden that counselors seem to manage well on a professional basis. Given the value placed on social support, counselors should consider these networks and how to utilize this resource in counseling.

Additionally, the church is viewed as a conduit for counseling as spiritual support and prayer were found to be necessary to some participants. The sample population was from a

Christian church; therefore, it is not conclusive that spiritual support was a necessary component to counseling and that this could be generalized to the Afro-Caribbean population.

Overall, the study did not corroborate with the literature review in that Afro-Caribbean underuse mental health support services. Almost half of the study participants have used professional mental health services to cope. Those who did not use professional mental health support did not identify a presenting issue that required mental health support or care. This result is a positive outcome for the literature in that it is indicative that Afro-Caribbeans are seeking professional help when needed.

The study does extend on previous research by demonstrating the impact of social networks and culture on counseling. If social networks are essential, they can be viewed as an essential gateway to professional counseling. One novel contribution that this study does add to the field is the need for teaching young adolescents about mental illness. Mental care does not have to be a *DSM–IV* diagnosed episode. Seeking preventive care and speaking with a psychiatrist to deal with day-to-day life concerns is good mental health practice and care. Participants may believe that mental illness is a significant, diagnosable episode. Additionally, the cost of mental health care was not addressed, so it is not known if this also affects use and understanding of mental health. The study does shed new light on the need for greater understanding of mental illness. Direct exposure seems to be the qualifier for knowing about mental illness.

Implications

Overall, the study demonstrated a positive outlook for counseling within the Afro-Caribbean community. Much of the research supports the idea that Afro-Caribbeans are seeking professional help when needed. However, there is still a small sample that sees counseling as

futile and view social support or spiritual counseling as the best path to healing. The mixed opinion indicates that there are opportunities for outreach with this community and that counselors can continue improving relationships with this population. Additional implications are discussed in the context of theoretical and practical implications.

Theoretical

Social support is one theoretical framework that undergirds this study on the mental health and well-being of those in the Afro-Caribbean community. This community is a tight-knit network, and social support is an essential component. The implications of the research is that social networks are important avenues for seeking help. Clinicians and counselors should work to understand this connection and how to leverage it in working with this population. The research shows that most Afro-Caribbeans are willing to speak with someone however, they most value friends and family's support. However, it is vital to get the right advice and support to meet their needs. If family and friends are key, another implication is understanding what mental illness is and what it may and may not look like. The younger study cohort agreed that counseling was important but they lacked the understanding of what mental illness may look or feel like.

Practical

The research study shows that there is a need for more professional counselors that can address the specific needs of Afro-Caribbeans. These needs include understanding the impact of immigration, keen sense of the importance of culture and the collective network. The data also shows a significant presence of family history with mental illness and that Afro-Caribbeans are open to discussing these issues with counselors and other professionals. As the study participants are from a local church, there is a practical need for churches to implement a formal counseling

ministry that has a referral system to outside professional support. Counseling ministry can serve as a gateway to professional counseling. Additionally, if pastors are equipped to handle issues those who need a spiritual aspect to their support will find that in a church ministry. Pastors can also collaborate with professional counselors to form a network that supports the spiritual and mental needs. For those who strongly believe in prayer and spirituality, this could serve as a conduit to professional counseling services.

Delimitations and Limitations

Delimitations are purposeful decisions that a researcher makes to limit or define the boundaries of the study. For this study, the population was limited explicitly to Caribbean immigrants or those born to Caribbean parents. This was intentional to stick with the aim of the study, which is to understand the utilization of mental health services within this population. Another delimitation was that participants were selected from a church population. The study did not take the experience of the unchurched into consideration.

Limitations are potential weaknesses of the study that cannot be controlled. Some study limitation was the location and the population sample. Study participants were drawn from one local church in the Philadelphia area. Nine out of 10 study participants identified as being from Jamaica or born to Jamaican parents. Data saturation would be achieved if participants were drawn from other churches, geographical area, and identified with other Caribbean nationalities other than Jamaican. The sample population represented a *convenience sample*, defined as participants who are readily available to the researcher (Warner, 2012). While generalization back to the main population is cautioned, representativeness of the sample is assessed based on the characteristics relevant to the research questions.

Recommendations for Future Research

In consideration of the study findings, limitations, and the delimitations placed on the study, recommendations, and directions for future research include understanding a need for more research on Afro-Caribbean population and their use or nonuse of mental health services. The study indicated that Afro-Caribbeans place importance on social networks and that the impact of race and culture in counseling sessions is important. Many participants have lived in the United States for a long time; perhaps future research should be a longitudinal study that follows a cohort to gain a better understanding of mental health use in the United States. The limited time, scope and format of the study did not allow for more robust data gathering such as deeper dive into family history of mental illness and management. Additionally, a clear understanding of mental illness was not present in the younger cohort. Further conversation or robust study design would be necessary to understand this phenomenon. The results do show that Afro-Caribbean are interested in counseling, they use the services of professional counseling, and most notably, many are suffering or have a family history of severe mental health issues.

Summary

The study began with a literature review, which highlights the challenges in seeking help and providing mental health service for those in the Afro-Caribbean community. The data demonstrate a need to reach children, adolescents, adults, and the elderly. Each one with their unique challenges and opposition to seeking and asking for help. Additionally, the data suggest that this population is unique in that cultural barriers can impede the care and treatment process. However, the three most important take-aways from the results of my research are that older generations are using mental health services at a greater rate than younger generations. They also demonstrate an understanding of the importance of seeking help. Those seeking help have not

allowed family history or shame to stop them from asking for help. For example, one of the themes that emerged from the research is the varying understanding of mental illness. The younger generation was not to able to articulate well their understanding of mental illness as compared to the older generation. Additionally it is the older generation that is more likely to be in counseling or are using the services of professional counselors. Secondly, there is still cultural remnant of stigma and shame that needs to be processed. This can be found in the themes around cultural impact on asking for help. Many still believed it was ok to try and work things out for themselves. For those who still hold on to this belief, prayer and support networks seem to be the most logical outlet for seeking help. However, as indicated in the literature review social networks are very important. These networks can still prove to be a conduit for professional help. Lastly, the literature speaks about reaching children and adolescents. As evidenced by the response from millennials, it is recommended that early discussions and support occur within the younger generations so that there is a clear understanding of mental health and available support services. In conclusion, the research offers a roadmap for counseling within the Afro-Caribbean community in that most of the participants view social support as complementary to seeking professional help and participants who have all used mental help support services all fall in the age range 30 and older with less mental health utilization in younger generation age range 20–30.

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APPENDIX A

My name is Heather Lewis, and as a graduate student in the Department of Community Care and Counseling/School of Behavioral Sciences at Liberty University, I am conducting research as part of the requirements for a doctoral degree. The purpose of my research is to study the help-seeking tendencies in the Afro-Caribbean Christian community. For example, does social support impede or facilitate help-seeking? Do generation and age play a role in help-seeking attitudes? I am here to invite you to participate in my study.

If you are 18-65 years of age, are an Afro-Caribbean immigrant or born to Afro-Caribbean parents, and are willing to participate, you will be asked to complete and return a screening survey to determine your eligibility for the study (approximately 5 minutes), participate in an interview (approximately 1 hour), and participate in a follow-up discussion with me (approximately 30 minutes). Your name and other identifying information will be requested as part of your participation, but the information will remain confidential.

A screening questionnaire and study consent form will be made available at the end of service in the foyer. The consent document contains additional information about my research.

To participate, please complete the screening survey, sign the consent document, and return them to me. The screening survey and consent forms will be available in the foyer following church. Upon completing the screening survey, if you meet the study criteria and are eligible to participate in the study you can complete the consent form at the same time and return both documents to me. I will then contact you to schedule an interview. Alternatively, if you meet the study criteria, you can return the signed consent form when we meet for your interview. If you have any questions, please contact me at 215-888-1198.

Sincerely,

Heather G. Lewis

APPENDIX B

CONSENT FORM

MENTAL HEALTH COUNSELING: A PHENOMENOLOGICAL STUDY OF AFRO-CARIBBEAN CHRISTIAN'S HELP-SEEKING TENDENCIES

Heather G. Lewis Liberty University

Department of Community Care and Counseling/School of Behavioral Sciences

You are invited to be in a research study on the help-seeking tendencies in the Afro-Caribbean Christian community. You were selected as a possible participant because you are born of Afro-Caribbean immigrant parents or are an immigrant from a Caribbean country and you are between the ages of 18-65. Please read this form and ask any questions you may have before agreeing to be in the study.

Heather G. Lewis, a doctoral candidate in the Department of Community Care and Counseling/School of Behavioral Sciences at Liberty University, is conducting this study.

Background: As a result of a cultural history of stigma and shame, Afro-Caribbean mental health patients continue to experience a disparity in help-seeking. Jackson et al., (2007) found that within the Afro-Caribbean population there is a link between willingness to seek help, perceived dissatisfaction in measures of helpfulness, stereotyped attitudes and lack of value in formal mental health care. The purpose of this study is to understand the help-seeking tendencies of Afro-Caribbeans at local Philadelphia churches. For example, does social support impede or facilitate help-seeking? Does generation and age play a role in help-seeking attitudes?

Procedures: If you agree to be in this study, I would ask you to do the following things:

1. Participate in an interview, approximately 1 hour. Interviews will be audio recorded.
2. Complete a follow-up discussion with researcher, approximately 30 minutes. Follow-up discussions will be audio recorded.

Risks: The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life. If the questions trigger any uncomfortable feelings, you will have the option to withdraw from the study.

Benefits: Participants should not expect to receive a direct benefit from taking part in this study. However, study results could enhance the counseling relationship of those in the Afro-Caribbean community. Counselors may gain a better understanding of the lived experiences of Afro-Caribbeans. African-Americans and Afro-Caribbeans have very similar but different lived experiences in the United States. These differences must be acknowledged and understood for

those in counseling and helping professions to be able to effect change and serve this population. Appreciation of the nuances serves to not only help the counselor understand this population but can foster trust in Afro-Caribbeans that will move this population towards utilizing the professional help services such as counseling, psychotherapy, and more.

Compensation: Participants will not be compensated for participating in this study.

Confidentiality: The records of this study will be kept private. In any sort of report I might publish, I will not include any information that will make it possible to identify a subject.

Research records will be stored securely, and only the researcher will have access to the records.

- Participants will be assigned a pseudonym. I will conduct the interviews in a location where others will not easily overhear the conversation.
- Data will be stored on a password locked computer and may be used in future presentations. After three years, all electronic records will be deleted.
- Interviews and follow-up discussions will be recorded and transcribed. Transcription and notes will be stored on a password locked computer for three years and then destroyed. Recordings will be stored in a separate locked cabinet and destroyed after the retention period. Only the researcher will have access to these recordings.
- While unlikely, if the consent forms, audiotapes, interview transcripts or any other materials related to this study were stolen, it could result in a breach of confidentiality.

Voluntary Nature of the Study: Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

How to Withdraw from the Study: If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Contacts and Questions: The researcher conducting this study is Heather G. Lewis. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at 215-888-1198 and/or hlewis17@liberty.edu. You may also contact the researcher's faculty chair, Dr. June Tyson, at jtyson15@liberty.edu.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Please notify the researcher if you would like a copy of this information for your records.

Statement of Consent: I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record me as part of my participation in this study.

_____

Signature of Participant   Date

_____

Signature of Investigator   Date

APPENDIX C

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

June 13, 2019
Heather G. Lewis
IRB Approval 3761.061319: Mental Health Counseling: A Phenomenological Study of
Afro- Caribbean Christian's Help-Seeking Tendencies

Dear Heather G. Lewis,

We are pleased to inform you that your study has been approved by the Liberty University
IRB. This approval is extended to you for one year from the date provided above with your
protocol number. If data collection proceeds past one year or if you make changes in the
methodology as it pertains to human subjects, you must submit an appropriate update form to
the IRB. The forms for these cases were attached to your approval email.

Your study falls under the expedited review category (45 CFR 46.110), which is applicable to
specific, minimal risk studies and minor changes to approved studies for the following
reason(s):

> 7. Research on individual or group characteristics or behavior (including, but not limited
> to, research on perception, cognition, motivation, identity, language, communication,
> cultural beliefs or practices, and social behavior) or research employing survey, interview,
> oral history, focus group, program evaluation, human factors evaluation, or quality
> assurance methodologies. (NOTE: Some research in this category may be exempt from the
> HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(2) and (b)(3).
> This listing refers only to research that is not exempt.)

Thank you for your cooperation with the IRB, and we wish you well with your research project.

Sincerely,

G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office

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APPENDIX D

Please answer the following screening questions. If you answer *Yes* to questions 1 and 2 or 1 and 3 then please complete the attached consent form and return both documents to the researcher. This screening questionnaire should be returned immediately, and you have the option to complete the consent form and return it to me immediately as well. Alternatively, if you meet the study criteria, you can sign the consent form and return it to me when we meet for your interview. If you answer *No* to either set of questions, you are not eligible to participate in the study, and you may discard the questionnaire.

Please provide your contact information.
Name:
Cell Phone Number:
House Phone Number:

1. Are you between the ages of 18 and 65? _____Yes _____No

2. Do you consider yourself an Afro-Caribbean immigrant (born in the Caribbean and

   immigrated to the U.S.)? ____Yes _____No

3. Do you consider yourself Afro-Caribbean (born in the U.S. to Afro-Caribbean

   parent/parents)? ____Yes _____No

APPENDIX E

1. Please introduce yourself to me, as if we just met one another.

2. Are you born here to Caribbean parents? If so how long have your parents lived in the U.S.?

3. If you are an immigrant, how old where you when you immigrated to the U.S.?

4. What were your experiences adjusting to living in the U.S.?

5. What is your highest level of education?

6. What is your understanding of mental illness?

7. Have you ever been to see a professional counselor? If so, what kind (some examples are: School Counseling, Mental Health Counseling, Addiction/Substance Abuse, Counseling, Marriage & Family therapist, Religious/Spiritual Counseling).

8. Are you aware of any history of mental illness in your family?

9. Have you ever sought mental health treatment? If so, tell me about your experience?

10. Did you address your Afro-Caribbean experience in counseling?

11. Is a counselor's race vital to you in counseling?

12. Have you used friends, family, or clergy for mental health support?

13. How likely are you to recommend counseling to family member or friend?

    ___Very likely   ___Likely   ___Neutral   ____Not likely   ____Very unlikely