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Exploring the Needs of Black Single Mothers in Therapy

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EXPLORING THE NEEDS OF BLACK SINGLE MOTHERS IN THERAPY

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This dissertation, by Nompelelo Boucher, has been approved by the committee members signed below who recommend that it be accepted by the faculty of Antioch University New England in partial fulfillment of requirements for the degree of

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ABSTRACT

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This qualitative study of 6 Black single mothers utilizes a focus group format to explore their experiences in mental health treatment. The specific barriers they face to seeking treatment are reviewed, given that this particular population is substantially underrepresented in mental health therapy. The study seeks to gain a better insight of what factors contribute to attracting and retaining them in therapy for positive outcomes. Six emergent themes surfaced highlighting the fact that these women overcome numerous historical and cultural barriers to present for treatment to address serious issues of stress, grief, and loss, that they have a desire to receive allied treatment from Black clinicians or from non-Black clinicians who can provide culturally sensitive therapy, and that they are desirous of clinicians with an engaging style who provide active feedback and tangible resources and advocacy. The results provide clinical implications for practitioners to employ in their practice to best serve these women. This dissertation is available in open access at AURA (https://aura.antioch.edu).

Keywords: Black single mothers, African American, cultural-sensitive therapy, common factors

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TABLE OF CONTENTS

Chapter 1: Introduction

Background Significance of Problem

In 2020, there were approximately 4.25 million Black families in the United States (US) headed by single mothers (Statista, 2021). This represents a 25% increase from 1990, when single mothers led roughly 3.4 million Black families in the US (Statista, 2021). Single-parent families, headed most commonly by mothers, often experience financial stress and loss, whether it be the loss of their partner or the loss of their dream about the family's future, and experience grief as a result (Anderson, 2003). Motherhood is a life-changing, demanding, and challenging experience, and not having a partner to assist physically and financially to raise the child/children increases these difficulties. For Black women who have additional obstacles related to cultural and socio-economic minority status, these challenges are compounded exponentially.

Despite progress made over the years, racism continues to impact the mental health of Black people to this day. Historical dehumanization, oppression, and adversity translate into socioeconomic disparities experienced by Black people today. Socioeconomic status, in turn, is linked to mental health. Individuals who are impoverished, homeless, incarcerated, or suffering from substance use problems are often at a higher risk of poor mental health (*Black and African American communities and Mental Health*, n.d.). Black single mothers are inevitably faced with grief and loss issues as they process the harsh reality of their circumstances, self-manage their household, and navigate racial and socioeconomic hardships (Anderson, 2003; Boyd-Franklin, 2003). Furthermore, single mothers with low income can be vulnerable to disrespect from schools, landlords, and a sense of being controlled by outside organizations (Anderson, 2003).

Intended Improvement

Seeking therapy is becoming a more commonly accepted practice by various people living in the US (Bell-Tolliver et al., 2009). Therapy has been shown to improve the daily lives of those receiving therapeutic services and can effectively treat complex issues such as depression, anxiety, and grief (Bell-Tolliver et al., 2009). According to The American Association of Marriage and Family Therapy (AAMFT):

> … almost 90% of clients who had received psychotherapy reported an improvement in their emotional health, and nearly two-thirds reported an improvement in their overall physical health. A majority of those clients also reported experiencing improvement in their functioning at work, and over three-fourths of those who received marital/couples, or family therapy reported an improvement in their relationship. (About marriage and family therapists. n.d.)

Given the substantial increase in households led by Black single mothers over the past few decades, we would expect to see a rise in the number of these women presenting for treatment. This is not the case, though. Despite the stressors of single Black motherhood, this population is one of the least represented groups in mental health services (Becker & Liddle, 2001). Non-Hispanic Black adults are 9.1% less likely than non-Hispanic white adults to have received any mental health treatment (Terlizzi & Norrisl, 2021). Despite the increased use of mental health services among minorities since the 1960s, African Americans continue to be underrepresented in the mental health system (DeCou & Vidair, 2017) and barriers to seeking help continue to exist (DeCou & Vidair, 2017). Although there are several well-known benefits to receiving therapy, there are still many logistical barriers that may prevent one from accessing therapeutic services, such as the availability of clinicians, cost, time commitment, and stigmas related to receiving mental health treatment.

Purpose

Providing systemic relational therapy to Black single mothers can have long-term, lasting advantages to improve family dynamics and mitigate intergenerational trauma. Children can benefit from witnessing their mother practice self-care, increase coping skills, manage work-related stress, and improve parenting practices and communication at home. Therapy can teach assertive communication skills through role-playing, improving confidence when speaking with people in authority, such as employers, landlords, and school officials. A therapist can serve as an additional source of support, and therapy itself can act as a protective factor against stress. The risk of not providing treatment to Black single mothers can have continued widespread societal implications, including increased risk behaviors of child abuse, depression due to lack of self-care, missed time at work, and feelings of isolation (Stack & Meredith, 2018).

One of these risk factors is that many mothers feel so profoundly responsible for their child's problems that their guilt inspired the philosophy of *mothers last*. That is, they believe it would be inappropriate to address their own needs before their child was well (Amankwaa, 2003; Anderson et al., 2006). Black single mothers have also expressed concern that mental health professionals might question their motherhood abilities and possibly deem them too ill to care for their children, resulting in their children being taken away (DeCou & Vidair, 2017; Mohr, 2000). According to Sue et al., (2019):

> In working with African American families living in high concentrations of poverty, the counselor may need to assume various roles, including advocate, case manager, problem solver, and facilitating mentor, and to help the family navigate community systems, including the educational or judicial system. (p. 305)

Due to the gap in services among this population, and consequently, the gaps in research for how best to serve them, the purpose of my dissertation is to explore and understand the unique needs of Black single mothers who may benefit from the therapeutic process, including what barriers exist to receiving their treatment and how to overcome them, as well as what they would consider to be effective treatment. To that end, I have formulated and implemented a qualitative focus group study of six single Black mothers who have previously presented for therapy treatment or are still in therapy. Participants have been asked, among other things, to describe how they view mental health providers, what they looked for in a mental health care provider, and what they believed the critical factors were that could lead to success in therapy for them. I identified their presenting issue(s), along with what was helpful to them in therapy and what was not. I assessed their understanding of the boundaries of therapy and inquired whether they felt seen and understood by their therapist. I also determined how therapy has affected relationships in their lives. My study evaluated whether Black single mothers tend to terminate therapy prematurely and what may have contributed to keeping them engaged.

Systemic implications for providing mental health therapy to Black single mothers in a study by Lowe (2000) found that Black single mothers struggle with the pain of an absent father, which can lead to de-triangulation of children, especially among sons, into a parent-child role. In this study, Lowe (2000) outlined two techniques to use in therapy when working with this population: the empty chair and bringing in photographs of the absent father as a way to help Black single mothers deal with their pain and improve parenting. The current study will ask the Black single mothers how receiving mental health therapy has affected their parenting practices. Marriage and family therapists can serve as a support for Black single mothers dealing with

issues of grief over the loss of a partner and help with increasing healthy coping skills which can cultivate improved relationships with their children.

Huff & Hartenstein (2020) predicate that children who experience the absence of one parent within the household through means such as divorce, or the exposure to harsh conflict between caregivers, are at a greater risk of negative mental health outcomes, such as behavioral or mental health issues (e.g., depression), and that providing developmentally appropriate manners is vital to healthy growth. Access to systems of parental support or places to process at-home conflict is vital. The children of single Black mothers often face added stressors that compound those happening within the home due to increased external stressors that are connected to socioeconomic, racial, or geographical status (Anderson, 2003; Becker & Liddle, 2001; Boyd-Franklin, 2003) that makes access to mental health care even more challenging to attain. (Harris-McKoy & Smith, 2020) provide evidence to strengthen the points made by Huffs et al. (2020). They note the historical lack of attention paid to cultural sensitivity by systems and mental health professionals and highlight the importance of that sensitivity to therapeutic practice today. They challenge professionals to focus on the pathways and barriers to mental health services, to critique foundational systemic family therapy theories and evidenced-based treatments; and to provide clinical, teaching, research, and policy recommendations within their spheres of influence.

Objective

This study is designed to gather data that can be used to educate and support marriage and family therapists who provide services to this population. It will investigate the experiences of Black single mothers receiving mental health therapy utilizing the lens of marriage and family therapy (MFT). In the field of MFT, it has been asserted that there are often many stereotypical

generalizations made about African American families (Leslie, 1995), and most of the literature concerning African Americans in the MFT field is largely theoretical (Bean & Crane, 1996). There continues to be a need for research-based knowledge to inform the field about how to serve the Black minority population best. Without empirically based literature on African Americans and other minorities, the MFT field cannot answer the call for more racially and ethnically relevant service (McGoldrick et al., 1996). In a 20-year review by Dwanyen in 2022 it was determined that although we increasingly speak about social justice, we still need to do more robust research on treatment for minority populations.

To accomplish this goal, my study addresses the overarching research question: What is the unique experience of Black single mothers in marriage and family therapy? The study results provide recommendations and interventions for marriage and family therapists working in clinical settings to better serve this disadvantaged community.

Chapter 2: Literature Review

Defining the Population

A single-parent household is one in which one adult is the primary caretaker for at least one biological, step, or foster child under the age of 18 (Kramer, 2019). According to Livingston, G. (2018, April 25,), the vast majority (81%) of single-parent households throughout the US were led by mothers; with only 19% led by fathers. This gender difference is even more pronounced among Black single parents, 89% of whom are mothers. These single-mother households are often the result of out-of-wedlock pregnancy, desertion by their partner, separation or divorce, or the result of the incarceration or death of their partner (Anderson, 2003). In some cases, women deliberately choose to parent alone via planned or unplanned pregnancy or adoption.

Throughout this dissertation, the terms “Black” and “African-American” may be used interchangeably based upon the source cited. The reference to either is specific to people who identify as non-Hispanic minority individuals of color who may be native to the US or who may have immigrated here from any other place including, but not limited to, Africa.

Research Literature

Recent literature and scholars build a strong case for why it is important to focus on the needs of our most marginalized clinical populations, such as single Black mothers, with the main point being that they have not been focused on sufficiently in the past and are now at a disadvantage within the field of family therapy. For instance, a recent critical overview of literature conducted by Dwanyen et al., (2022) found that despite the topic of social justice being mentioned in several works over the last decade, those from racial minority backgrounds are still not being included in research studies, with only 25%, or 68 out of 271 articles reviewed, focusing predominantly on participants from racial minorities or ethnic groups. The 271 articles

spanned across eleven mental health topics: infant and early child-hood mental health (IECMH; Kaminski et al., 2022), disruptive behavior problems (Sheidow et al., 2022), attention-deficit/hyperactivity disorder (ADHD; Babinski & Sibley, 2022), anxiety disorders (Goger & Weersing, 2022), depressive and bipolar disorders (Wittenborn et al., 2022), suicidal ideation and behavior (Frey et al., 2022), substance use disorders (Hogue et al., 2022), traumatic event exposure (McWey, 2022), intimate partner violence and child maltreatment (Stith et al., 2022), couple relationship education (Markman et al., 2022), and couple relationship distress (Doss et al., 2022). This research shows a general need for additional focus on these groups, yet an even stronger need to focus on the specific needs of under-represented segments of these groups, such as single Black mothers.

What has been written about Black single mothers seeking mental health services often focuses on the barriers they encounter to receiving treatment (Becker & Liddell, 2001; DeCou & Vidair, 2017; Ward, 2005) and insufficient attention has been placed on elevating the voices of Black single mothers to communicate what they believe effective treatment should look like once they do seek treatment. In some cases, Black single mothers harbor emotional or culturally internalized barriers leading them to believe that seeking therapy would be a failure on their part or a shameful experience. In other cases, external forces prohibit women who would like to access therapy services from obtaining them. In the following sections, I will explore what is known about multicultural issues in therapy affecting single Black women, their treatment experiences, and what has been written about the various barriers to their treatment.

Multicultural Therapy

Multicultural therapy gained popularity during the Civil Rights movement of the 1960s. Recognition of ethnoracial minority concerns originated in the late 1960s and 1970s, as

increasing numbers of minorities entered the field and focused greater attention on the limitations of mainstream interventions (Abreu et al., 2000). Various terms have been used to refer to the consideration of culture in mental health treatment, including *multicultural competence, culturally sensitive, culturally competent, and culturally responsive.* Much of this discourse has focused on maximizing treatment utilization and effectiveness for minority clients, such as through racial and linguistic matching of clinicians and clients (Cabral & Smith, 2011), culturally adapted therapies (Bernal & Domenech Rodríguez, 2012), and standards of cultural competence (Sue et al., 2009).

Although the field continues to struggle toward operationalizing multicultural counseling competence and its parts (Sue et al., 2009), researchers have suggested that therapists' multicultural therapy competence is critical for effectively working with clients of color, accounting for a significant proportion of the variance in clients' satisfaction beyond ratings of general therapist competence (Meyer & Zane, 2013). Eurocentrism is characterized as a perception in which European (White) values, customs, traditions, and behaviors are used as the exclusive normative standards of merit against which other races and events in the world are viewed (Helms, 1989; Jones, 1997; Katz, 1985). Moreover, racial and ethnic minority clients were not seeking therapeutic services as often as White clients. When they did seek assistance, they had higher rates of premature termination and dropout and reported more minor levels of symptom improvement relative to White clients (Sue et al., 2019). These findings disturbed many mental health professionals, who devoted their careers to thinking and writing about why therapy did not seem to work well for racial and ethnic minority clients and what could be done to improve the situation (Sue et al., 2019). These mental health professionals critiqued many therapeutic models and techniques. They pointed out significant limitations of the generic

therapeutic models aimed at all people, regardless of cultural background. Researchers worked to articulate the role of culture in shaping individuals' beliefs, values, thoughts, feelings, behaviors, and interpersonal relationships (Hook et al., 2017; Sprenkle et al., 2009; Sue et al., 2019). Corcoran (2000) highlights the importance of using culture-sensitive therapy when working with diverse populations. Sue et al. (2019) state that they believe the reasons minority-group individuals underutilize and prematurely terminate therapy is influenced by the hostile nature of techniques used that are not culturally appropriate for the clients and their experiences, and worldviews. Considering this, clinicians must utilize culturally sensitive therapeutic approaches such as being directive and solution-focused when working with diverse populations.

To address issues in cross-cultural therapy, it is important for non-African-American therapists to invite their clients to discuss their feelings about being seen by a therapist from outside their ethnic group (Sue & Sue, 1990). Therapists and supervisors need to realize that ethnic differences can affect a family's confidence in the therapist's ability to understand their life circumstances and context-specific challenges. By inquiring about possible concerns in the early stages of treatment, the therapist demonstrates that they are sensitive to possible differences and willing to discuss their views on the topic (Bean et al., 2002).

To consider the complexities of attending to the larger context, the definition of contextual consciousness in MFT education includes three dimensions: (a) consciousness about the inherent power differentials in a person's social contexts, including gender, race, socioeconomic status, and sexual orientation; (b) sensitivity to clients' unique experiences within these different contexts; and (c) attention to the intersection of the larger context with clients' relational processes and presenting issues (Almeida et al., 2008; McDowell & Fang, 2007). This definition highlights a critical understanding of cultural differences as part of a more

comprehensive set of societal power relations (Almeida et al., 2008; McDowell & Fang, 2007) and sociocultural attunement to client experience at the emotional level (Knudson-Martin & Huenergardt, 2010).

Wieling et al. (2020) offer several suggested resolutions to help address the inequity of the systemic family therapy of minority, international and indigenous cultured families by presenting the need for recognition of historical traumas, the demand for allied therapists to perform equitable clinical work, and the promotion of *"leaning-in"* to work with diverse populations and ecosystems in a way that builds toward the development of systemic models that more closely align with the realities of the families most clinicians are tasked to serve, such as single Black mothers.

While efforts to further multicultural competence among therapists to provide culturally appropriate treatment for single Black mothers continues to advance, it is also important that we consider other factors which contribute to this population presenting for treatment at lower-than-average rates. Many historical, cultural, personal and financial factors often act as barriers to these women seeking treatment. In the next section I will explore what has been studied and written about these various barriers.

Barriers to Treatment

Financial

The cost of therapy can be an extreme barrier preventing many African Americans from seeking treatment, especially when insurance is unavailable (Thompson et al., 2004). Median wages for Black women in the US are $41,098 per year, compared to median salaries of $65,208 annually for White, non-Hispanic men (National Partnership for Women & Families, 2021). This annual wage gap of $24,110 results in Black women having less money to support themselves

and their families, save and invest for the future, and spend on goods and services. The average therapy session costs $100–200 an hour (Therapy FAQs. (2014); *Cost and insurance coverage - Psychology Today,* n.d.), making treatment cost-prohibitive for many single Black mothers.

In a study conducted by Atkins (2016), 208 Black single mothers were asked what coping mechanisms they rely upon when feeling depressed. Of the 327 usable responses given, not even one indicated that they sought professional help. In the face of more pressing needs and financial challenges, psychotherapy is often considered a luxury. Some participants questioned the value of services given the perception of high costs, whereas others questioned the ability to receive quality services without adequate income or insurance. Participants who used Medicaid benefits complained that medication was the most frequently recommended treatment, and that psychotherapy and counseling were not options offered (Atkins, 2016; Thompson et al., 2004).

Logistical

In a study conducted by Anderson et al. (2006) consisting of 127 low-income mothers who sought professional mental health treatment for their children, it was uncovered that this population rarely uses mental health services to attend to their own needs. These mothers face so many daily difficulties that seeking treatment might seem like one more burden (Kazdin, 2000; Owens et al., 2002; Verhulst & van der Ende, 1997). Some of the participants spoke of difficulties in asking family members to provide childcare when they are going to therapy, and to avoid losing valuable wage-earning time, and they voiced a preference for weekend and evening appointments. The advent of telehealth therapy over the past few years due to technological advances and its prevalence, primarily due to the Covid-19 pandemic, has opened up tremendous opportunities to overcome this barrier; however, this process is still relatively new and may not be recognized as an available option for many single Black mothers yet.

Cultural Privacy

Open communication is a barrier that prevents some African Americans from accessing therapy because for many of these families, talking about their private business with people outside of the family is considered taboo. As part of a response to experiences of oppression many African American families are mistrustful of sharing their private lives with people outside of the family, particularly when this information could potentially be used to hurt and profile them (Awosan et al., 2011; Ward, 2005).

These mothers might be best served by offering advocacy and case management services as a primary intervention. Those women who are acutely aware that their real-life dilemmas cannot be fixed with a prescription, altered cognitions, or a sympathetic ear, might respond to concrete services that facilitate survival and indirectly decrease the emotional stress they are experiencing. Once these issues are addressed, they may, or may not, need or want therapy or medication (Anderson et al., 2006).

In a study by Meyer and Zane (2013) of 102 clients who had received mental health treatment from outpatient mental health clinics, research of whether culturally related elements involving race and ethnicity as being essential to clients, and related to client satisfaction, was conducted. Some of the common themes included mothers who stated that they dislike talking about personal issues, can deal with problems on their own, and were taught to keep their problems to themselves during childhood. As one mother indicated, “Well when I grew up, we were told that you don’t tell anyone your business… What’s in the home stays in the home” (p. 2257).

Cultural Stigma

Stigma and fear of judgment prevent Black people from seeking help with mental health issues (Sue et al., 2019). Research indicates that Black individuals often believe admitting to mild depression or anxiety would be considered *crazy* in their social circles (Nicolaidis et al., 2010). Furthermore, many believe that discussions about mental health would not be appropriate, even among their family members. Many Black people also have concerns about treatment effectiveness due to lack of education and cultural misgivings, such as viewing the mental health system as part of an oppressive structure (Thompson et al., 2004). In a study conducted by Thompson et al. (2004), 261 Black people were asked about their perception of psychotherapy. Findings revealed that respondents feel the psychotherapy process is invasive and that seeking treatment was shameful and embarrassing.

Additionally, most participants noted the historical expectation that life would be difficult and that Black individuals could cope with all adversity as a cultural group. This expectation inhibits help-seeking behaviors, and participants also had concerns about self-disclosure to a total stranger. Also of interest were participants' fears, including misdiagnosis, labeling, and brainwashing (Anderson, 2003; Thompson et al., 2004).

Lack of Allied Clinicians

There has been a growing recognition by mental health professionals over the years that clients' and therapists' cultural identities are an essential aspect of therapy (American Psychological Association, 2003; Comas-Díaz, 2012). Yet, racial matching may not always be an option because of the lack of minority therapists available in the workforce. Participants in a study conducted eighteen years ago by Thompson et al. (2004) reported struggling to find a qualified African American or ethnic minority therapist. Those participants also mentioned a

reluctance to trust professionals not active in the African American community and activities directed toward community well-being.

The lack of available Black marriage and family therapists continues to persist today. The most common ethnicity among marriage and family therapists is White, comprising 76.6% of all marriage and family therapists (*Marriage and family therapist demographics and statistics in the US. (n.d.)*). Comparatively, 10.8% of MFTs are of Hispanic or Latino ethnicity and 7.7% are of Black or African American ethnicity (*Marriage and family therapist demographics and statistics in the US. (n.d.)*). Unfortunately, Black and African American providers make up a tiny portion of the behavioral health provider workforce (mhanational.org, 2019). Goldenberg and Goldenberg (2013) mention that family therapists are trying to apply existing therapy models to previously underserved cultural groups whose values, gender roles, discipline practices, and forms of emotional expression are different from those of the majority culture. These authors highlight the importance of using culture-sensitive therapy when working with diverse populations. The lack of sufficient Black clinicians creates a void for those hoping to develop a therapeutic alliance with someone they feel they may have an ethnic or cultural bond.

Medication Avoidance

One of the challenges faced by minorities in mental health therapy is that they are offered medication as the first option instead of talk therapy (Pakes & Roy-Chowdhury, 2007). The issue of therapists pushing medication as the first line of defense to Black clients due to their inability to listen to and understand the client often leads to an outcome of early termination of therapy (Pakes & Roy-Chowdhury, 2007; Wade & Bernstein, 1991). Although these tactics have largely been abandoned in favor of a modern approach to providing proper therapy to all clients, including minorities, the lingering stigma may still exist. This may cause single Black mothers to

fear their problems will be misunderstood, and an attempt may be made at medicating them away.

Single Black mothers who have faced the various challenges of single motherhood and racial inequality may view medication treatment as a patronizing process and a failure of their resilience. Even without administration of the medication itself, the existence of a professional medication recommendation record could be again perceived as a threat that these mothers are not mentally stable or capable enough of continuing to have custody of their children (DeCou & Vidair, 2017; Mohr, 2000).

Summary of Barriers

Many of these barriers can be attributed to the implications of systemic cultural racism propagated against this population. Historical adversity has led Black people in general to be suspicious of what they often view as traditional therapy, designed, and performed by White therapists. Due to the socio-economic disparity resulting from generational imbalance, we find that Black single mothers are disadvantaged with respect to financial and logistical ability to engage in therapy and furthermore, have had fewer of their peers be able to afford the opportunity to become qualified therapists in order to be able to provide them with allied, culturally appropriate therapy.

Racism

The issue of racism is essential to discuss when working with African American clients. Given the diversity within the African American population, therapists need to understand each family's feelings about racism. Experiences with discrimination can vary considerably between families and within families, along with the family's comfort level in discussing said experiences (Bean et al., 2002). This study focuses on Black single mothers who often have become the

victims of negative stereotyping in mainstream American culture. Historical and contemporary instances of adverse treatment have led to a distrust of authorities, many of whom do not have the best interests of Blacks in mind (*Black and African American communities and Mental Health*, n.d.). Participants with psychotherapy experience noted that specific problems, such as experiences with racism, discrimination, the stress of paying bills, balancing work and family life, and exposure to community trauma, were avoided because of fears that the therapist would not understand (Chang & Berk, 2009; Goldenberg & Goldenberg, 2013; Sue et al., 2019).

Developing cultural competence and humility in the mental health practice demands that nested or embedded emotions associated with race, culture, gender, and other social identity differences be openly experienced and discussed (Sue et al., 2019). In a study conducted by Awosan et al. (2011), participants stated the importance of bringing up race in sessions, primarily when Black people work with White therapists. Hardy and Laszloffy (2000) state that family therapists need to move beyond racial awareness to racial sensitivity. These authors define racial awareness as "the ability to recognize that race exists and that it shapes reality in inequitable and unjust ways" (p. 36); however, racially sensitive individuals "actively challenge attitudes, behaviors, and conditions that create or reinforce racial injustice" (Hardy & Laszloffy, 1998, p. 119).

In an environment that Black clients inherently perceive as unsafe, they will often feel guarded against allowing self-disclosure. White therapists, whom they have some level of cultural paranoia for (Boyd-Franklin, 2003), can impede the therapeutic process by making the process less beneficial and effective for Black clients.

Racial distrust and misdiagnosis of Black people in therapy can lead to a lack of self-disclosure for clients (Nickerson et al., 1994; Garretson, 1993; Terrell & Terrell, 1984). In a

study conducted by Meyer and Zane (2013) which consisted of 102 clients who had received mental health treatment from outpatient mental health clinics to investigate whether culturally related elements involving race and ethnicity were essential to clients and related to client satisfaction, it was identified that the race of the counselor did affect the clients' perceived treatment outcomes. Ethnic minority clients generally felt that issues regarding race and ethnicity were more important than did White clients. When these elements were considered necessary but not included in their care by the therapist, clients were less satisfied with treatment. Mental health disparities show that although African Americans, compared to their White counterparts, tend to have significantly higher rates of depression, posttraumatic stress disorder (PTSD), dual diagnoses, and lower levels of life satisfaction, happiness, and marital satisfaction, only one-third will receive mental healthcare treatment when they need it (Jackson et al., 2004; Jimenez et al. 2012).

Stereotypes of Black Single Mothers

Negative stereotypes and attitudes of rejection have decreased but continue to occur with measurable, adverse consequences. Two common stereotypes of single, Black women have been identified as strong black woman (SBW) and angry black woman (ABW). Dow (2015) addressed the concept of the SBW, which emphasizes the resilience and independence of Black women. The SBW identity appears to empower Black women; however, recent research has found that some Black women do not fully embrace this identity because of its pressure on being a leader and taking responsibility for the entire family (Dow, 2015). This pressure has negatively impacted the mental health and physical well-being of Black women (Black & Peacock, 2011). Depressive symptoms result when this identity is internalized and used as a coping mechanism (Donovan & West, 2015; Schreiber et al., 2000). The SBW identity may also impact a woman's

willingness to seek mental health services because of its emphasis on independence and self-reliance (Amankwaa, 2003; Nicolaidis et al., 2010). For some Black women, the adherence to being an SBW increases the likelihood of experiencing trauma and distress (Harrington et al., 2010). Walsh (2006) cautioned against highlighting the strengths of single mothers before accepting the challenges. Focusing on their strengths alone can lead to early termination because of the fear of seeming weak and not living up to the therapist's view of them as vital.

Another negative stereotype of single Black women in mainstream American culture is the ABW, which characterizes these women as aggressive, ill-tempered, illogical, overbearing, hostile, and ignorant without provocation (Wendy, 2014). Symptoms presented by Black women during mental health treatment may reinforce this myth. However, many of the negative characteristics of the ABW developed in response to external stressors and historical factors. Black women also have a unique experience with expressions of anger that shape the presenting symptoms interpreted by the mental health clinician. This myth, and corresponding negative stereotypes, significantly affect Black women intrapsychically and interpersonally, and are likely to influence the efficacy of mental health treatment (Ashley, 2014).

When treating Black single mothers, a therapist should consider the client's cultural norms and sociopolitical dynamics. Successful mental health treatment requires cultural competence and clinicians who are well prepared to navigate the inherent complexities of cultural stereotypes with clients.

Religion and the Church

Regularly attending religious services is an essential part of many Black family cultures and the Church and its congregation serve as protective factors in response to stressors. Religious participation provides comfort, economic support, and opportunities for self-expression,

leadership, and community involvement. Avent and Cashwell (2015) state that over 75% of African Americans believe that religion is essential to them and rely on their religious and spiritual communities to deal with mental health issues before seeking professional help. They further stress the importance that therapists need to enlist spiritual leaders to help clients, or their family, deal with social and economic stressors or conflicts involving the family, school, or community. Boyd-Franklin (2003) states that religious personnel are often aware of parishioners' family dynamics and living conditions. In addition, religious organizations often sponsor parenting programs or activities that enrich family life. Given the centrality of the Black Church for many African Americans, church leaders are often gatekeepers who facilitate making referrals to outside mental health services (Neighbors et al.1998; Oppenheimer et al., 2004; Payne, 2009).

Best Practices for Working with Black Clients

An issue facing African American people who enter mental health treatment is misdiagnosis, pathologizing, and cultural mistrust. Mercer (1984) asserted that the misdiagnosis of Black people in mental health services has a profound connection to the pathologization of Black culture. Pathologization or over-pathologization of Black patients has been linked to most non-Black clinicians' lack of empathy or understanding of Black culture and system values (Garretson, 1993). For example, African Americans' personality scores for suspiciousness, mistrust, and paranoia have been commonly misinterpreted as pathological rather than functional survival mechanisms (Parham et al.,1999). This overdiagnosis may result in enduring stigma associated with severe mental illness and severe side effects from unnecessary antipsychotic medication. Mental health systems operate using a diagnostic model that implies that symptoms

of distress are evidence of an illness when some distress could be caused by societal issues such as racism, minimal resources, and difficult life circumstances (Anderson et al., 2006).

In a study conducted by Awosan et al. (2011), comprising 16 Black clients and utilizing both Likert and open-ended questions to examine the obstacles Black clients face in their attempts to attend family therapy, the most frequently identified obstacles were related to concerns over family member response and cultural barriers to treatment. Participants also reported racial and cultural differences and a lack of understanding by non-Black therapists.

Bell-Tolliver et al., (2009) conducted a study with 30 mental health professionals who identified as African American. These Black therapists recommended strategies that can be used when working with African American clients, such as incorporating beliefs, values and including the families' understanding and use of spirituality in the session to build and maintain their trust and shape the therapy process. They further stated that therapists should listen intentionally to families and display curiosity about their strengths, including their sense of resilience when working with African American clients. They should also listen for and integrate the families' use of stories or storytelling in their therapeutic journey toward finding successful outcomes. The implications of this study are helpful to therapists, both African American and other races, who are interested in providing effective therapy to African American families from a perspective of strength.

To serve minorities in cross-cultural family therapy, Pakes and Roy-Chowdhury (2007) encourage therapists to take a not-knowing stance (Anderson & Goolishian, 1992). In the not knowing stance, therapists working with minority clients can elevate their voices by letting them be experts of their lived experience. Providing culturally responsive therapy (CRT) means having a strength-based, non-pathologizing stance, and family therapists are aware of the

importance of offering interventions that consider families within their socio-political and socio-cultural contexts (even within the same families) while paying particular attention to neighborhoods, communities, and support systems (Waites, 2008). The field of MFT is making strides in working towards culturally responsive therapies and integrating more diverse material affecting minorities in their training programs. Laird (1998) suggests that therapists directly address cultural issues by making culture the central metaphor for therapy. Culture as a metaphor for therapy implies understanding people within their context, and this helps clients and families by empowering them to change within their context.

In studies by Chang and Berk (2009) and Thompson et al. (2004), participants indicated that they often looked for subtle cues to determine therapists' cultural attitudes and sensitivity. They reported that items easily overlooked, such as ethnic minority reading material in the waiting room, diversity of artwork in the office, and ethnic minorities who work for and with the therapist, affected their perceptions and made them feel more welcomed and comfortable. Safety in the therapeutic relationship can lead to self-disclosure because of the sense of trust, and emotional comfort felt when working with their therapists.

The participants' views speak to the best practices that therapists working with Black clients need to keep in mind to feel welcome. Chang and Berk (2009) conducted a study with 16 minority clients who received cross-racial counseling and found a preference for an active therapist engagement versus a passive style. Regarding the counselor's responsiveness, participants spoke about whether the therapist saw them as unique individuals or focused on their presenting issue. This could mean spending time in the joining process and engaging in small talk to ease Black people into the therapeutic relationship. More than twice as many unsatisfied clients described their therapists as passive or not "proactive" enough. Complaints included the

lack of feedback, progress reports, or deep questioning regarding the client's experience compared to satisfied clients.

Conversely, indications that the therapist had an active or directive style were more frequent in happy clients. Chang and Berk (2009) identified three subcategories that described a therapist's desired energetic style. These subcategories are "offering concrete advice, suggestions, skill development, asking thought-provoking questions, and challenging the client's thinking by providing psychoeducation" (p. 527).

Best Practices for Working with Single Black Mothers

Working with Black single mothers resembles crisis management and case management therapy by focusing on the immediate needs instead of increasing insight (Anderson et al., 2006). When working from a strength-based approach, therapists must have an unshakable belief that all clients have significant strengths no matter how severe their situation appears. A telling self-assessment might be asking if the therapist has a sense of hope about the treatment. How would the therapist convey a sense of hope during the session, and what are the client's expectations about the problem and the therapy?

Therapy can be brief if both the client and therapist can reorient themselves in the direction of strengths and clarify goals. In working with Black single mothers, the therapist must identify strengths such as resilience and their resourceful nature. Williams and Drury (2009) define resilience as "a person's capacity of adapting psychologically, emotionally, and physically reasonably well and without lasting detriment to self, relationships, or personal development in the face of adversity, threat, or challenge" (p. 268).

Awareness of the *Angry* and *Strong* Black woman personas, including its genesis, manifestations, and the unique experiences of Black women, may raise the standards of cultural

competence for clinicians and provide more successful treatment outcomes when working with this population. Black single mothers also raised a point of wanting group therapy to feel connected to people experiencing the same hardships (Anderson et al., 2006; DeCou & Vidair 2017).

In a grounded theory study conducted by DeCou and Vidair (2017), consisting of 12 low-income mothers who met the criteria for depression, the study focused on asking the participants six questions:

1. What are some reasons that you do not currently talk to a mental health professional about your problems?
2. What do you think it would be like to talk to a mental health professional about your problems?
3. What would help you to seek the services of a mental health professional?
4. If you could create the perfect mental health professional, what would they be like?
5. What would services that are right for you look like?
6. What advice would you give to other mental health professionals who want to help mothers like you? (p. 2255)

This study uses questions related to the therapist/client relationship, and its main focus was what makes therapy effective for single mothers.

The participants wanted their therapist to be available to talk between sessions, use convenience and technology such as telephone, video sessions, and home visits, and provide childcare if needed (DeCou and Vidair, 2017). They said that they would seek therapy only if they are too overwhelmed or unable to take care of their children and tend to put off treatment because they are trying to meet the needs of their children. The single mothers also stated that

they would like a mental healthcare provider who is accepting, non-judgmental, caring, and willing to engage in self-disclosure. The participants reported wanting a therapist who would meet them halfway, as some of them stated, “I am telling you everything, and what are you bringing to the table” (p. 2258).

According to McGoldrick et al. (2016), single parenthood is a growing world phenomenon mostly involving mothers. We need to develop helpful attitudes towards it, such as realizing that the structure of single motherhood is not a problem. They further state that single-parent families range from highly functional to dysfunctional depending on economics, family support, community connectedness, and emotional stability. When working with single mothers, therapists should assess the single mother’s support system, financial resources, and emotional wellbeing and remember that all these factors can serve as protective measures.

Perceived Therapist Effectiveness

In a study conducted by Ward (2005), consisting of thirteen participants (8 females and 5 males), participants’ reasons for seeking counseling included drug and alcohol abuse, parenting issues, stress, coping, bipolar disorder, children’s behavioral problems, and court mandate. All the participants were parents. Twelve (92%) of the participants reported having a European American counselor, and one (8%) had an African American counselor. Eight (62%) of the participants reported having a female counselor, and five (38%) had a male counselor. This study used grounded theory to study the experiences of Black people in therapy. Results indicated that these participants performed an assessing process while engaging in counseling. They assessed the following three dimensions of their counseling experience: client-therapist match, safety in therapy, and counselor effectiveness.

Ward (2005) conducted another grounded theory study of thirteen African American college students. The goal of the study was to learn about the experiences of minorities in mental health therapy. Some of the questions asked were: “How do you feel about working with a counselor who is from a different culture than yours?” (p. 473). Follow-up questions included the reasons why Black students sought therapy: “What made you decide to come to counseling?”; “Was your counseling mandated by the court?”; and “What about the counselor made you feel comfortable?” (p. 474). This study relates to the current research as the present study examines the factors that keep Black people in therapy or lead to early termination. Participants in the study by Ward (2005) described a therapist’s effectiveness as “a therapist who is good” and “who could help me” (p. 476). Analysis indicated that two core conditions guided clients’ assessment of their therapist’s effectiveness: counselor’s experience and counselor’s responsiveness (Ward, 2005).

The study by Ward (2005) revealed that participants’ assessment of therapist experience was two-dimensional: professional and personal. Professional experience included the therapist’s education, training, years of experience, and, more importantly, experience working with Blacks (Ward, 2005). The participants in this study talked about how they assess the therapist’s experience by how much eye contact the therapist is comfortable with and ease in asking questions and engaging clients. Participants reported wanting an experienced counselor for them to feel comfortable. One participant talked about the need to ask the therapist about “how many people of color have you worked with.” (Ward, 2005 p. 477). Regarding the therapist’s responsiveness, participants spoke about whether this therapist sees them as individuals, or as their presenting issue. This could mean spending time in the joining process and engaging in small talk to ease Black people into the therapeutic relationship.

Black identity of the clinician was determined to be less salient when participants focused more on different aspects of their identity, such as parenthood, religion, gender, and alcohol and other drug issues, but salient when treatment focus was racial issues (Ward, 2005). Elevated cultural mistrust and strong internalized Afrocentric attitudes were associated with a more substantial choice for a Black counselor (Townes et al., 2009; Ward, 2005). Often, the essential therapist characteristic for African Americans is the cultural sensitivity of the counselor. Culturally sensitive therapists are seen as those who invite their clients to discuss cultural, racial, and environmental stressors and avoid being color-blind (Gushue et al., 2017; Want et al., 2004).

Gaps in Knowledge

While a wealth of information is available regarding historical causes of single Black motherhood and the economic, cultural and socio-economic challenges they face, leading them to present for mental health treatment at lower rates than other races, little is clearly known about why they persist in doing so to this day. Advances in the field to develop culturally competent therapy mean that if they do present for therapy, they should be able to receive effective treatment. Whether it is a prevalence of one or more barriers to treatment that continue to inhibit single Black mothers from seeking treatment, or the perception that therapy is not culturally attuned to their needs, requires further exploration. Questioning those who have sought treatment to discover how and why they overcame barriers to seeking treatment, the significance of the race of the therapist, and the overall experience in therapy should offer better insight into finding solutions to better engage single Black mothers in the future. This study aims to go beyond identified barriers to mental health treatment and uncover what single Black mothers experience in the therapy room and what else can be done to enrich their experience and lead to successful outcomes.

Theoretical Framework

My study draws on the common factors framework (Sprenkle et al., 2009), a model that addresses what is known to work in therapy; common characteristics that lead to positive outcomes. Broad common factors include general aspects of treatment such as client and therapist factors, extra-therapeutic variables, therapist-client relationship factors, and the client's expectancy of therapy success. Common factors are defined as the general mechanisms of change that cut across models rather than aspects of treatment unique to models (Asay & Lambert, 1999; Sprenkle et al., 2009). No matter the clinical approach utilized in treatment, it is crucial to assess whether the client feels respected and supported. Most writings and presentations about family therapy, and more broadly, about psychotherapy today, focus on specific intervention methods. Yet, there is much more to family therapy than such model-centric thinking and practices (Sprenkle et al., 2009). It has been documented many times that intervention strategies only account for a small percentage of the variance in change that occurs in treatment (Sprenkle et al., 2009).

Asay and Lambert (1999) identified four common factors (later expanded by Hubble et al., 1999) that promote change in therapy. These factors are identified as client, extra therapeutic factors, alliance factors, model or technique factors, and expectancy factors and have become widely familiar. In therapist factors, it is believed that effective therapists need to be passionately present, responsive, creative, and flexible because these are the qualities required to foster and maintain the therapeutic alliance (Simon, 2012). Therapists should ask themselves what personal characteristics they bring into the therapy and how they will benefit the client system. The therapist must question themselves if their understanding of the problem matches that of the knowledge of their client. It is helpful to assess how you decide to be active or passive in the

session and how the therapist adapts to the client system during the session (Sprenkle et al., 2009).

Common factors are the general mechanisms for all effective therapies and can be incorporated into systemic family therapy (SFT) training and research (Karam & Blow, 2020). Flexibility and cultural sensitivity are key therapist common factors (Blow et al., 2007). Adapting to the client's personality to speed up or slow down conversation and provide insight or directives based on their mindset can foster engagement. Furthermore, the therapist should adjust his or her style to keep the client's emotional arousal at a moderate level since moderate arousal seems to facilitate change (Blow et al., 2007). When therapists have more than one individual present for treatment, the skill of the therapist to manage multiple personalities becomes much more critical and more studies to identify these complexities in the SFT field are sorely needed (Blow & Karam, 2017).

Common factors attributed to the client include their demographics, personality and personal motivations (Blow et al., 2009; Sprenkle et al., 1999). Another important factor is the stage of change they may be in at any point during therapy (Prochaska, 1999). Prochaska identified five stages that a client may navigate through beginning with pre-contemplation (not being aware of a problem), contemplation (awareness and reflection of the problem), preparation (beginning to take steps to resolve the problem), action (actively taking steps to resolve the problem), and maintenance (performing ongoing steps to manage the resolution of the problem). Clients who are aware of their problem and actively engaged in fostering the change they seek will contribute to the success of their treatment. When treating multiple parties in SFT, it is worth noting that individuals may be at different stages of this process. Although Prochaska

developed this model of stages some time ago, little has been done in SFT to study this topic more thoroughly (Karam & Blow, 2020).

Another important common factor in SFT is the therapeutic alliance. Bordin (1979) identifies three elements which establish the alliance between therapist and client: bonds (the affective quality of the client-therapist relationship that includes dimensions like trust, caring, and involvement), tasks (the extent to which the client and therapist are both comfortable with the major activities in therapy and the client finds them credible), and goals (the extent to which the client and therapist are working toward compatible goals). Wampold (2001) concludes that the alliance is responsible for up to seven times the variance of ingredients attributed to different models and that "the relationship accounts for dramatically more of the variability in outcomes than the totality of specific ingredients" (p. 158). Other common elements which enhance the therapeutic alliance include formalizing a process for soliciting active feedback from the client and instilling a sense of hopefulness regarding a positive outcome (Karam & Blow, 2020).

Furthermore, when considering the nature of SFT, we must be cognizant of the ever-changing definition of the term family. Shifting cultural norms create a socially expansive definition of family which can affect human development and the mental health of those in these often, system-involved populations (McCauley & PettyJohn, 2020)

Summary

It is therefore critical that we, as therapists, continue to explore and understand the reasons why single Black mothers do not present for therapy as frequently as their White counterparts (Becker & Liddle, 2001; Terlizzi & Norris, 2021), how we can make therapy more accessible to them, and how we can provide culturally sensitive, appropriate therapy that will be most effective for them. This qualitative study of six single Black mothers seeks to further our

understanding of this underserved population and inform the field so that we can help identify and break down existing barriers to treatment and help normalize the therapeutic process by no longer trying to force a square peg into a round hole, but rather adapt to meet their needs and address their concerns on an appropriate level.

Multicultural counseling strives to help therapists provide culturally appropriate therapy instead of using Eurocentric models of therapy. This is vital to consider because the lack of cultural sensitivity in therapy can lead to ineffective results and early termination. The Black church is a good example of an organization that has been a consistent and reliable support group for the Black population (Boyd-Franklin, 2003). Therapists can glean insight from the Black church and even enlist their help as religious leaders often know and understand the needs of the parishioners and their families.

In order to provide appropriate therapy to assist single Black mothers, we must recognize the various barriers to treatment that exist and understand how to navigate around them. Some concrete obstacles include financial and/or logistical challenges, while others may be more mindset oriented, such as prioritizing privacy, the wellbeing of their children above themselves, or a cultural fear of being misunderstood and misrepresented (Anderson, et al.,2006). The sheer lack of Black therapists in the marketplace makes it difficult to easily match Black clients peer to peer so, it is important for non-Black therapists to recognize and appreciate the unique perspective that single Black mothers may have (Thompson et al., 2004).

Even today, we unfortunately find that racism persists and while we may like to turn a blind eye in the hopes of creating a sense of immunity to it, therapists are encouraged to discuss racism in therapy and avoid diminishing its existence and effect (Awosan et al., 2011; Bean et al., 2002; Gushue et al., 2017). We must be cautious not to default to the practice of prescribing

medication to alleviate issues we do not understand fully. Even the mention of medication prematurely can lead to early termination by single Black mothers (Pakes & Roy-Chowdhury, 2007). Therapists should examine their own beliefs and biases as they relate to Black people and Black culture in order to address issues of pathologizing cultural practices. Pathologizing the Black culture can lead to misdiagnosis which can perpetuate feelings of mistrust.

Some of the studies outlined above detail the importance of the therapist's style. Participants in these studies have mentioned that they would like a therapist who is direct, engaged, asks thought provoking questions, and engages in appropriate self-disclosure. It is important to display diverse artwork and reading materials to make minorities feel welcomed in the space (Chang & Berk, 2009; Ward, 2005). Offering evening and weekend hours, as well as telehealth options also make therapy more accessible for single Black mothers in need. Some Black single mothers spoke of an interest in group therapy sessions to help feel more connected to others who are dealing with the same issues (Anderson et al., 2006; DeCou & Vidair, 2017).

It is important for therapists to focus on the strengths of single Black mothers; however, focusing on the strengths alone, without acknowledging the challenges that exist can lead to early termination (Walsh, 2006). Too much focus on the strengths can reinforce the stereotypes of the SBW and ABW and lead to ineffective care. Therapy should provide a safe space for Black single mothers to be authentic, vulnerable, and become empowered along the way. Therapists can provide culturally sensitive therapy by maintaining a not-knowing stance in order to help their clients change in their own context. Maintaining curiosity by allowing the clients to engage in storytelling can lead to better client comprehension (Anderson & Goolishian, 1992; Pakes & Roy-Chowdhury, 2007). The common factors framework focuses on building a strong

therapeutic alliance despite a chosen theoretical lens (Blow & Karam, 2017; Sprenkle et al., 2009).

Chapter 3: Methodology

Research Design

I chose a qualitative research method for this study because it assists in developing a picture of the issue under investigation by reporting multiple perspectives and identifying the many factors involved in the situation and the larger image that emerges (Creswell, 2017). A qualitative approach respects people's stories and gives them room to express themselves. An experience such as attending therapy or terminating therapy can be difficult to quantify with numbers because there might be information missed in the process. Creswell and Poth (2018) further state that a qualitative study empowers participants to tell their stories without the researcher bringing in any preconceived ideas on the subject. This study utilized the qualitative data collection method of a focus group. McLafferty (2004) describes a focus group as a semi-structured group session moderated by a group leader and often held in an informal setting, with the purpose of collecting information on a designated topic.

Morgan (2019) identifies two components of the focus group to generate data by relying on the participants' interaction. Regarding relying on interaction, what makes focus groups unique as a research method is the use of the participants' discussions to produce data that would be less accessible without that interaction. However, focus group research methods do not hold philosophical assumptions, and focus group researchers do (Morgan, 2019; Piercy & Hertlein, 2005). In other words, there is no inherent philosophical assumption attached to the use of focus groups. It is up to the researcher to clarify their philosophical beliefs and use the focus group methodology consistent with those assumptions.

The focus group included six participants because, according to Morgan (2019) and Piercy and Hertlein (2005), this is an appropriate number for a focus group. Even smaller groups may be easier to manage but may have caused some members to feel exposed. In comparison,

larger groups may promote more significant interaction, but are more challenging to manage and could cause some participants to engage in side conversations and feel they did not have the opportunity to express all their thoughts/concerns (Brotherson, 1994; McLafferty, 2004). The focus group met on Saturday, June 25, 2022, for two hours as Morgan (2019) and Piercy and Hertlein (2005) state that two hours is enough engagement for participants before fatigue sets in and people start repeating what has been said.

Participants and Demographics

The sample of participants consisted of a convenience sample of six Black single mothers who met the following inclusion criteria: (a) 18–45 years of age, (b) self-identifying as Black, (c) providing primary parenting for children living with them, (d) widowed, divorced, separated, or never married (e) physically and mentally able to participate in the study, (f) have attended therapy in the past five years or are currently attending, and (g) able to read and comprehend the English language. Excluded were those (a) who have never attended therapy or (b) those who are married and cohabiting with their spouse.

Participants completed a demographic screening questionnaire providing their age, race/ethnicity, cultural identifications, religion, sexual orientation, socioeconomic status, education, occupation, racial heritage qualification, relationship status, number of children, type of counseling received, reasons for seeking counseling, and number of sessions attended. A telephone screening was also conducted prior to meeting with the participants on Zoom for the focus group study to gather any missing demographic information, answer questions, and outline the process of the study.

The Zoom format offered the researcher the advantage of engaging participants from various geographic locations. It also benefited the participants as a convenience factor, as they

did not have to travel to a study location and could participate comfortably from their own location. This also may have helped contribute to the participants' ability to speak as candidly as possible**.** The possible disadvantage for conducting the study on Zoom was that participants may attempt to talk over one another; however, with approximately two years of experience providing therapy, teaching, and speaking on the Zoom format, I was comfortably able to control the dialogue in an orderly manner.

Methods of Sampling and Recruitment

Following receiving approval from the Antioch University New England Institutional Review Board (IRB) to carry out this research project, I began the sampling procedure and recruitment process. Flyers were distributed to local venues in my area of northern Rhode Island and southeast Massachusetts, including traditionally Black churches, community mental health agencies, pediatrician offices, local hospitals, and on my social media platforms. I promoted the recruitment effort through my online network in a concerted effort to acquire participants from various geographic locations. Potential participants were asked to contact me to receive and complete the demographic screening questionnaire. The first six who met the study's criteria were selected to participate. Ethical approval was granted by Antioch University New England and written informed consent was obtained from all participants before they participated in the study.

Two forms of sampling methods were conducted to recruit participants. Purposive sampling was used to seek participants who identify as Black single mothers who have attended mental health therapy. The second type of sampling occurred as I searched my network to inquire if those people knew of any single Black mothers who may qualify for the study. A snowball recruitment strategy was also used when qualified participants were asked to invite

others they know who may meet the criteria to join the research (Creswell, 2017). The participants signed the informed consent document before participating in the study, and I advised each of them that they may withdraw their participation at any time.

Focus Group Interpretive Analysis: Data Sources and Coding

A single, semi-structured focus group interview with all participants was conducted for 2 hours online utilizing Zoom videoconferencing communication. The focus group questions were guided by the common factors framework (Sprenkle et al., 2009) and are listed in Appendix I.

The interview was recorded and transcribed utilizing Zoom's audio transcription service. The recorded interviews and my detailed notes have been stored on my computer with password protection. I have also kept notes to capture reflexivity, personal observations, participant reactions, decisions made, and unexpected additions or changes to the process. The transcripts were then read and analyzed, with statements from the participants grouped into themes, based on their responses to the questions posed during the interview.

This study used thematic analysis to analyze focus group data (Morgan, 2019). The main distinction is emphasizing themes as the basis for reporting results, capturing what was learned from a focus group, and communicating those insights to readers (Morgan, 2019). Saturation for each question is achieved when all the participants in each focus group have shared an experience or perspective similar to someone else or when at least half of the participants repeat their unique perspective.

Braun and Clarke (2013) identify seven stages of data analysis, (1) transcription, (2) reading and familiarization, (3) coding, (4) theme searching, (5) reviewing themes, (6) defining and naming themes, and (7) writing the final analysis and reading of the entire transcripts to gain a general feeling and understanding of each participant's shared experience. The researcher used

supervision to test and develop the coherence and plausibility of the interpretation. Many of the direct quotes obtained during interview have been included in the results. To protect the privacy and confidential information of the participants, pseudonyms have been used instead of real names.

Ethical Considerations

In addressing the topic of ethical considerations in this study, all participants were provided an informed consent that outlines the purpose of the study, confidentiality, risks, and benefits for contributing to this study. The researcher explained why the interview is being recorded and that the recordings are to be reviewed and then ultimately destroyed according to IRB policies. The participants were informed that pseudonyms would be used to increase confidentiality, and the transcriptions and data will be securely stored to avoid breaching confidentiality.

Researcher's Reflexivity and Biases

As a Black woman, mother, adjunct faculty at an MFT program, clinical supervisor, and owner of a private mental health counseling practice focusing on helping families, I believe that it is important to learn more about how we can help single Black mothers address their mental health concerns appropriately. This information will help inform and educate the next generation of clinicians on best practices to serve this population. As a trauma-informed, culturally-informed, and community-oriented researcher, I believe that I have created a relationship with the Black community to build trust in conducting this research. My long-term goal is to bring the findings of this research to my native country of South Africa, especially in the rural KwaZulu Natal region, as more and more people are beginning to understand mental health, trauma, oppression, and are working towards reducing the stigma in the Black community.

I have worked with single Black mothers since 1998 in both South Africa and the US in different capacities such as a caseworker, an in-home therapist, and an outpatient therapist. I have also provided support in various settings, including community mental health clinics, hospital settings, and private practice. I believe these factors helped facilitate rapport and trust with participants. This has become particularly important when working with racial and ethnic minority clients who may harbor high levels of cultural mistrust. I have often supported Black single mothers in therapy and have seen their challenges in my career, but in conducting this study, I maintained neutrality by remaining authentically engaged, present, and kept an openness to learning about the Black single mothers' experiences. I used my social distinction as a Black woman to create a sense of safety.

I attended to my role as a researcher by reflecting on my activities throughout the research process, keeping a journal and maintaining research notes as part of the process. This process has helped me attend to any potential bias throughout the research, as I have spent years providing therapy to single Black mothers. I utilized the bracketing process to recognize and set aside my preconceived notions about the subject matter to fully understand the participants' lived experiences (Creswell, 2017).

Maxwell (2005) describes reactivity as the researcher's influence on the site or individuals studied. The participants may have viewed me as part of their group and assumed that I am a single Black mother, and my race and gender may influence the participants' view of and comfort with me. I introduced myself and presented my background and interest in supporting single Black mothers to address this concern. I briefly discussed my professional knowledge and personal connection to the subject matter to avoid any perception by participants that I may be evaluating them and to foster an atmosphere where they felt comfortable talking

about their experiences of the mental health field. I made clear that I am a researcher and a clinician. I reminded the participants that I am gathering data to help us meet their needs and also that they can skip any uncomfortable or irrelevant questions. A traditional and widely accepted description of "reflexivity" includes two integrated and ongoing activities: (a) the researcher's self-reflection on biases, preconceptions, and pre-understandings and their evolution as research progresses and (b) critical reflection on the integrity of the research process and product and how they are affected by personal commitments and theoretical predispositions (Schwandt, 2001).

Maxwell (2005) describes reflexivity as the fact that the researcher is part of the world they study and has a powerful and inescapable influence. My goal was to understand my effect on the participants and be conscious of the non-verbal and verbal messages I displayed. Maxwell (2005) describes researcher bias as selecting data that fits the researcher's existing theory or preconceptions. As a systemic clinician, I have also learned to incorporate the social justice orientation in therapy, especially when working with single Black mothers, such as offering weekend and evening appointments and not terminating treatment after three missed appointments without a conversation about the logistical challenges of attending therapy.

During the study, I remained conscious of how my prior knowledge on this subject might enrich or hinder my experience. Creswell and Poth (2018) remind us that our words flow from our personal experiences, culture, history, and backgrounds. They further state that when researchers go to the field to collect data, they need to approach the task with care for the participants and sites and be reflexive about their role and how it shapes what they see, hear, and write.

Reliability and Validity: Credibility and Trustworthiness

To confirm the accuracy of the information, each participant was sent a copy of the completed study via an encrypted email for their review. This process is known as *member checking* (Birt et al, 2016) and is an essential part of any focus group study to ensure the integrity of the transcribed information. It is especially important to complete this step for this population who may be skeptical of the process and concerned about being misrepresented. Member checking, or seeking participants' input, can help with increasing the validity and reliability of the study by having participants agree or disagree with the content of the transcripts (Carlson, 2010). The member checking process brings a collaborative effort to the qualitative inquiry as participants can see that their story is being told authentically. This can also help the participants understand that they are participating in something important and were not just used for data collection. If any participant had decided to withdraw from the study upon the transcript and analysis review, their wishes would have been respected per the informed consent agreement.

Each participant responded positively upon receipt and review of the study and did not have any concerns or requests to revise the data.

Chapter 4: Results

The purpose of this qualitative research study was to better understand the unique needs of single Black mothers in mental health therapy. A single, semi-structured focus group interview was conducted on June 25, 2022. The study utilized the focus group format to ask the six qualifying participants several questions; listed in Appendix 1, designed to explore their thoughts and experiences related to receiving mental health treatment and allowed for open discussion to gain valuable insight from the participants.

Participants

The study included six single Black mothers who met the inclusion criteria for participation. All identified as Black or African American. Some participants had previously attended mental health therapy, and some are currently receiving mental health therapy. In some cases, participants had experience working with multiple therapists.

Table 1

Participant Demographic Information

Name	Age	Relation. Status	Children – Age(s)	Education / Employment	# of Sessions Attended	Race and Gender of Therapist(s)	A or T
Kelis	31	Single	4 – 15, 10, 9, 2	GED	15	Mexican Female	A
Ebony	36	Divorced	1 – 10	Assoc. Degree Self-Employed	60	Hispanic Male	A
Judy	37	Single	3 – 13, 6, 2	Some College Life Coach/Analyst	25	White Female Hispanic Female	T
Tiffany	32	Single	1 – 11	Some college Student	8	White Female	T

Kati	44	Divorced	3 – 19, 14, 10	Masters Level-PhD Candidate Student	1000	White Female White Male	A
T.C.	34	Single	1 – 5	Associate Degree	3	White Female	T

Note: Pseudonyms have been used to protect the identity and privacy of the participants.

Note: "A" denotes a participant who is actively in therapy. "T" denotes a participant who has terminated therapy.

Data Analysis

Using thematic analysis to interpret the focus group data as detailed by Braun and Clarke (2013) and Morgan (2019), I first began by transcribing the video-recorded interview and familiarizing myself with the data. The responses were then categorized by question and re-read in detail so that I could identify any relevant feedback and patterns of common responses. Often, I would review the recorded video footage to be certain I was capturing the context of the response correctly. As common patterns developed, I noted excerpts which expressed those responses clearly and made annotations accordingly. I then coded the transcript by assigning descriptive labels to those excerpts and compared my codes to those of my peer analyst. Upon review and comparison of our notes, we summarized our findings into a final, collaborative version.

I selected my peer analysist because she is a Black scholar and someone whom I have worked with closely throughout my academic career. She is also a recent Ph.D. graduate in Couple and Family Therapy and understands focus group methodology and the thematic analysis process. My peer analysist was able to bring an alternate perspective to the coding process and re-affirmed my data as well as highlighted some thematic data in ways I had not thought of initially. We compared notes and went over the transcripts multiple times until we agreed on the prevailing codes that resulted in emergent themes and subthemes.

Some examples of the annotation and coding are demonstrated in Table 2 below.

Table 2

Response Excerpts and Annotations

Excerpt	Annotation	Code
“I was highly overwhelmed with life, frustrated, not being able to find my own answers”	Stress is a factor inhibiting the ability to function normally.	I have a serious need for help.
“We need a safe place, and in this place, we need a foundation to be established, we need someone that can educate us to say, ‘hey Judy, this is me, I am here for you’”	There is a need to be welcomed warmly and allowed to open up gradually when entering therapy.	Usher in with Grace. Show love support and compassion. Get to know me first.
“Race and gender were not important at first, but they became important later on.”	Truly understanding these women and their culture is important.	Understanding and acceptance without judgement or the need for an explanation.
“My couples’ therapist, within 30 minutes of meeting me, she suggested medication, and all because she thought I was angry.”	Don’t view me as a presenting problem; learn to understand my culture and me as a person.	I should not have to explain Black culture to you.
“It seemed like the entire session would just be allowed to be filled up with me venting, and I was looking for a therapist that could jump in and we could have a dialogue.”	Needs feedback and engagement from the therapist, not just for them to listen.	Don’t waste my time. I need active feedback and direction.
“What's the solution? Like resources, and real resources. Not like a dead-end, giving me a 1-800 number and then what's next, you know what I mean?”	Be aware of systemic barriers and help identify solutions.	I need real help, support, and advocacy.

Journaling

Given my strong personal connection to this topic personally and clinically, I kept a journal throughout while conducting this research. I did not want my biases or preconceived notions to influence the research process. This intentional suspension of judgement, allowed me

to assume an attitude of noninvolvement towards the remarks of participants, preventing me from unintentionally attaching meaning derived from my own biases to their words.

Themes

Upon completion of the annotating and coding process to summarize the many response excerpts from the interview, I was able to identify some emergent patterns among responses and organized the codes into six distinct themes in the process. I then reviewed the entire focus group interview with these six themes in mind to find any additional areas of convergence or diversion to those patterns. The six themes were confirmed and labeled and shown below in Table 3.

Table 3

Emergent Interview Themes

Initial Code	**Theme**
I have a serious need for help.	Stress, grief, and loss are the main reasons single Black mothers seek therapy.
Usher in with Grace. Show love support and compassion. Get to know me first.	Create a safe space for vulnerability.
Understanding and acceptance without judgement or the need for an explanation.	Need for Black clinicians.
I should not have to explain Black culture to you.	Non-Black Therapists need to have a racially informed approach.
Don't waste my time. I need active feedback and direction.	Therapists should be engaging and provide direct feedback.
I need real help, support, and advocacy.	Provide real resources that match my circumstances.

These six themes were a compilation of the various themes that each participant touched upon throughout the focus group study. For further transparency, and to demonstrate the strength of various themes based upon the responses from each participant, I have listed the major themes discussed by each individual participant below. Since I did not conduct this research study as a

quantitative method study and did not poll each participant on their opinions towards any individual theme, I have not given any particular weight to any one theme over another. Rather, the themes that each participant touched upon were organically provided during the study interview in response to the discussion that followed the focus group questions.

Table 4

Emergent Themes by Participants

Participant	Themes within interview
Kelis	● Feedback and engagement ● Need for structure in the therapy process instead of being allowed to vent ● Need for a Black therapist ● Connection and compassion ● Relationship stress ● Culture-sensitive therapy ● Parenting support ● Compassion and understanding of stresses facing Black single mothers ● Help with managing emotions
Ebony	● Vulnerability ● Referrals ● Connection ● Patience ● Need for a Black therapist
Judy	● Respect and compassion ● Need to have a trusting relationship before being asked personal questions ● Therapists' self-disclosure ● Direct style/Feedback ● Joining and gentle introduction into the therapy process ● Listen without judgement
Tiffany	● Connection ● Need for coping strategies and effective interventions ● Showing up as herself/need for Authenticity in the therapy relationship ● Acceptance ● Need for a Black therapist ● Culture and race sensitive care
Kati	● Education and research on the part of the therapist ● Trauma informed lens and racially informed approach ● Tasked with the responsibility to educate her therapists about how to meet her needs ● Parenting support

	● Culture-sensitive therapy ● Power of Black women
TC	● Connection ● Support ● Joining ● Need for a Black therapist to understand her experiences ● Research and education

Furthermore, some of the six themes appeared to contain subcategory themes that were prevalent and worthy of notation. Although closely associated to each main theme, these subcategory themes stood out as important distinctions are listed below in Table 5.

Table 5

Major and Subcategory Themes

	Major Category Themes	**Subcategory Themes**
1	Stress, grief, and loss are the main reasons single Black mothers seek therapy.	
2	Create a safe space for vulnerability.	Show acceptance Build connection Therapist self-disclosure Transparency
4	Need for Black clinicians.	Free to be authentic
3	Non-Black therapists need to have a racially informed approach.	Talk about race and racism Therapists must educate themselves about Black culture
5	Therapists should be engaging and provide direct feedback.	
6	Provide real resources that match my circumstances.	Advocacy

Stress, Grief, and Loss Are the Main Reasons Single Black Mothers Seek Therapy

The first emergent theme was an acknowledgement that stress, grief, and loss are the main reasons single Black mothers seek therapy. All six participants experienced some form of traumatic experience leading them to seek professional mental health treatment. With an estimated 4.25 million Black families in the US headed by single mothers (Statista, 2021) who

often experience stress, grief, and loss, there is a huge demand for mental health services for this underserved population. The consensus appears to be that these women would not have sought treatment for reasons other than substantial issues that they struggled with managing via their own devices. Their treatment was not for general well-being, but rather for issues of substance which they acknowledged they were not properly equipped to manage on their own. Therefore, when single Black mothers present for treatment, it should be recognized that their needs are tangible and significant. For example, Kelis stated:

> *I went to therapy for relationship challenges and trying to heal from abusive relationships; healing from narcissistic abuse.*

Ebony sought therapy because of stress related to learning her son was diagnosed with cerebral palsy. Judy suffered the loss of a child. Tiffany sought therapy following her son being diagnosed with autism. Kati sought therapy as part of her training as a Marriage and Family therapist, but also admitted that she wanted therapy to deal with gender and racial trauma**.**

TC stated:

> *I went to therapy because I needed an outlet, was overwhelmed with personal issues going on in my life, aside from being pregnant.*

Create a Safe Space for Vulnerability

Secondly, the participants spoke of entering treatment with a skepticism due to many of the cultural historical barriers that they were traversing. In this case, none had the opportunity to engage with a Black therapist. In most cases, these participants' therapists were White. In two cases, the therapist was Hispanic, which helped ease the tension somewhat because the women felt that the Hispanic therapist may have a better understanding of their needs as a cultural minority individual. In all cases, though, the women entered therapy cautiously and with some

doubt in their minds as to whether this would be effective treatment or not. The factors that they felt would be best to ease that tension were a gentle introduction with an emphasis on creating a safe, welcoming space and a clear desire to meet the specific needs of the women. Participants expressed a desire to feel comfortable in the therapy space and with their therapist.

Participants in this study expressed a desire to make a human connection, to show up in therapy as themselves, and to have a therapist willing to share their own experiences in order to lessen the stigma of mental health treatment.

Judy Stated:

> *We need a safe place, and in this place, we need a foundation to be established, we need someone that can educate us to say, "hey Judy, this is me, I am here for you," because I think what a lot of our therapists are forgetting, is that this is a service, and it should be a service of love and compassion. When you do anything in your life there's an introduction that needs to be there, whether you're going to choose a restaurant, buying a car, meeting a man, there has to be this presentation of sorts, you have to show me who you are and what I am supposed to expect while walking in here. And a lot of times they shoot off these questions. They know that you're there because of pain, but they'll quickly say "never mind that because I gotta ask you these 30 triage questions." We all have relationship hurt, we all have pain hurt. They know this, but then in trying to walk into this door of healing they're like "hey you've been raped? you've been molested? what's your triggers? you do drugs? you want to die?, what else? And it's like, I don't want to have this conversation anymore. There's no heart at the entry of this thing that we call therapy. It needs to be reintroduced for people like us, because we have such a hard time already.*

Kelis Stated:

> *I feel like just a certain level of compassion, like if you could just level with me sometimes, and you know, it is intimidating to just take that first step to go in there and get the help that's necessary.*

TC Stated:

> *I internally asked myself during the session; "What am I doing? Why am I here?" and it made me realize that I felt uncomfortable. I excused myself and never returned simply because I felt like the therapist couldn't identify with my specific life issues being a young Black woman and stepping into motherhood.*

Need for Black Clinicians

As the need for therapy was driven by a strong need for professional intervention, the desire to engage specifically with a Black therapist was initially not a strong factor for the participants. They primarily were seeking professional help for their trauma. Having a Black therapist only emerged as common theme after stories unraveled regarding less than satisfactory experiences some of the participants had in dealing with non-Black therapists who were not culturally informed and spent more time asking questions to satisfy their curiosities than providing meaningful therapy. Therefore, their desire for a Black therapist does not appear to be racially motivated in any way, but rather driven by their desires to connect with a therapist who can understand their culture better, and who better to do that than someone from their culture?

The seeming complete lack of availability of allied Black clinicians left the participants in a position of having to accept therapy from non-Black clinicians while holding out hope a Black clinician may come available at some time for them in the future.

Participants expressed a strong desire to be able to present for therapy as their authentic selves without having to guard against mistrust or misunderstanding. With non-Black therapists, they often felt that they had to couch their comments and presentation to be respectfully and clearly accepted and understood without fear of being stigmatized. Those who pursued therapy with a non-Black clinician spoke of wanting to transfer to a Black clinician, if only one were to become available.

Tiffany Stated:

> *Race was not important, but after the first session race mattered.*

Kelis Stated:

> *I'd like to be able to find somebody that can fully identify with, and I don't even know if that's like a realistic expectation at this point.*

Judy Stated:

> *Yes, so my ethnic therapists were Spanish. I don't recall exactly which country they were from, but it worked for me, because there was a middle ground because they too are brown people and there's some discrimination that they face that similar to ours.*

Tiffany Stated:

> *What I need in a therapist is somebody that I could show up as me with. I saw a Twitter feed of a Black woman just being so appreciative that she had a Black therapist for small reasons, like getting on a Zoom call with your braids half off and the therapist not saying "you look crazy." They were saying, "I appreciate you still coming in." And it doesn't turn into an education lesson, it turns into "I know you're not doing well right now and you still showed up to take care of your mental health, and I appreciate that." And it's the little things like that. We could just show up as our real selves without having to think*

> *"oh, I can't say that because they're not going to know what I'm talking about" or "I'm going to have to explain this because I know they're not going to understand where I'm coming from." I need to feel safe showing up as myself, like authentically my crazy self here; no makeup, no lashes, my son screaming in the background. I need to be able to do that and not feel like I'm a crazy person, because my life is in shambles.*

Non-Black Therapists Need to Have a Racially Informed Approach

While having an allied Black clinician may be the ideal solution for many single Black mothers, the participants did not seem to object to non-Black clinicians providing this service, as long as they come into the therapy room with a nominal level of cultural awareness and are prepared to take a certain approach, consistent with the clinical implications set forth in the study results below. There is a great opportunity for non-Black clinicians to become more culturally competent and serve these women's needs as there is a desire of participants to find a therapist who understands their culture and can make them feel authentically comfortable,.

Therapists who waste session time by curiously questioning the client about trivial cultural differences, such as braided hair, risk causing the client to terminate therapy early for concern that their time is being wasted. Furthermore, clinicians who do not educate themselves on real cultural differences such as family dynamics and historical racial implications that may cause rational or irrational preconceived notions about the therapeutic process are navigating themselves into murky waters that may inhibit the ability to create a bond of trust and understanding.

Tiffany Stated:

> *I spent more time teaching my therapist about Black culture than anything else. Normal things in Black family dynamics, like why this was normal for me. I felt like I spent a lot*

of time teaching her about Black women, instead of her helping me. It was like I came in with my hair braided and we spent the first 20 minutes talking about how I don't have to wash my hair every day, and I can keep it in for a few months. Stuff like that. So, I spent a lot of time explaining myself, my family, my culture, instead of learning anything about how to cope with what I was going through.

Kati Stated:

My therapist didn't know, and because I was trying to explore racial trauma with somebody that didn't know, we had to rely on her willingness to be curious, but not put it back on me to educate her…but I think that's the state of mental health, it's not prepared to deal with the needs and the power of Black women.

Tiffany Stated:

I did suspect the therapist was a little bit uncomfortable talking about race and racism, just because I felt like she just didn't know what to say, like walking on eggshells. She didn't know how to be supportive, so it was blatantly obvious that she was uncomfortable because she just didn't know how to handle it. but I definitely felt like she was uncomfortable just discussing race, like most White people are. Like it's a mixture of guilt and not really knowing how to support you through that.

Kati Stated:

You cannot be trauma or racially informed, unless you understand the intersections of gender and sexual identity and race, and so, if you have no experience outside your own, you have no business doing therapy with Black women, so either educate yourself or let us know up front what we're dealing with so that we can bring all those tools, you know that we have, but my first thing is educate yourself, so that you can actually meet us

where we need to be. I think raising Black children is not the same as raising White children, or being a bi-racial mother of lighter skin children, you know, like they have to be willing to engage with us on that topic.

TC Stated:

The therapist did not speak on or mention anything from the topics of culture, race, or spirituality. This is most likely what led to my questioning and hesitance of the session to begin with. Although the session was brief, and the therapist was attentive. I can't remember much other than that. What I remember more than anything is asking myself internally during the session; "What am I doing? Why am I here?

Judy Stated:

My couple's therapist, within 30 minutes of meeting me, suggested medication, and all because she thought I was angry and the way I handled my anger. I don't think I should have had to explain my anger. I think it's just a people thing, and so the fact that she pushed medication on me so quickly without even getting to know me, the fact that I often had to explain things to her, because I felt like she wasn't listening to me. She was listening to the words that I said and analyzed it in her White mind and gave it back to me in a way that makes sense to her but did not relate to either one of us at all.

Therapists Should be Engaging and Provide Direct Feedback

Another overarching theme from participants was a desire for a therapist with an active engagement style who could participate in therapy as a useful partner by providing honest, helpful feedback rather than just being an empathetic ear. Participants shared feelings of trepidation and inconvenience by attending therapy sessions and they were hungry to get

practical feedback from their therapist to demonstrate that they were spending their time and money wisely by attending therapy sessions.

Kelis Stated:

> *One of the things that I didn't like with a lot of my experiences with my therapist were that it seemed like the entire session would just be allowed to be filled up with me venting, and I was looking for a therapist that could jump in and we could have a dialogue, but it just seemed like I'll just be sitting on the couch and it would be an open venting session and I felt like I wasn't really receiving therapy.*

Judy Stated:

> *I think it's so important for me to find out where you are right now, before we dive into what brought you here. Where are you right now? Because I've been seeking help for so long. I was even desperate enough to go to a mental hospital. It would have been so beneficial for them to just ask me "where are you right now, what do you need right now."*

Ebony Stated:

> *What I didn't like was that it always seemed that at the end of the session is when I got very vulnerable, and it was like, okay, your time is up. We'd build the conversation and then get to the end of the time, and then I felt worse than before I started. Because we're digging deep into some issues that I may not have thought about, and it brings up emotions for me. It's like, okay I'm cut off and now I'm leaving with these feelings.*

Provide Real Resources That Match My Circumstances

Participants expressed a need for therapy to be effective if they were to attend. For all their effort in overcoming all of the barriers to treatment that they faced, single Black mothers

who present for treatment need and deserve concrete solutions and positive outcomes. Engaging therapists who can also provide appropriate guidance and resources for these mothers to get the real world help they need bring value to the therapy room. Being an advocate to assist them through real world challenges will help solidify the client therapist relationship.

Kelis Stated:

> *I remember just going through the system, and whenever I was expecting to meet her it was for welfare, whether and to do with having child protective services being involved in your life at the time. When you're trying to survive for so long and kind of just go into that survival mode you forget that the way that you learn how to survive is not the way that you should have to live, and it's like when you're in therapy sometimes it's just nice to be able to have that safe space to have someone to help manage those emotions so that you can properly get everything done so that you can take care of everything that you're balancing at the time and it's so hard because it's like everyone is kind of hitting you at the same time, like "hey, see your therapist," "hey make sure that you're keeping up with your work requirements if you have a job or if you're currently unemployed," or if you have a child that you just gave birth to and you're using government assistance. How do you balance all of that, while also struggling with your mental health? And I think that is so important for people in the healthcare field to understand that we have a lot on our plate, and particularly it's coming from the system to be able to get the help that we need, and to survive, and sometimes it's just like they don't care. They really don't care, a lot of the times they're just like "Oh well, if you want this, or if you need this, you got to do xyz," and I don't have the mental capacity or the mental bandwidth right now to be able to do that so what do you do at that point? Sometimes you're in that gray area of hey, I*

don't completely need to be on anything where it says that I can't perform my duties, because of any extreme mental health issues, but at the same time, I'm not so able to right now. I'm really, really going through a tough spot. I'm not able to fully fulfill all of what's required of me right now. I think that a better approach and more compassionate is someone should help a little bit more with that.

Ebony Stated:

Not only your therapist identifying with you, but what's the solution? Like resources, and real resources. Not like a dead-end, giving me a 1-800 number and then what's next, you know what I mean? So that's what we're missing, identifying the solution and then what resources to get help.

Chapter 5: Discussion

The outcome of this focus study confirmed much of what has been written prior in the literature on Black single mothers in therapy. The participants were comfortably verbose expressing their experiences with therapy, and the information I was able to gather was plentiful. There is clearly a need to improve services for these women and this study identifies a clear set of clinical implications therapists can refer to in order to do so.

This study's focus was not on any particular therapy model in relation to the mental health treatment of single Black mothers, but to identify what barriers may still be hindering these women from seeking therapy treatment and to explore what effective therapy looks like for them. The focus group participants had each received prior mental health treatment, in some cases from multiple therapists, and had first-hand information to share about their experiences. The goal of the study was to determine what was productive for engaging and retaining these women in treatment and what led them to terminate treatment early or not achieve satisfactory results.

Consistent with the literature review, I have found that many of the historic barriers to treatment still exist. In some cases, these barriers are internalized predispositions to avoid seeking treatment due to historical injustices against Black people, and in other cases they are a result of the economic circumstances many of these women find themselves in by virtue of being in a lower socio-economic class, again, often due to historical injustices, as well as the financial and logistical hardships they face as single mothers. Therefore, when they do present for treatment, it is usually for significant issues of stress, grief, or loss, and they are desperate for effective professional guidance to manage these problems. There is often trepidation and skepticism surrounding the initial intake process as these women typically are not familiar with

the process of therapy and may not trust it to be a viable solution for them. In their experience, when they have encountered non-Black therapists, the experience usually ended poorly due to the therapist not being culturally sensitive or being too passive, creating a situation that left the client feeling that their time and money was being wasted.

The study revealed six emergent major themes and nine subcategory themes that the participants focused on relative to their overall treatment experience. These themes connect to the literature previously published in many ways.

Stress, Grief, and Loss Are the Main Reasons Single Black Mothers Seek Therapy

Black single mothers seek therapy because of issues of loss and grief. According to Lowe (2000), Black single mothers often struggle with the loss of a partner and can triangulate their adult male children into the role of the absent parent. These single-mother households are often the result of out-of-wedlock pregnancy, desertion by their partner, separation or divorce, or the result of the incarceration or death of their partner (Anderson, 2003).

Participants in the study talked about going to therapy for reasons such as losing a child, experiencing grief after learning that their child had been diagnosed with special needs, being pregnant and alone, and recovering from abusive relationships. These women came to therapy desiring a direct approach to alleviate immediate stressful situations. As stated by Andersen 2006, working with BSMs resembles case management because you have to attend to the immediate needs and provide support right away and after being supported, some of these women might need ongoing therapy. Some participants in the study went to therapy overwhelmed after failing to find answers on their own. Therefore, it is recommended to start with immediate presenting issues by providing referrals and advocacy before trying to work on long-term goals and/or focusing on increasing insight.

Create a Safe Space for Vulnerability

These women are seeking a safe, confidential space where they can be vulnerable. Safety in the therapeutic relationship can lead to self-disclosure, because of the sense of trust and emotional comfort felt when working with their therapists. In a grounded theory study conducted by DeCou and Vidair (2017), consisting of 12 low-income single mothers, participants stated that they would like a mental healthcare provider who is accepting, non-judgmental, caring, and willing to engage in self-disclosure. This study strongly highlights the major and subcategory themes.

The participants in this study desired a comforting place to be able to address their emotions, a place where they could feel safe enough to open up as their authentic selves, and to have a therapist who is engaged in conversation. They expressed a wish to be greeted on a human level as an individual, rather than as a patient with a presenting problem.

Show Acceptance

A 2005 study by Ward revealed that participants' assessment of therapist experience was two-dimensional: professional and personal. The participants in this study discussed how they assess the therapist's experience by how much eye contact the therapist is comfortable with and ease in asking questions and engaging clients. Results indicated that these participants performed an assessing process while engaging in counseling. They assessed the following three dimensions of their counseling experience: client-therapist match, safety in therapy, and counselor effectiveness. A big part of making s successful therapeutic alliance has been shown to be the therapist's ability to show acceptance of the client to create an atmosphere of confidence.

Participants in the study expressed a desire for a therapist who would be non-judgmental and accepting of them as they were.

Build Connection

Chang and Berk (2009) conducted a study with 16 minority clients who received cross-racial counseling. Participants spoke about whether the therapist saw them as unique individuals or focused on their presenting issue. This could mean spending time in the joining process and engaging in small talk to ease Black people into the therapeutic relationship.

Building a solid connection before digging in too deep exploring problems was a common sub-theme in this study as participants related the therapy intake session to dating. If they do not feel comfortable with a man on the first date, there is not going to be a second. In the same manner, they felt it is important for the therapist to be warm, inviting, and open so that they can acclimate on a conversational level initially.

Therapist Self-Disclosure

In the same 2009 Chang and Berk study, the participants reported wanting a therapist who would meet them halfway, as some of them stated, “I am telling you everything, and what are you bringing to the table” (p. 2252 – 2265).

One of the needs expressed by participants is a therapist who would engage in self-disclosure, with statements such as “I’ve worked with people in your situation”, and “we will try to make sense of all of this together”. The use of inclusive language is important, so they feel that they have a partner who is walking alongside them.

Transparency

The study participants expressed a skepticism or uneasiness about presenting for treatment, not knowing entirely what to expect. In cases where the therapist provides a transparent overview of the therapy process, it can put clients at ease and set expectations accordingly.

Need for Black Clinicians

There has been a growing recognition by mental health professionals over the years that clients' and therapists' cultural identities are an essential aspect of therapy (American Psychological Association, 2003; Comas-Díaz, 2012). When a Black therapist is available, the factor of shared race often eases the transition into treatment for a family. Sometimes Black clients are less suspicious and guarded when they are working with an allied Black therapist. Black families frequently expect something different from a Black therapist on a personal level. They are searching not just for an expert but also for someone whom they feel they can trust (Boyd-Franklin, 2003).

In a study conducted by Meyer and Zane (2013) which consisted of 102 clients who had received mental health treatment from outpatient mental health clinics to investigate whether culturally related elements involving race and ethnicity were essential to clients and related to client satisfaction, it was identified that the race of the counselor did affect the clients' perceived treatment outcomes.

Participants in a study conducted in 2004 by Thompson et al. reported struggling to find a qualified African American or ethnic minority therapist. Those participants also mentioned a reluctance to trust professionals not active in the African American community and activities directed toward community well-being.

The findings of the study confirm that Black single mothers would feel much more comfortable working with a Black clinician. The reasons are that they would like to show up for therapy and work on their issues without having to explain their Black cultural experience or family dynamics. These women want to bypass the need to explain themselves in this regard, and

effectively start working on their challenges. As these participants came to therapy due to issues of stress, grief, and loss, they required immediate support and coping skills.

This was true in Ward's 1995 study, in Thompson et al's 2004 study, and still holds true today. People have a desire to work with someone from their own ethnic/racial group.

Free to be Authentic

By having a racial ally, these women feel relaxed and free to present as their authentic selves, without the need to explain themselves or their cultural differences (Thompson et al., 2004). Racial distrust and misdiagnosis of Black people in therapy can lead to a lack of self-disclosure for clients (Nickerson et al., 1994; Garretson, 1993; Terrell & Terrell, 1984).

Having an allied Black therapist means that these women can feel free to show up for therapy as their authentic selves. They discussed examples such as having their braids out, or children making noise in the background of a Zoom call as stressors when meeting with a non-Black therapist, whereas a Black therapist would likely understand their predicament and be more at ease with the situation. This would allow them to skip through excuses or explanations and get to the heart of the matter of the session more quickly.

Non-Black Therapists Need to Have a Racially Informed Approach

Often, the essential therapist characteristic for African Americans is the cultural sensitivity of the counselor. Culturally sensitive therapists are seen as those who invite their clients to discuss cultural, racial, and environmental stressors and avoid being color-blind (Gushue et al., 2017; Want et al., 2004).

In studies by Chang and Berk (2009) and Thompson et al. (2004), participants indicated that they often looked for subtle cues to determine therapists' cultural attitudes and sensitivity. They reported that items easily overlooked, such as ethnic minority reading material in the

waiting room, diversity of artwork in the office, and ethnic minorities who work for and with the therapist, affected their perceptions and made them feel more welcomed and comfortable.

A study by Ward (2005) revealed that participants' assessment of therapist experience was two-dimensional: professional and personal. Professional experience included the therapist's education, training, years of experience, and, more importantly, experience working with Blacks (Ward, 2005). The participants in this study talked about how they assess the therapist's experience by how much eye contact the therapist is comfortable with and ease in asking questions and engaging clients. Participants reported wanting an experienced counselor for them to feel comfortable. One participant talked about the need to ask the therapist about "how many people of color have you worked with." (Ward, 2005 p. 477). Regarding the therapist's responsiveness, participants spoke about whether this therapist sees them as individuals, or as their presenting issue.

Each of the participants in this study received therapy from a non-Black therapist. One of the common frustrations was having to explain themselves and answer trivial questions such as how they care for their hair. While a non-Black therapist may feel this is part of the joining phase, it was actually pushing the clients away. Therapists treating minorities should not treat their clients like minorities, but rather research their cultural differences in advance and be prepared to normalize those differences.

Talk About Race and Racism

The study participants acknowledged that issues of racism and discrimination continue to persist and that a therapist should be comfortable addressing those issues if the client would like to do so. If the therapist does not bring up race and racism in therapy, this could lead to racial distrust (Awosan et al. 2011; Sue et al., 2019; Gushue et al. 2017). Often, the essential therapist

characteristic for African Americans is the cultural sensitivity of the counselor. Culturally sensitive therapists are seen as those who invite their clients to discuss cultural, racial, and environmental stressors and avoid being color-blind (Gushue et al., 2017; Want et al., 2004).

Participants in this study welcomed a discussion about bias and racism and the effects of it in their lives. Non-Black therapists who avoided the topic appeared incapable of providing effective multi-cultural therapy and left the participants with a lack of confidence in the therapist.

Therapists Must Educate Themselves about Black Culture

In a study conducted by Awosan et al. (2011), comprising 16 Black clients and utilizing both Likert and open-ended questions to examine the obstacles Black clients face in their attempts to attend family therapy, the most frequently identified obstacles were related to concerns over family member response and cultural barriers to treatment. Participants also reported racial and cultural differences and a lack of understanding by non-Black therapists. Although being open to learning something new about a client's culture is a positive therapist attribute, clients are not interested in spending valuable session time education their therapist on their culture. They expect their therapist to show up with some familiarity of their cultural norms if they are going to be providing cross cultural counseling.

Pathologization or over-pathologization of Black patients has been linked to most non-Black clinicians' lack of empathy or understanding of Black culture and system values (Garretson, 1993).

Therapists Should be Engaging and Provide Direct Feedback

Chang and Berk's (2009) study of 16 minority clients who had received cross-racial counseling found a preference for an active therapist engagement versus a passive style. Those participants also spoke about whether the therapist saw them as unique individuals or focused on

their presenting issue. More than twice as many unsatisfied clients described their therapists as passive or not "proactive" enough. Complaints included the lack of feedback, progress reports, or deep questioning regarding the client's experience compared to satisfied clients. Recommendations from this study included offering concrete advice, suggestions, skill development, asking thought-provoking questions, and challenging the client's thinking by providing psychoeducation.

A major theme that emerged from this study was the need for therapists to play an active role in sessions by asking questions, providing feedback and challenging the participants to uncover solutions to their problems rather than just be a sounding board. These women are hungry for results-based treatment as opposed to an ear to bend weekly.

Provide Real Resources That Match My Circumstances

Participants in the study by Ward (2005) described a therapist's effectiveness as "a therapist who is good"; and "who could help me" (p.476). Analysis indicated that two core conditions guided clients' assessment of their therapist's effectiveness: counselor's experience and counselor's responsiveness (Ward, 2005).

The participants spoke of coming to therapy at low points in their lives, when they were vulnerable and in need of more help than they could find elsewhere. They often were struggling emotionally as well as financially and had serious concerns about the safety of their children. One participant revealed that at one point, she checked herself into an in-patient psychiatric ward when she didn't know where else to turn. Since presenting for therapy is not a first course of action for single Black mothers, they generally need hands on assistance when they finally do present which means that they desire a therapist who can provide real world guidance and

provide them with appropriate resources such as help with housing, food stamps, child care, education, etc.

Advocacy

In a 2009 study conducted by Chang and Berk with 16 minority clients who received cross-racial counseling, three subcategories that described a therapist's desired energetic style were identified. These subcategories are “offering concrete advice, suggestions, skill development, asking thought-provoking questions, and challenging the client’s thinking by providing psychoeducation” (p. 527). In the study interview, Ebony expressed it perfectly by asking *“what's the solution? Like resources, and real resources. Not like a dead-end, giving me a 1-800 number and then what's next, you know what I mean? So that's what we’re missing, identifying the solution and then what resources to get help.”*

Women who are acutely aware that their real-life dilemmas cannot be fixed with a prescription, altered cognitions, or a sympathetic ear, might respond to concrete services that facilitate survival and indirectly decrease the emotional stress they are experiencing. Once these issues are addressed, they may, or may not, need or want therapy or medication (Anderson et al., 2006).

In many cases, the participants found themselves in situations where they needed an ally to help them make a call or write a letter to assist with resolving an issue with their landlord, child’s teacher or boss. Having a therapist who can advocate for them was one of the sub themes that prevailed in this study.

Common Factors Findings

Common factors integrated among various individual MFT theories suggest that positive outcomes in therapy can be attributed to certain critical elements, many of which were prevalent

in this study. Important to note is that since stress, grief, and loss are primary reasons single Black mothers attend therapy, therapists have the benefit of starting treatment with a positive client factor. These women are generally sincere, motivated individuals who want to take therapy seriously and work towards achieving their goals for healing.

The second major theme of this study highlights the apprehension these women often bring to the initial sessions due to having depleted morale and concern about the effectiveness of the treatment. The importance of easing into the joining process and showing care and empathy are critical elements for getting off on the right foot, as is being transparent about the process. One major common factor throughout therapeutic treatment modalities is being able to convey a sense of hope and positive expectancy early in the treatment process. This ties together seamlessly and exemplifies what the participants sought when initiating treatment.

Another major common factor in successful therapy is the strength of the therapeutic alliance. Features which bolster this client-therapist relationship include trust, understanding and bonding, which are much easier to achieve when the therapist and client share commonalities such as race or gender. Not having to overcome or learn about cultural differences allows the relationship to sync naturally and quickly. The desire for participants to be able to connect with a Black therapist, or a non-Black therapist who is culturally aware, speaks directly to the organic desire for therapeutic alliance. Flexibility and cultural sensitivity are key therapist common factors (Blow et al., 2007).

Therapist factors, such as being passionately present, responsive, creative, and flexible are the qualities required to foster and maintain the therapeutic alliance (Simon, 2012). Other common elements which enhance this alliance include formalizing a process for soliciting active feedback from the client and instilling a sense of hopefulness regarding a positive outcome

(Karam et al., 2020). The fifth major theme of this study confirms this need by the participants and is further evidenced by the fact that some attributed their premature termination of treatment to a lack of active feedback from their therapist.

Participants also spoke of a sixth major theme, a need for real resources that matched their circumstances. This overarching desire for effective results requires actual clinical interventions initiated by the therapist to affect a specific change in the client's behavior pattern, or skill.

Clinical Implications and Recommendation

The results of this study provide the following specific clinical implications for therapists who provide services to single Black mothers. These findings are summarized as a guide for therapists on best practices for assisting this population.

Stress, Grief, and Loss are the Main Reasons Single Black Mothers Seek Therapy

This focus group highlights the fact that single Black mothers are significantly underrepresented in the process of receiving mental health therapy but may have sincere needs to seek treatment and are often motivated to do so if they can get effective treatment; however, it is often ill-equipped therapists who cause this population to terminate treatment prematurely. The first step to providing quality treatment should be for therapists to respect the fact that if these women do present for therapy, they have overcome numerous cultural barriers to seeking treatment because the issues that they need help with are significant issues of stress, loss or grief and should be respected and taken very seriously.

Being respectful includes showing up on time, smiling and providing a warm welcome, maintaining eye contact, and showing genuine concern. Therapists should not disengage with difficult topics and should not create a sense of watching the clock or rushing the client.

Create a Safe Space for Vulnerability

Since these women often enter the therapy process guarded and with reservations about how productive or not this process may be, it is critical for the therapist to show acceptance and provide a warm, welcoming atmosphere in which the client can feel at ease. It is recommended that clinicians delay the structure of the intake process and take a slower approach with this population. Best practices include spending additional time in the joining process and engaging in small talk to ease Black people into the therapeutic relationship (Chang & Berk, 2009). Clinicians should understand the socio-cultural context first and focus on building rapport before asking probing questions, so long as they are not making cultural inquisitions and putting the client in the uneasy position of explaining themselves and their culture as noted previously. Approximately three sessions dedicated to joining and creating a sense of trust may be ideal. The intake process can seem jarring and accusatory if rushed.

A good clinician can re-establish the intake process over the course of the first few sessions with relevant, but soft questions such as: Where are you right now? What do you need right now? Due to the mistrust harbored by many single Black mothers of the process, it is also an important factor for the therapist to be transparent about the logistics of therapy so that they can know what to expect from the process. Painting a picture of what successful therapy may look like, such as number of sessions, the work involved, and what a positive outcome may look like is important, so that these women can feel like a clear path has been laid out before them and they can set their expectations accordingly. These women are putting themselves in an uncomfortable position because they are desperate for professional help and want to know that there is a real solution to be found.

Need for Black Clinicians

Although the world continues to become more diverse, it is often a basic human desire to surround oneself with people that share their culture, values, and experiences. Never does this seem more important than when we are at our most vulnerable. Although many participants did not initially feel that the race of the therapist was important, they soon determined that it was an important factor after meeting with a non-Black therapist who clearly was not equipped to understand and treat them. Unsatisfactory experiences included stories of White therapists using session time to ask the women about their braids and try to learn about their culture, making these women feel that their time was being wasted and their needs were not being met. The clearest solution would be for these women to have had an opportunity to meet with a Black therapist who would understand to a much greater degree the shared experiences of being Black, making the session more productive.

Efforts by couple and family therapy programs should prioritize the recruitment and retention of Black students, to as much extent possible, to fill this need.

Non-Black Therapists Need to Have a Racially Informed Approach

Only 7.7% of Marriage and Family Therapists are of Black or African American ethnicity (*Marriage and family therapist demographics and statistics in the US. (n.d.)*), making it very difficult for single Black women to locate a culturally allied clinician with availability. Therefore, until there are more Black clinicians available, it is critical that non-Black therapists have a racially informed approach that is culturally competent. As one participant stated, “The therapist should take the time to educate themselves on the Black experience instead of waiting for their clients to provide education.”

Non-Black therapists who treat Black individuals should be sensitive to the doubt that this populations brings to the therapy room and appreciative of the barriers that they overcame to

bring themselves there. They should educate themselves on Black culture including cultural family dynamics and be open to learning and understanding without pathologizing or putting labels on these clients too soon. A study participant spoke of being offered medication within the first 30 minutes of her first session, causing her to lose trust in the process and terminate treatment immediately. Therapists need to engage in an ongoing self-evaluation and become aware of their values, assumptions, and biases (McGoldrick & Hardy, 2019). Strategies that can be utilized to gain that deeper reflection are receiving cross-cultural training, going to workshops focusing on minority dynamics, and/or conducting a cultural genogram. This information provides a guide for therapist in becoming both empathetic and knowledgeable clinical advocates for clients of diverse cultural backgrounds. It is important to recognize how our clinical preparation for work with diverse client populations influences their contextual reality.

Non-Black therapists should also be aware that it is ok to address discrimination and racism head on and not dance around the topic on eggshells for fear of offending the client. Racism still persists and often contributes to challenges faced today by single Black mothers. The topic should be broached with comfort and explored if the client feels comfortable doing so. If the therapist does not bring up race and racism in therapy, this could lead to racial distrust (Awosan et al. 2011; Sue et al., 2019; Gushue et al. 2017). In the joining phase of therapy Non-Black therapists should bring up race and racism by asking questions such as: What has your experience been as a Black single mother in America? How has racism impacted your life? Use open ended questions such as: what has been your view or experience of the mental health field? Gently ease your clients into the therapy process. It is recommended that you assess for any traumatic experiences by conducting the Adverse Childhood Experiences questionnaire, family history by doing a genogram, attachment issues, and a abbreviated Life Timeline. By doing these

assessments who might learn a lot about the clients strengths and resilient nature and this can guide your treatment.

Recommendations for Non-Black therapists to create a sense of safety for the client and share their cultural awareness include opening with statements such as, “I have worked with minority clients, specifically Black clients before, and I continue to educate myself on diverse cultures by reading books, attending trainings, supervision, and consulting with other therapists”. Invite conversation by asking “What are your hopes and concerns as we enter this therapeutic relationship?” Clients can be reassured of your engagement by statements such as, “I am really looking forward to our work together”.

Conversations about medication should occur only when the client broaches it or if you feel confident that that conversation needs to become a part of the treatment. Before recommending medication, a therapist should consider asking soft questions such as, “When do you think that medication is necessary to help with mental health challenges?”, “What are your views on medication?”, “Have you ever been prescribed medications and if so, what was your experience?”, and/or “Do you know someone who has been prescribed medication and what do you know about their experience?”.

Non-Black clinicians should also find resources to educate themselves about the numerous cultural issues specifically related to raising Black children in this society. This issue can be addressed in therapy by asking questions such as: “What parenting challenges have you faced or are currently facing? What parenting successes have you had and what things are you doing well? “How has parenting affected your mental health?” Furthermore, mental health professionals can find ways to reach out and build a relationship within the Black community to gain cultural education and foster a trustworthy bond.

Some resources worth consulting are books such as *Counseling the culturally diverse: theory and practice by Sue et al., 2019, Socioculturally attuned family therapy: guidelines for equitable theory and practice by McDowell et al., 2022*, and *Emotionally focused therapy with african american couples: love heals by Guillory (2022).*

Therapists Should be Engaging and Provide Direct Feedback

Having overcome many barriers to present for treatment, it is important that therapists utilize these sessions to be engaging and to provide direct feedback so that the visits can be effective and productive. Many of the participants in this study lamented their experience of using the session time to open up about their concerns only to be told that their time is up at the end. They often felt like they were given an opportunity to vent but did not receive any feedback or guidance on how they could improve their circumstances. A common desire was for a therapist who could engage them in conversation and provide insight and ideas on how they can manage their pain better so that they could leave the session with some directive.

Failing to provide structure and feedback in the therapeutic process, such as letting the client talk for a long time without asking questions or providing feedback, will most likely cause them to second guess the value of the therapist. Having an engaged style is therefore key to building a bond of trust to move through the therapeutic process. The therapist engaged style comprises of psychoeducation, thought provoking questions, concrete advice, and skill development (Chang and Berk, 2009).

Provide Real Resources that Match My Circumstances

In many cases, these women are struggling with day-to-day challenges that are overwhelming, and they do not know where to turn. As single mothers, they may not have a strong support system to provide them with the guidance they need. An effective therapist should

be able to provide resources for them that match their circumstances. This may be with obtaining financial or medical assistance, finding or managing their housing or childcare situation, or more. Having a trusted advocate who can provide real world assistance brings value to the relationship and can create a strong alliance between therapist and client.

In addition, to overcome several of the barriers these women face to receiving therapy and engage this population in mental health services, we should consider promoting the availability of telehealth therapy, home therapy, and group therapy as available services. These practices will help make mental health services more affordable and/or accessible (Abreu et al., 2000).

Limitations

Recruitment and Sampling

Despite the strengths of the study, the sample size of only 6 participants was quite small and should be generalized with caution. Due to sample size restrictions in this limited, exploratory study, the results led to several keyways. As with most qualitative studies, generalizability of the findings is limited to the group studied; however, it is important to note that generalization was not the goal of this study. Rather, the goal was to understand the experiences of this particular group of participants. Despite these limitations, this study builds upon research aimed at understanding that Black women underutilize mental health services. Future studies should find more diverse samples of this population utilizing larger sample sizes. The study was also limited to an online format focus group. Another limitation was the virtual nature of the focus group interview. In an in-person setting, there may have been more opportunities to observe interpersonal interactions and nonverbal communication.

Demographics

The six participants representing single Black mothers in this study all resided in the northeast US, ranging in age from 31 to 44 years, and had between 1 and 4 children. Income of the participants to identify socio-economic status was not asked or determined. A larger sample size may provide the ability to categorize responses based on age, education, socio-economic status, residence location, and more to determine of any of these additional demographic factors affect the experiences of single Black women in therapy.

Interview Process

The focus group interview was conducted via a 2-hour online Zoom videoconference. The participants were each given ample opportunity to answer questions and follow-up accordingly; however, out of respect not to talk over one another, some participants may not have used every opportunity to provide their full feedback. Out of respect for their time, the question-and-answer process moved the meeting session along so as to complete it within the allocated two-hour window. With additional time for each participant to elaborate more thoroughly, it is possible that additional feedback could be gleamed. Although the member checking process provided an opportunity for the participants to assess their remarks for accuracy, the study did not provide an opportunity for further discussion or elaboration from the participants.

Recommendations for Future Research

This qualitative study, with a marginalized population, informs us that CFT programs should integrate cultural sensitivity training into their curriculum as well as focus on recruiting and retaining more minority students to help increase the number of racially diverse providers in the work force (Bean et al. 2002). Given the fact that results of this study indicate a strong preference for a greater availability of allied Black clinicians, future research can also be

conducted to better understand how to recruit and retain minority students and support minority student success. Future research should continue to study how Black women experiences mental health services, how Black women deal with emotional issues, and how they navigate getting help. Due to historical discrimination and trust issues, mental health professionals and researchers may need to gain the trust of this population before engaging in research. Since the nexus of these study results relate largely to the Black experience, similar focus groups of single Black fathers, Black individuals, Black couples, and Black families could be conducted to determine if they reveal similar results or provide additional relevant insight.

Social Justice Perspective

One of the most significant themes revealed in this study is simply the need for more Black clinicians in the field. As an industry, I believe it is critical that we promote this field of study to Black students and encourage them to pursue therapy as a viable career path due to the great need for their services. They, and their parents, may still feel that therapy is for White people and that White clients would not trust their Black children to counsel them; however, the need for therapy for Black clients is a tidal wave just racing to our shore. An effort to educate school guidance counselors may be a good start. Advertising campaigns, attending job fairs and other methods of recruitment should all be considered. A concerted campaign to promote mental health therapy as a viable career path to historically black colleges and universities could be an effective way to engage students early. Ensuring that these schools offer programs in the MFT field should be first and foremost.

The participants of this focus group study reported that they felt a sense of community and empowerment being amongst their peers and sharing their similar experiences. The focus group format resembles group therapy and participants reported feeling connected to one another

and left them requesting follow-up meetings of this variety. Conducting this study led me to evaluate the way in which I have been providing therapy for the past twenty years. I am now engaging in the person of the therapist and person of the supervisor work to evaluate how we conduct the intake process and how much time we spend in the joining phase. I am also striving to become more cognizant of using the motivational interviewing lens to assess for stage of change rather than assuming that when a client enters my therapy room, they are already in the action stage. Conducting this research and engaging in the journaling process has led to personal growth and self-reflection pertaining to the self of the therapist. I believe that this new found humility will convey respect for my clients as I will be better able to pace treatment. It is my hope that this practice might also strengthen my therapeutic alliances.

Conclusion

The findings from this study emphasize the importance for clinicians to have a better understanding of the unique needs of single Black mothers' experiences in counseling. From this study, we know that this population faces unique, historical barriers which they must overcome in order to present for treatment. The reasons for them to overcome these barriers are not trivial, but rather significant influences of grief, stress, or loss that cause them to put themselves in the uncomfortable position of seeking a type of treatment that runs contrary to their cultural norms. Clinicians must be cognizant that when single Black mothers seek treatment their needs are often sincere and relevant for receiving proper mental health therapy.

When these women do present for therapy, they are often skeptical of the process and enter the therapy room guarded. Best practices for clinicians to initiate treatment have been identified as being sincere and transparent about the process and their intentions. Good practitioners should take time to ease into the joining process and get to know these women

while at the same time being aware that single Black mothers also face additional financial and logistical barriers which may cause them to terminate therapy prematurely if they aren't seeing a clear path to wellness. Therefore being clear about what the process of therapy entails and the possible duration of effective treatment can help make these women more comfortable about what they are getting themselves into.

Being sorely underrepresented in the field, Black clients in general face the additional challenge of having to overcome a cultural obstacle with clinicians that often do not share their ethnicity and world experiences. The looming doubt over whether a client's therapist can truly understand them inhibits the client from ever opening up completely or trusting their therapist fully. The addition of more Black clinicians in the field is sorely needed to address this issue properly, but in the absence of that at this time, it is critical that non-Black therapists educate themselves on this cultural schism. Being open to learning about the cultural differences that someone brings to the therapy room is fine but using the session as a curiosity happenstance to inquire about trivial differences such as a Black woman's hair braids is not conducive to providing effective therapy and should be avoided. Pathologizing these clients, stereotyping them, or leading with medication treatment without gaining a full understanding of the client and their circumstances are all ways to foster early client termination.

The services these women seek are efficient, effective, and productive. Once therapists have created a bond of trust and paved a transparent path of treatment protocol, they should pursue meaningful conversation and add relevant context to move these women towards the positive outcomes they seek. Therapists should be active listeners and engage and challenge the clients to confront the underlying issues and take real steps towards improvement. Clinicians can reinforce this alliance by being advocates for their clients and providing real world assistance to

problems they face in their day-to-day activities. Being knowledgeable about government assistance programs, unemployment benefits, housing programs, food stamps, school systems and more will come in handy to assist those in need as economic disparities for single Black mothers still loom large.

The participants in this study expressed gratitude and appreciation for being a part of a process that allowed them to speak to, and hear from, other women like them about the process of therapy. They felt empowered and praised the opportunity to join with other Black women to discuss their issues collectively. Group therapy may be an empowering community-based solution for women like them. I intend on organizing group therapy sessions for single Black mothers come together and help empower one another and share encouragement. If the groups resemble my focus group in any way, they will share stories of adversity and success and offer guidance and mentorship to one another so that they can feel more cared for, appreciated, and confident in who they each are as beautiful and resilient single Black mothers.

REFERENCES

About marriage and family therapists. (n.d.). American Association for Marriage and Family Therapy. https://www.aamft.org/About_AAMFT/About_Marriage_and_Family_Therapists.aspx

Abreu, J. M., Chung, R. H. G., & Atkinson, D. R. (2000). Multicultural counseling training: Past, present, and future directions. *The Counseling Psychologist, 28*, 641-656. https://doi.org/10.1177/0011000000285003

Almeida, R. V., Dolan-Del Vecchio, K., & Parker, L. (2008). *Transformative family therapy: Just families in a just society*. Pearson Education.

Amankwaa, L. C. (2003). Postpartum depression among African American women. *Issues in Mental Health Nursing, 24*, 297–316. https://doi.org/10.1080/01612840305283

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58*, 377-402. https://doi.org/10.1037/0003-066x.58.5.377

Anderson, C.M. (2003). *The diversity, strengths, and challenges of single-parent households.* Normal family processes: Growing diversity and complexity edited by Froma Walsh. Pages 128-148

Anderson, H., & Goolishian, H. (1992) The client is the expert: A not-knowing approach to therapy. In S. McNamee and K. J. Gergen (Eds.) *Therapy as Social (pp 25-39) Construction*. Sage

Anderson, C. M., Robins, C. S., Greeno, C. G., Cahalane, H., Copeland, V. C., & Andrews, R.

M. (2006). Why lower-income mothers do not engage with the formal mental health care system: Perceived barriers to care. *Qualitative Health Research*, *16*(7), 926–43. https://doi.org/10.1177/1049732306289224

Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 23–55). American Psychological Association. https://doi.org/10.1037/11132-001

Ashley W. (2014). The angry black woman: The impact of pejorative stereotypes on psychotherapy with black women. *Social Work in Public Health*, *29*(1), 27–34. https://doi.org/10.1080/19371918.2011.619449

Atkins, R. (2016). Coping with depression in single black mothers. *Issues in Mental Health Nursing, 37*(3), 172–81. https://doi.org/10.3109/01612840.2015.1098760

Avent, J. R., & Cashwell, C. S. (2015). The Black church: Theology and implications for counseling African Americans. The Professional Counselor, 5(1), 81-90. https://doi.org/10.15241/jra.5.1.81

Awosan, C. I., Sandberg, J. G., & Hall, C. A. (2011). Understanding the experience of black clients in marriage and family therapy. *Journal of Marital and Family Therapy*, *37*(2), 153–168. https://doi.org/10.1111/j.1752-0606.2009.00166.x

Babinski, D., & Sibley, M. (2022). Therapy for attention- deficit/hyperactivity disorder in families: A review of randomized controlled trials from 2010– 2019. *Journal of Marital and Family Therapy.Volume 48, Issue 1, 83-106.* https://doi.org/10.1111/jmft.12572

Bean, R., & Crane, D. R. (1996). Marriage and family therapy research with ethnic minorities:

Current status. *American Journal of Family Therapy*, *24*(1), 3–8. https://doi.org/10.1080/01926189508251011

Bean, R. A., Perry, B. J., & Bedell, T. M. (2002). Developing culturally competent marriage and family therapists: Treatment guidelines for non-African-American therapists working with African-American families. *Journal of Marital and Family Therapy, 28*(2), 153–164. https://doi.org/10.1111/j.1752-0606.2002.tb00353.x

Bernal, G., & Domenech Rodríguez, M. M. (2012). Cultural adaptations: Tools for evidence-based practice with diverse populations. *American Psychological Association*. https://doi.org/10.1037/13752-000

Becker, D., & Liddle, H.A. (2001). Family therapy with unmarried African American mothers and their adolescents. *Family Process, 40*, 413-427. https://doi.org/10.1111/j.1545-5300.2001.4040100413.x

Bell-Tolliver, L., Burgess, R., & Brock, L. J. (2009). African American therapists working with African American families: An exploration of the strengths perspective in treatment. *Journal of Marital and Family Therapy*, *35*(3), 293–307. https://doi.org/10.1111/j.1752-0606.2009.00117.x

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research*, *26*(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Black and African American communities and mental health. (n.d.). Mental Health America. https://www.mhanational.org/issues/black-and-african-american-communities-and-mental-health

Black, A. R., & Peacock, N. (2011). Pleasing the masses: messages for daily life management in

African American women's popular media sources. *American Journal of Public Health*, *101*(1), 144–50. https://doi.org/10.2105/AJPH.2009.167817

Blow, A. J., & Karam, E. (2017). The therapist's role in effective marriage and family therapy practice: The case for evidence based therapists. *Administration and Policy in Mental Health and Mental Health Services Research, 44*(5), 716–723. https://doi.org/10.1007/s10488-016-0768-8

Blow, A. J., Morrison, N., Tamaren, K., Wright, K., Schaafsma, M., & Nadaud, A. (2009). Change processes in couple therapy: An intensive case analysis of one couple using a common factors lens. *Journal of Marital and Family Therapy*, *35*(3), 350–368. https://doi.org/10.1111/j.1752-0606.2009.00122.x

Blow, A. J., Sprenkle, D. H., & Davis, S. D. (2007). Is who delivers the treatment more important than the treatment itself? The role of the therapist in common factors. *Journal of Marital and Family Therapy*, 33, 298–317. https://doi.org/10.1111/j.1752-0606.2007.00029.x

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy, 16*, 252–260. https://doi.org/10.1037/h0085885

Boyd-Franklin, N. (2003). *Black families in therapy: Understanding the African American experience* (2nd ed.). Guilford Press.

Braun, V., & Clarke, V. (2013). *Successful qualitative research*. SAGE.

Brotherson, M. (1994). Interactive focus group interviewing: A qualitative research method in early intervention. *Topics in Early Childhood Special Education*, *14*, 101-119. https://doi.org/10.1177/027112149401400110

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in

mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of counseling psychology*, *58*(4), 537–554. https://doi.org/10.1037/a0025266

Carlson, J. A. (2010). Avoiding traps in member checking. *Qualitative Report*, *15*(5), 1102–1113.

Chang, D. & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology*. October 1; *56*(4): 521–536. https://doi.org/10.1037/a0016905

Comas-Díaz L. (2012). *Multicultural care: A clinician's guide to cultural competence*. American Psychological Association. https://doi.org/10.1037/13491-000

Corcoran, J. (2000). Solution-focused family therapy with ethnic minority clients. *Crisis Intervention & Time-Limited Treatment, 6*(1), 5-12. https://doi.org/10.1080/10645130008951292

Cost and insurance coverage. (n.d.). Psychology Today. https://www.psychologytoday.com/us/basics/therapy/cost-and-insurance-coverage

Creswell, J. W. (2017). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry & research design: Choosing among five approaches* (4th ed.). Sage.

DeCou, S.E., & Vidair, H.B. (2017). What low-income, depressed mothers need from mental health care: Overcoming treatment barriers from their perspective *Journal of Child and Family Studies, 26*, 2252-2265. https://doi.org/10.1007/s10826-017-0733-5

Donovan, R. A., & West, L. M. (2015). Stress and mental health: Moderating role of the strong

Black woman stereotype. *Journal of Black Psychology*, *41*(4), 384–396. https://doi.org/10.1177/0095798414543014

Doss, B., Roddy, M., Wiebe, S., & Johnson, S. (2022). A review of the research (2010–2019) for evidence-based treatments for couple relationship distress. *Journal of Marital and Family Therapy. Volume 48, Issue 1, 283 - 306 https://doi.org/10.1111/jmft.12552*

Dow, D. M. (2015). Negotiating "the welfare queen" and "the strong Black woman": African American middle-class mothers' work and family perspectives. *Sociological Perspectives, 58(*1), 36–55. https://doi.org/10.1177/0731121414556546

Dwanyen, L., Holtrop, K., & Parra-Cardona, R. (2022). Reducing mental health disparities among racially and ethnically diverse populations: a review of couple and family intervention research methods (2010-2019). *Journal of Marital and Family Therapy*, *48*(1), 346–365. https://doi.org/10.1111/jmft.12573

Frey, L., Hunt, Q., Russon, J., & Diamond, G. (2022). Review of family- based treatments from 2010– 2019 for suicidal ideation and behavior. *Journal of Marital and Family Therapy*. *Volume 48, issue 1, 154 - 177*. https://doi.org/10.1111/jmft.12568

Garretson, D. (1993). Psychological misdiagnosis of African Americans. *Journal of Multicultural Counseling and Development, 21*, 119 –127. https://doi.org/10.1002/j.2161-1912.1993.tb00590.x

Goger, P., & Weersing, V. R. (2022). Family based treatment of anxiety disorders: A review of the literature (2010–2019). *Journal of Marital and Family Therapy. Volume 48, issue 1, pages 107 -128.* https://doi.org/10.1111/jmft.12548

Goldenberg, I., & Goldenberg, H. (2013). *Family therapy : An overview* (8th ed.). Brooks/Cole, Cengage Learning.

Guillory, P. T. (2022). *Emotionally focused therapy with African American couples: Love heals.* Routledge. https://doi.org/10.4324/9780429355127

Gushue, G. V., Walker, A. D., & Brewster, M. E. (2017). Motivation and color-blind racial attitudes among White psychology trainees. *Training and Education in Professional Psychology*, *11*(2), 78–85. https://doi.org/10.1037/tep0000146

Hardy, K. V., & Laszloffy, T. A. (1998). The dynamics of a pro-racist ideology: Implications for family therapy. In M. McGoldrick (Ed.), *Re-visioning family therapy* (pp. 118–128). Guilford Press.

Hardy, K. V., & Laszloffy, T. A. (2000). The development of children and families of color: A supplemental framework. In W. Nichols, D. Becvar & A. Napier (Eds.), *Clinical handbook of individual and family development* (pp. 109–128). John Wiley and Sons.

Harrington, E. F., Crowther, J. H., & Shipherd, J. C. (2010). Trauma, binge eating, and the "strong Black woman." *Journal of Consulting and Clinical Psychology*, *78*(4), 469–479. https://doi.org/10.1037/a0019174

Harris-McKoy, D. A., & Smith, S. M., (2020). Improving culturally sensitive interventions for youth and parent-child relationships. In K. S. Wampler and L. M. McWey (Eds). *The handbook of systemic family therapy.* (pp. 621–644). John Wiley & Sons. https://doi.org/10.1002/9781119788393.ch25

Hook, J. N., Davis, D. D., Owen, J., & DeBlaere, C. (2017). *Cultural humility: Engaging diverse identities in therapy* (1st ed.). American Psychological Association. https://doi.org/10.1037/0000037-000

Helms, J. E. (1989). Eurocentrism strikes in strange ways and unusual places. *The Counseling Psychologist, 17*, 643–647 https://doi.org/10.1177/0011000089174010

Hogue, A., Schumm, J., MacLean, A., & Bobek, M. (2022). Couple and family therapy for substance use disorders: Evidence- based update 2010– 2019. *Journal of Marital and Family Therapy.Volume 48, issue 1, pages 178 - 203*. https://doi.org/10.1111/jmft.12546

Hubble, M. A., Duncan, B. L., & Miller, S. D. (Eds.). (1999). *The heart and soul of change: What works in therapy.* American Psychological Association. https://doi.org/10.1037/11132-000

Huff, S. C. & Hartenstein, J. L.(2020). Helping children in divorced and single-parent families, In K. S. Wampler and L. M. McWey (Eds). T*he handbook of systemic family therapy.* (pp. 521–539). John Wiley & Sons. https://doi.org/10.1002/9781119788393.ch21

Jackson, J. S., Torres, M., Caldwell, C. H., Neighbors, H. W., Nesse, R. M., Taylor, R. J., & Williams, D. R. (2004). The national survey of American life: A study of racial, ethnic and cultural influences on mental disorders. *International Journal of Methods in Psychiatric Research, 13*(4), 196–207. https://doi.org/10.1002/mpr.177

Jimenez, D. E., Bartels, S. J., Cardenas, V., Dhaliwal, S. S., & Alegria, M. (2012). Cultural beliefs and mental health treatment preferences of ethnically diverse older adult consumers in primary care. *The American Journal of Geriatric Psychiatry, 20*(6), 533–542. https://doi.org/10.1097/JGP.0b013e318227f876

Jones, J. M. (1997). *Prejudice and racism* (2nd ed.). McGraw-Hill.

Kaminski, J., Robinson, L., Hutchins, H., Newsome, K., & Barry, C. (2022). Evidence base review of couple and family based psychosocial interventions to promote infant and early childhood mental health, 2010-2019. *Journal of Marital and Family Therapy*. Volume 48, issue 1, 23 - 55. https://doi.org/10.1111/jmft.12570

Karam, E. A. & Blow, A. J. (2020). Common factors underlying systemic family therapy. In K. S. Wampler and L. M. McWey (Eds). *The handbook of systemic family therapy* (pp. 147–169). John Wiley & Sons. https://doi.org/10.1002/9781119438519.ch7

Katz, J. H. (1985). The sociopolitical nature of counseling. *The Counseling Psychologist, 13*, 615–624. https://doi.org/10.1177/0011000085134005

Kazdin, A. E. (2000). Perceived barriers to treatment participation and treatment acceptability among antisocial children and their families. *Journal of Child & Family Studies*, *9*, 157-174. https://doi.org/10.1023/A:1009414904228

Knudson-Martin, C., & Huenergardt, D. (2010). A socio-emotional approach to couple therapy: Linking societal context and couple interaction. *Family Process, 49*, 369–386. https://doi.org/10.1111/j.1545-5300.2010.01328.x

Kramer, S. (2019, December 12). *U.S. has world's highest rate of children living in single-parent households*. Pew Research Center. https://www.pewresearch.org/fact-tank/2019/12/12/u-s-children-more-likely-than-children-in-other-countries-to-live-with-just-one-parent/

Laird, J. (1998). Theorizing culture: Narrative ideas and practice principles. In M. McGoldrick (Ed.), Re-visioning family therapy: Race, culture, and gender in clinical practice (pp. 20–36). The Guilford Press.

Leslie, A. M. (1995). A theory of agency. In D. Sperber, D. Premack, & A. J. Premack (Eds.), *Causal cognition: A multidisciplinary debate* (pp. 121–149). Clarendon Press/Oxford University Press.

Livingston, G. (2018, April 25,). The changing profile of unmarried parents. Pew Research

Center, https://www.pewresearch.org/social-trends/2018/04/25/the-changing-profile-of-unmarried-parents/

Lowe, W. J. (2000). Detriangulation of absent fathers in single-parent black families: Techniques of imagery. *American Journal of Family Therapy*, *28*(1), 29–40. https://doi.org/10.1080/019261800261798

Markman, H., Hawkins, A., Stanley, S., Halford, K., & Rhoades, G. (2022). Helping couples achieve relationship success: A decade of progress in couple relationship education research and practice, 2010– 2019. *Journal of Marital and Family Therapy. Volume 48, issue 1, 251 - 282.* https://doi.org/10.1111/jmft.12565

Marriage and family therapist demographics and statistics in the US. (n.d.). ZIPPIA. https://www.zippia.com/marriage-and-family-therapist-jobs/demographics/

Maxwell, J.A. (2005) *Qualitative Research Design – An Interactive Approach* (2nd ed.). Sage.

McCauley, H. & PettyJohn, M. E.(2020). Redefining "family": lessons from multidisciplinary research with marginalized populations. In K. S. Wampler and L. M. McWey (Eds). *The handbook of systemic family therapy* (pp. 79–95). John Wiley & Sons. https://doi.org/10.1002/9781119790181.ch4

McDowell, T., Knudson-Martin, C., & Bermudez, J. M. (2022). Socioculturally attuned family therapy: Guidelines for equitable theory and practice (2nd ed.). Routledge. https://doi.org/10.4324/9781003216520-9

McDowell, T. M., & Fang, S. S. (2007). Feminist-informed critical multiculturalism. *Journal of Family Issues*, *28*, 549–566. https://doi.org/10.1177/0192513X06297331

McGoldrick, M., Giordano, J., & Pearce, J. K. (1996). *Ethnicity and family therapy* (2nd ed.).

Guilford Press.

McGoldrick, M., & Hardy, K.V. (Ed) (2019). Re-visioning family therapy: Race, culture, and gender in clinical practice (pp. 20–36). Guilford Press.

McGoldrick, M., Carter, E. A., & Garcia-Preto, N. (Eds.). (2016). *The expanding family life cycle: Individual, family, and social perspectives* (5th ed.). Boston :Pearson,

McLafferty, I. (2004). Focus group interviews as a data collecting strategy. *Journal of Advanced Nursing*, *48*, 187-194. https://doi.org/10.1111/j.1365-2648.2004.03186.x

McWey, L. (2022). *Systemic interventions for traumatic event exposure: A 2010– 2019 decade review. Journal of Marital and Family Therapy. Volume 48, Issue 1, 204 - 230.* https://doi.org/10.1111/jmft.12547

Mercer, K. (1984). Black communities' experience of psychiatric services. *The International Journal of Social Psychiatry*, *30*, 22–27. https://doi.org/10.1177/002076408403000105

Meyer, O. L., & Zane, N. (2013). The influence of race and ethnicity in clients' experiences of mental health treatment. *Journal of Community Psychology*, *41*(7), 884–901. https://doi.org/10.1002/jcop.21580

Mohr, W. K. (2000). Rethinking professional attitudes in mental health settings. *Qualitative Health Research, 10*, 595-611. https://doi.org/10.1177/104973200129118679

Morgan, D. L. (2019). *Basic and advanced focus groups*. Sage.

National Partnership for Women & Families. (2021). Black women and the wage gap. https://www.nationalpartnership.org/our-work/resources/economic-justice/fair-pay/african-american-women-wage-gap.pdf

Neighbors, H. W., Musick, M. A., & Williams, D. R. (1998). The African American Minister as

a source of help for severe personal psychology crisis: Bridge or barrier to mental health care? *Health Education and Behavior, 25*, 759–777. https://doi.org/10.1177/109019819802500606

Nickerson, K. J., Helms, J. E., & Terrell, F. (1994). Cultural mistrust, opinions about mental illness, and Black students' attitudes toward seeking psychological help from White counselors. *Journal of Counseling Psychology, 41*, 378 –385. https://doi.org/10.1037/0022-0167.41.3.378

Nicolaidis, C., Timmons, V., Thomas, M. J., Waters, A. S., Wahab, S., Mejia, A., & Mitchell, S. R. (2010). "You don't go tell White people nothing": African American women's perspectives on the influence of violence and race on depression and depression care. *American Journal of Public Health*, *100*(8), 1470–1476. https://doi.org/10.2105/AJPH.2009.161950

Oppenheimer, J. E., Flannelly, K. J., & Weaver, A. J. (2004). A comparative analysis of the psychological literature on collaboration between clergy and mental-health professionals—Perspectives from secular and religious journals: 1970–1999. *Pastoral Psychology, 53*(2), 153–162. https://doi.org/10.1023/B:PASP.0000046826.29719.8d

Owens, P. L., Hoagwood, K., Horwitz, S. M., Leaf, P. J., Poduska, J. M., Kellam, S. G., Ialongo, N. S. (2002). Barriers to children's mental health services. *Journal of the American Academy of Child & Adolescent Psychiatry*, *41*, 731-738. https://doi.org/10.1097/00004583-200206000-00013

Pakes, K., & Roy-Chowdhury, S. (2007). Culturally sensitive therapy? Examining the practice of cross-cultural family therapy. *Journal of Family Therapy*, *29*(3), 267–283. https://doi.org/10.1111/j.1467-6427.2007.00386.x

Parham, T. A., White, J. L., & Ajamu, A. (1999). *The psychology of Blacks: An African centered perspective* (3rd ed.). Prentice-Hall.

Payne, J. S. (2009). Variations in pastors' perceptions of the etiology of depression by race and religious affiliation. *Community Mental Health Journal, 45*(5), 355–365. https://doi.org/10.1007/s10597-009-9210-y

Piercy, F.R. & Hertlein, K.M. (2005). *Focus groups in family therapy research.* In Research methods in family therapy (2nd ed.). Guilford Press.

Prochaska, J. O. (1999). How do people change, and how can we change to help many more people? In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change* (pp. 227–255). American Psychological Association. https://doi.org/10.1037/11132-007

Schreiber, R., Stern, P. N., & Wilson, (2000). Being strong: How Black West Indian Canadian women manage depression and its stigma. *Journal of Nursing Scholarship*, *32*(1), 39–45. https://doi.org/10.1111/j.1547-5069.2000.00039.x

Schwandt, T. A. 2001. *Dictionary of qualitative inquiry*, Sage.

Sheidow, A., McCart, M., & Drazdowski, T. (2022). Family- based treatments for disruptive behavior problems in children and adolescents: An updated review of rigorous studies (2014– April 2020). *Journal of Marital and Family Therapy*. *Volume 48, issue 1, 56 - 82*. https://doi.org/10.1111/jmft.12567

Simon, G. M. (2012). The role of the therapist: what effective therapists do. *Journal of Marital and Family Therapy*, *38*, 8–12. https://doi.org/10.1111/j.1752-0606.2009.00136.x

Sprenkle, D. H., Blow, A. J., & Dickey, M. (1999). Common factors and other nontechnique variables in marriage and family therapy. In M. A. Hubble, B. L. Duncan, & S. Miller

(Eds.), *The heart and soul of change: What works in therapy* (pp. 329–360). The American Psychological Association. https://doi.org/10.1037/11132-010

Sprenkle, D. H., Davis, S. D., & Lebow, J. L. (2009). *Common factors in couple and family therapy: The overlooked foundation for effective practice*. Guilford Press.

Stack, R. J., & Meredith, A. (2018). The impact of financial hardship on single parents: An exploration of the journey from social distress to seeking help. *Journal of Family and Economic Issues*, *39*(2), 233–242. https://doi.org/10.1007/s10834-017-9551-6

Statista. (2021, October 5). *Number of Black single mothers U.S. 2020*. https://www.statista.com/statistics/205106/number-of-black-families-with-a-female-householder-in-the-us.

Stith, S., Topham, G., Spencer, C., Jones, B., Coburn, K., Kelly, L., & Langson, Z. (2022). Using systemic interventions to reduce intimate partner violence or child maltreatment: A systematic review of publications between 2010 and 2019. *Journal of Marital and Family Therapy*. *Volume 48, issue 1, 231 - 250.* https://doi.org/10.1111/jmft.12566

Sue, S., Zane, N., Hall, G. C. N., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60*, 525–548. https://doi.org/10.1146/annurev.psych.60.110707.163651

Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2019). *Counseling the culturally diverse: Theory and practice* (8th ed.). John Wiley & Sons.

Sue, D. W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice* (2nd ed.). Wiley.

Terlizzi, E. P., & Norris, T. (2021). Mental health treatment among adults: United States, 2020

(NCHS Data Brief No. 419, October 2021). Center for Disease Control and Prevention; National Center for Health Statistics. https://doi.org/10.15620/cdc:110593

Terrell, F., & Terrell, S. (1984). Race of counselor, client sex, cultural mistrust level, and premature termination from counseling among Black clients. *Journal of Counseling Psychology*, *31*, 371–375. https://doi.org/10.1037/0022-0167.31.3.371

Therapy FAQs. (2014). How much does therapy cost? GoodTherapy. https://www.goodtherapy.org/blog/faq/how-much-does-therapy-cost

Thompson, V.L., Bazile, A., & Akbar, M. (2004). African Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychological Research and Practice, 35*(1), 19-26. https://doi.org/10.1037/0735-7028.35.1.19

Townes, D. L., Chavez-Korell, S., & Cunningham, N. J. (2009). Reexamining the relationships between racial identity, cultural mistrust, help-seeking attitudes, and preference for a Black counselor. *Journal of Counseling Psychology*, *56*, 330–336. https://doi.org/10.1037/a0015449

Verhulst, F. C., & van der Ende, J. (1997). Factors associated with child mental health service use in the community. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*, 901-909 https://doi.org/10.1097/00004583-199707000-00011

Wade, P., & Berstein, B. L. (1991). Cultural sensitivity training and counselor's race: Effects on Black female clients' perception and attrition. *Journal of Counseling Psychology*, *38*, 9 – 15. https://doi.org/10.1037/0022-0167.38.1.9

Waites, C. (Ed.). (2008). *Social work practice with African-American families : An intergenerational perspective*. Routledge.

Walsh, F. (2006). *Strengthening family resilience* (2nd ed.). Guilford Press.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Erlbaum.

Want, V., Parham, T. A., Baker, R. C., & Sherman, M. (2004). African American students' ratings of caucasian and African American counselors varying in racial consciousness. *Cultural Diversity & Ethnic Minority Psychology*, *10*(2), 123–136. https://doi.org/10.1037/1099-9809.10.2.123

Ward, E. C. (2005). Keeping it real: A grounded theory study of African American clients engaging in counseling at a community mental health agency. *Journal of Counseling Psychology*, *52*(4), 471–481. https://doi.org/10.1037/0022-0167.52.4.471

Wendy A. (2014). The angry Black woman: The impact of pejorative stereotypes on psychotherapy with Black women. Social Work in Public Health, 29(1), 27-34. https://doi.org/10.1080/19371918.2011.619449

Wieling, E., Derrick, J. M., Dwanyen, L., Escobar-Chew Ana Rocío, Gassas, R. F., Orieny, P. O., Tichenor, K. J., Yeager, C. E., & Yumbul, C. (2020). Letters to the field: Voices from underrepresented systemic family therapists. In K. S. Wampler, M. Rastogi, R. Singh (Eds). *The handbook of systemic family therapy* (pp. 569–599). John Wiley & Sons, https://doi.org/10.1002/9781119438519.ch105

Williams, R., & Drury, J. (2009). *Psychosocial resilience and its influence on managing mass emergencies and disasters*. National Emergency Training Center. https://doi.org/10.1016/j.mppsy.2009.04.019

Wittenborn, A., Woods, S., Priest, J., Morgan, P., Tseng, C.- F., Huerta, P., & Edwards, C.

(2022). Couple and family interventions for depressive and bipolar disorders: Evidence base update (2010– 2019). *Journal of Marital and Family Therapy*. https://doi.org/10.1111/jmft.12569

APPENDIX A - Focus Group Questions

1. Why did you go to therapy?

2. Was race or gender important? If so, why?

3. What do you expect from a therapist?

4. How has therapy been for you? Has it been positive or negative? Why do you say so?

5. What did you like about how your therapist worked with you? What didn't you like?

6. Was the therapist comfortable enough to talk about race? Culture? Spirituality? Racism?

   a. How did that impact you if they didn't talk about these things?

   b. If they were comfortable enough to talk about these issues, how did that impact you?

   c. Did you feel that any issues/topics were specifically avoided? If so, which?

7. What do people most important to you think about you being in therapy? Does their opinion affect you at all? If so, how?

8. Did you decide to stay in therapy? Why or why not? Are there particular factors you can think of that made you either stick with it or leave?

9. Has attending therapy affected your relationships at home and at work? If so, how?

10. What do you feel is important for me to know in learning about the experiences of Black single mothers in therapy that I haven't asked about or that hasn't come up yet?

Appendix B - Recruitment Flyer

Seeking volunteer participants

Are you a single Black mother?

Have you received mental health therapy in the past 5 years?

If so, would you be willing to participate in a brief, focus group research study designed to help therapists better understand the unique needs of single Black mothers?

8 participants will be asked to join me on a 2-hour ZOOM meeting to describe how they view mental health providers, what they look for in a mental health care provider, and what they believe the important factors are that would lead to success in therapy for them. I will moderate the meeting by asking the group approximately ten questions.

Participation is voluntary and may be discontinued at any time. There are minimal, if any, risks for participating in this research project. Your input is valuable, and several steps will be taken to protect your confidentiality.

Interested participants are invited to contact me and will receive a Demographic Screening Questionnaire to verify that you meet the qualifications of participating in this study.

Lets Make A Difference!

Contact:

Nompelelo Boucher, LMFT, LMHC

APPENDIX C - Demographic Screening Questionnaire

Please complete the following form. The answers will contribute to the descriptive aspect of the study and will assist the researcher in understanding your responses to the interview questions. This form will be kept confidential and assigned a code number for a referral. You may leave any line blank or use N/A if it is appropriate.

Name:_____

Age:_____

Race/Ethnicity:_____

Relationship Status:_____

Number of children residing with you:_____

Highest level of education and occupation:_____

Are you currently, or have you attended therapy in the past 5 years:_____

What type of therapy did you receive individual, family, and couples:_____

How many sessions have you attended:_____

What was the gender and race of your therapist:_____

_____ _____

Signature Date

For researcher use only

Qualified:_____Selected:_____Code:_____Pseudonym:_____

APPENDIX D

Informed Consent

Dear Participant,

Thank you for your interest in participating in this research study. This qualitative study aims to explore the needs of single Black mothers in mental health therapy. To participate, you must be between 18 and 45 years old and self-identify as Black and as a single mother. In the last ten years, you must currently be receiving or have received mental health therapy treatment, must speak and understand English, and possess the cognitive ability to participate in the study.

The insights that may be gained from the study assist clinicians in understanding the needs of single Black mothers in therapy. During this interview, you will have the opportunity to share your experiences of receiving mental health therapy. The discussion will take place on Zoom for two hours. Your privacy and confidential information will remain protected. Some of the notable direct quotes obtained during the interview may be included, but your name and other personal information will remain anonymous and confidential. The report will be reviewed by a committee overseeing my research. After the data is transcribed in written report form, I will send a copy to you from my Antioch University email account in a password-protected attachment. I will manually share the password for the attachment containing the written report with you. You will use the password to open the attachment. I will invite you to review the written report and provide feedback regarding its consistency with your experiences shared during the interview. I plan to use these results to provide knowledge via academic journals. Once completed, all documents obtained throughout the study, including the video recording, demographic screening questionnaires, and notes taken, will be destroyed. Although there are no

major risks in the research, you are not required to respond to any questions you feel uncomfortable with, and you may withdraw from the study at any time.

Acknowledgment

I understand this project is for academic research and that my participation is voluntary. I also understand that if I decide to participate in this study, I may withdraw my consent at any time and stop participating without explanation, penalty, or prejudice.

I, _____ understand and consent to all the stipulations outlined above. _____Signature _____Date

Nompelelo Boucher, LMFT, LMHC

Applied Psychology Department

Antioch University New England

If you have any questions about your rights as a research participant, you may contact:

Chair of the Antioch University New England Institutional Review Board

https://www.antioch.edu/online