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A Phenomenological Exploration of Intracommunity Attitudinal and Experiential Barriers to the Utilization of Psychotherapeutic Services in BIPOC Populations

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A PHENOMENOLOGICAL EXPLORATION OF INTRACOMMUNITY ATTITUDINAL AND EXPERIENTIAL BARRIERS TO THE UTILIZATION OF PSYCHOTHERAPEUTIC SERVICES IN BIPOC POPULATIONS

By

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Abstract

This study used Interpretative Phenomenological Analysis to explore the role that intracommunity attitudes and beliefs and negative mental healthcare experiences play in determining treatment-seeking behavior in BIPOC communities. Through in-depth semi-structured interviews, five participants shared their perspectives and experiences, providing rich and nuanced insight into the subjective landscape of mental healthcare avoidance among racial and ethnic minority populations. The analysis revealed five overarching themes (pray it away, isolated and invisible, fear, perceived importance of racial matching, and therapeutic experiences profoundly impact treatment-seeking) shedding light on the nuanced ways in which BIPOC individuals make sense of and navigate mental health within their communities and how that, in turn, determines well-documented lower rates of mental health service utilization. Findings suggest that negative attitudes towards mental illness and treatment avoidance are prevalent in BIPOC communities, and adverse encounters with culturally incompetent providers perpetuate these attitudes and disparities in utilization. Improving BIPOC treatment outcomes and patient satisfaction could slowly mitigate intracommunity stigma and normative beliefs and significantly increase help-seeking behavior, especially for future generations. This research contributes to our understanding of this phenomenon and emphasizes the urgent need to equip all therapists with the competency skills essential for effectively addressing the diverse needs of BIPOC patients.

Keywords: BIPOC, treatment-seeking behavior, intracommunity attitudes, stigma, cultural competence, mental health, normative beliefs, racial matching

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A Phenomenological Exploration of Intracommunity Attitudinal and Experiential Barriers to the Utilization of Psychotherapeutic Services in BIPOC Populations

As psychotherapeutic services become increasingly available and socially accepted, barriers to the utilization of these services are becoming evident. Black, indigenous, and people of color (BIPOC) experience higher levels of psychological distress and are overexposed to a myriad of health stressors, including racism, poverty, transgenerational trauma, and environmental hazards (Roberts et al., 2022; Williams, 2018). BIPOC, however, are significantly less likely to utilize psychotherapeutic services (Office of the Surgeon General et al., 2001). Disparities in mental health outcomes and utilization of care tools are multifaceted and cannot be merely attributed to factors such as socioeconomic position. This research aims to investigate the role that intracommunity attitudes and perceptions of therapeutic cultural insensitivity play, if at all, in explaining disparity in service utilization.

Communities, in contrast to groups, are social units characterized by the shared commonalities of its members, including culture, values and identity, often, but not necessarily sharing a common geographic location (World Health Organization, 1998). The definition of community is contested, and health promotion research frequently defines community based on spatial delineations; however, the above conceptualization was intentionally chosen because it centers psychosocial ties, and acknowledges that, although interrelated, the characteristics of communities defined by their psychological and relational experiences do not necessarily align with those of communities defined by geography (Chappell et al., 2006). Thus, this study defines intracommunity attitudes as the dominant preconceived notions and beliefs held by members within specific BIPOC

communities, placing particular emphasis on personal relationships (i.e., family and friends).

Understanding racism as a determinant of health, the relevance and urgency of this issue cannot be understated. In 2020, the world witnessed the pervasiveness of police brutality against Black people and significant racial differences in disease outcomes in the midst of a global pandemic (Gelaye et al., 2020), and so racism was highlighted as not only a social justice issue but a public health issue (APHA, 2021). Following these events, the American Psychological Association (APA) released an official apology for its racist history, including subjecting BIPOC to abusive treatments, denying treatment, and establishing racialized theories to justify oppression; the organization also acknowledged how this continues to affect BIPOC mental health outcomes and service utilization today (APA, 2021). Moreover, the current and historical disenfranchisement of people of color in health contexts has thus left significant gaps in research and knowledge regarding BIPOC populations. Achieving justice and equity in the psychotherapeutic field necessitates research that specifically addresses the differing needs of racial and ethnic minorities.

Racial disparities in mental health service access and utilization have been well-documented in numerical data (CDC, 2013; McGuire & Miranda, 2008), but there is a lack of qualitative research on how and why these disparities are perpetuated, and more specifically, how structural barriers intersect with intracommunity transgenerational attitudes towards mental health and illness. Qualitative research aims to interpret social phenomena through the experiences of individuals and, although not capable of drawing causal relationships, is able to englobe plurality and capture the nuance of people's

unique perspectives in a way that quantitative research cannot (Mays & Pope, 2000). Qualitative research is central to shifting outdated Eurocentric theoretical frameworks in psychology to better serve society and its diverse populations, and thus, as further discussed in later sections, the present study utilized a qualitative research design to gain phenomenological insight into BIPOC experiences and fill in the gaps in current knowledge.

The overarching goal of the present qualitative study was to better understand the psychological factors (attitudes, perceptions, and experiences) behind why BIPOC underutilize mental health (MH) services. Our findings hope to inform future studies on how the psychotherapeutic field can adapt to adequately serve communities of color, and thus reduce disparities in mental health outcomes and service utilization rates.

Literature Review

To understand disparities in mental health service utilization, we must understand that racism is the most fundamental cause of racial health inequities. Racism does not only refer to explicit acts of discrimination on the basis of race; it encompasses the implications and phenomena that follow the process of racialization, where societies assign hierarchical value to socially constructed racial groups and systematically oppress and disenfranchise the groups deemed inferior through unequal power, resource and opportunity distribution (Bonilla-Silva, 1997; Paradies, 2006; Williams et al., 2019). Racism occurs on internalized, interpersonal and systemic levels, and although racial discrimination is now unlawful, racism persists through mechanisms of institutional and systematic oppression (Wood & Patel, 2017).

Racism and Health Disparities

It has been well-established that persistent exposure to stressors leads to increased allostatic load and inflammation and worse overall health outcomes (Mariotti, 2015). People of color are systematically overexposed to a disproportionate number of stressors and pathogenic factors, including poverty, transgenerational trauma, internalized racism, environmental hazards, incarceration of loved ones, food deserts, and a lack of clean drinking water (Roberts et al., 2022; Williams & Mohammed, 2009). For example, despite the fact that most poor people in the US are White, it is poor BIPOC who are systematically concentrated in disadvantaged areas and regions which lack infrastructure for vertical mobility (Williams, 2012), with almost three-fourths of all Black and Latino children growing up in worse residential conditions than the poorest White children (Acevedo-Garcia et al., 2008). BIPOC individuals in the United States experience higher morbidity and earlier onset of chronic disease and disability, including diabetes, cancer, arthritis, hyperlipidemia, and hypertension (Lim et al., 2018; Williams, 2012). Moreover, chronic experiences of racism and discrimination have been shown to cause dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis, which in turn damages bodily systems, causing cognitive impairments, obesity, and disease in the immune and cardiovascular systems (Mays et al., 2007; Paradies et al., 2016),

Research shows that after accounting for factors like socioeconomic stress, racial differences in health outcomes remain, highlighting race-related stress as an independent cause (Phelan & Link, 2015). A recent study of stress weathering in African American women found that elevated physiological inflammation was a primary mediator between racial discrimination and quantity of chronic diseases and, interestingly, that health risk

behaviors such as heavy smoking were not major causes of disease among this demographic (Simons et al., 2021). In fact, the mere anticipation of discrimination and prejudice elicits significant physiological and psychological stress responses, and thus, for racial and ethnic minorities in a racially charged society enshrouded by stereotypes and prejudice, often forced to exist in a near-constant state of hypervigilance, uncertainty, and preparedness, both racial discrimination and its anticipation can account for racial disparities in health outcomes (Sawyer et al., 2012).

Systematic Undertreatment of Mental Illness

Strong associations have been shown between racism and poor mental health outcomes, putting BIPOC individuals at a higher likelihood of developing affective, psychotic, and mood disorders (Paradies et al., 2015). Racial trauma also causes symptoms of anxiety, depression, complex trauma, and PTSD (Cénat, 2022). Although BIPOC are at higher risk for developing a mental disorder, they are also less likely than White people to utilize mental health services (Lu et al., 2021). Therefore, mental illness often goes untreated in BIPOC communities, exacerbating the above-mentioned racism-related poor mental health outcomes. In other words, because systematic racism creates barriers to seeking and accessing treatment, it is not only a determinant of mental health, but also a perpetuating factor.

Mental illness continues to be undertreated among the US population, particularly among African Americans, who seek mental health treatment half as frequently as White people (Buser, 2009). People of color utilize mental health services with lower frequency and have significantly lower treatment adherence rates, citing mistrust and lack of communication as principal causes of early treatment termination (Sue et al., 1994).

Barriers to access are at the center of disparities in service utilization rates. Studies show that the main barriers BIPOC encounter in seeking help for mental illness include lack of information regarding how or where to seek treatment, experiencing poverty, being underinsured, and living in care deserts where there is no nearby access to healthcare (Lu et al., 2021). Moreover, people of color often report negative encounters with healthcare providers. This includes negative perceptions such as not being taken seriously, feeling pathologized, and experiencing cultural insensitivity and racism from providers, commonly in the form of microaggressions (Sue et al., 2007). BIPOC, and in particular Black patients, are significantly less likely to be treated for the same illness than their White counterparts (Green et al., 2007), and Black patients are systematically undertreated for pain (Hoffman et al., 2016). Provider implicit bias is associated with worse communication and poor clinical decision-making (Cooper et al., 2012).

Attitudinal and Experiential Barriers

Beyond the aforementioned structural barriers to accessing mental health treatment, there often exist overarching attitudinal cultural barriers towards psychotherapy and mental illness in BIPOC communities that determine people's likelihood to seek treatment. Firstly, culturally specific constructs of illness can affect how people judge or perceive their symptoms. In other words, what is seen as abnormal behavior varies from culture to culture, with different baseline levels of stress, anger, or depression (Gureje et al., 2020; Memon et al., 2016). Moreover, mental illness stigma determines help-seeking behavior; in communities or cultures where mental illness is considered taboo or associated with negative attitudes, people are more likely to conceal their symptoms and avoid seeking help (Conner et al., 2009; Carpenter-Song et al., 2010).

Stigma can manifest through past negative experiences of discrimination or prejudice, the anticipation of future discrimination, or the internalization of societal scripts and stereotypes (Fox et al., 2018). Social circles can also act as attitudinal barriers to entry to seeking professional help, as many BIPOC individuals show a preference towards seeking help from family and friends; otherwise said, they primarily rely on their close-knit community for aid in distressing times (Nelson, 2006). In these cases, due to mistrust in existing healthcare systems, visiting a healthcare provider (HCP) is considered a last resort option (Schwartz et al., 2010). Finally, Black communities in the UK have been found to associate the concept of mental illness with involuntary psychiatric detention, and thus, fear also determines mental health help-seeking behavior and service utilization (Keating, 2004).

Legacy of Racism in Mental Healthcare

The acknowledgment of historical mistreatment is critical to understanding current mistrusting attitudes. Racism has shaped every aspect of American institutions, including healthcare and psychology. Psychiatric diagnosis was historically used to justify oppression and White supremacy. Early American psychiatrists coined and supported the diagnosis of disorders such as Drapetomania and Dysaethesia Aethiopica, which were solely used to categorize Black people's attempts to escape captivity or resist work as mental illnesses (Suite et al., 2007). Moreover, the 1840 US census fabricated data on insanity rates among Black Americans to falsely correlate living in Northern states with higher rates of mental illness (Suite et al., 2007).

This historical legacy is ever-present today, as BIPOC are over-diagnosed with mental illnesses such as psychosis and underdiagnosed with depression (Neighbors et al., 2003);

specifically, Latinos and African Americans are three to four times more likely than European-Americans to be diagnosed with schizophrenia (Schwartz & Blankenship, 2014). Moreover, identical psychological symptoms are deemed more severe in African Americans than in European Americans (Kutchins & Kirk, 1999). Mistrust is associated with ethnicity and experiences of discrimination; as aforementioned, certain Black populations fear mental health services and providers and specifically associate mental illness with involuntary psychiatric detention. This fear and mistrust can be partly traced back to the fact that Black people are significantly less likely to access traditional psychotherapy and instead receive treatment through criminal justice routes, often compulsorily, subject to solitary confinement and being disproportionately admitted to maximum security wards (UK Department of Health and Social Care, 2019).

Studies, however, show that for BIPOC, positive encounters with an HCP, where trust, communication, and responsiveness are present, lead to better diagnostic accuracy and treatment outcomes and also determine future health-seeking behaviors (Arday, 2018; Dowrick et al., 2009; Martin et al., 2013; Keating & Robertson, 2004). Thus, negative attitudes and perceptions may not be all-encompassing and can be shifted through positive experiences. Thus, taking into account the seeming value of positive healthcare experiences, when BIPOC do seek out psychotherapeutic help, provider cultural knowledge could have a mediating effect.

Psychotherapy and Cultural Competence

The APA defines psychotherapy as "a collaborative treatment based on the relationship between an individual and a psychologist. A psychologist provides a supportive environment that allows patients to talk openly with someone who is

objective, neutral, and nonjudgmental" (APA, 2022). It aims to heal psychological distress by identifying and modifying distressing feelings, thoughts, and behaviors (Evans, 2013; Strong & Matross, 1973). This definition stresses the importance of the therapeutic alliance. As it currently stands, mental health providers are seldom trained on how to address issues relating to race, perhaps due to the values of Whiteness inherent to the current paradigms of the psychotherapeutic field (Wood & Patel, 2019). The urgency of ensuring therapists and mental healthcare providers are prepared to treat the differing needs of BIPOC patients is emphasized by studies that show Black people report racist experiences so often that distressing emotions stemming from racism are one of the most common issues presented by Black patients in psychotherapeutic sessions (Klonoff et al., 1999). Cultural competency training has been proposed and begun to be implemented as a way to equip psychotherapists with a multicultural perspective that better serves racially diverse populations. The term cultural competence refers to a person's capacity to respect, understand, and interact with culturally differing attitudes, beliefs, and values, in short, being able to effectively work cross-culturally (Nair & Adetayo, 2019). Although research on this topic is very limited, studies show that therapist cultural competence has a moderate positive effect on treatment outcomes, adherence, and satisfaction (Griner & Smith, 2016).

Nevertheless, it is important to highlight that culture is not a monolith, and thus to term the diverse experiences of all non-White populations "culture" as a uniform singularity in juxtaposition to the Eurocentric is reductive and prejudicial and perpetuates notions of Whiteness as the norm (Weinrach & Thomas, 2002). Moreover, oppression is not the same thing as culture; perhaps that is where "cultural" psychology falls short

(Wilcox, 2022). BIPOC who seek psychotherapeutic treatment need an HCP who respects their cultural backgrounds and belief systems, but also understands how chronic racist experiences impact their health as well as their ability to thrive and feel safe. Otherwise said, therapists must not only be equipped to understand cultural differences but also treat and heal race-related trauma specifically. Without holistic perspective and competency, unintentional racist microaggressions in psychotherapeutic contexts run the risk of re-traumatization for BIPOC patients by mimicking larger societal dynamics, making a therapy session feel unsafe for the BIPOC patient, and causing further distressing emotions (Pascoe & Smart Richman, 2009). This begs the nuanced question of how we can make cross-racial client-therapist pairings become safe spaces and how current efforts towards establishing cultural competency in the psychotherapeutic field can be expanded to encompass not only understandings of cultural background but also comprehension of the formation and implications of race-related stress and trauma, and how to treat it specifically.

The question of cross-racial pairings is particularly relevant, given that there is a notable lack of BIPOC in the psychology workforce (Roberts et al., 2020). According to the APA, only 16% of the field is non-White (APA, 2022). Moreover, studies show that research by BIPOC psychology academics is less likely to be published or be awarded NIH grants (Ginther et al., 2011). Previous research has explored the question of whether there is a benefit to racial matching in therapy and found that BIPOC clients strongly prefer to have a therapist of the same race, and those who do have better treatment outcomes and adherence (Ziguras et al., 2003; Cabral & Smith, 2011; Traylor et al., 2010). This perhaps could be related again to the topic of mistrust towards providers in

the BIPOC community. Thus, the imperativeness of making the field of psychology more diverse is clear. However, simultaneously, we speculate that these preferences are largely determined by internalized stigma and negative past experiences with White therapists and healthcare providers. If psychotherapy could become more culturally informed and intelligent and Eurocentric paradigms shifted, would these tendencies still be as present? Understanding racism as more than a personal affliction, a product of the social construction of race and racial domination, embedded structurally and institutionally across society, we believe that to effectively meet the needs of BIPOC individuals and communities, antiracist and cultural competency interventions in mental healthcare contexts necessitate long-term educational initiatives that encompass and address not only culture, race, and racism, but also the construction of race and the systems through which discrimination continues to be upheld (Hamed et al., 2022).

Current research highlights disparities in mental health service utilization and mental health outcomes for BIPOC. However, this literature review revealed a lack of existing qualitative research into the determinants of BIPOC mental health service utilization. Furthermore, most psychological research was conducted by, on, and for Western, educated, industrialized, rich, and democratic (WEIRD) people (Henrich et al., 2010); thus, current theoretical frameworks are oriented towards WEIRD populations and inherently comprise a Eurocentric evidence base (Wood & Patel, 2017). In fact, little research has been done evaluating the effectiveness of evidenced-based and empirically supported treatment methods on ethnic minorities (Constantine et al., 2008), which begs whether "gold-standard" treatments are equally effective for BIPOC populations and whether cultural competence alone could be enough to ameliorate the racism embedded

in psychotherapeutic infrastructure and research. Reducing racial disparities in mental health service utilization rates requires dismantling the institutions that systematically uphold inequities (Williams, 1997). Finally, there is a lack of research concerning the effects that cultural competency interventions have on quality of care, and further research is needed to identify the most effective antiracist culturally sensitive intervention methods (Rice & Harris, 2021).

Methods

Purpose

The research question for this study was to understand the role of attitudes, perceptions, and experiences on psychotherapeutic treatment-seeking tendencies in BIPOC communities, with specific attention to the role that negative experiences with culturally insensitive providers plays. This aim was achieved through the means of the following objectives: to explore and describe the intracommunity attitudes towards mental illness and mental health services that exist in BIPOC communities; to explore and describe the experiences of BIPOC individuals in mental healthcare contexts, specifically psychotherapy, and to suggest how cultural competency may be further implemented in psychotherapeutic contexts to better serve members of ethnic and racial minorities. We considered that interpretative phenomenological analysis would show stigma, negative experiences, and cultural insensitivity as primary causes of mental health service underutilization. Consequently, we proposed that interventions aimed at reducing intracommunity BIPOC mental health stigma, and interventions aimed at increasing cultural competency among mental health providers, are crucial to increasing the utilization of mental health services among the BIPOC community. Experiences and

concerns shared by participants hope to inform future studies building toward culturally sensitive solutions.

Theoretical Frameworks

Addressing research questions that target social phenomena requires careful selection of theoretical frameworks and paradigms upon which to base the investigation. In this section we present the a priori knowledge to the study to ensure self-understanding in the research process and allow readers to adequately assess the transferability of our findings (Frechette et al., 2020). Thus, the present study takes a phronetic approach to qualitative research, seeking to investigate the nature of the problem of psychotherapeutic hesitancy in BIPOC populations and outline possible suggestions for change while acknowledging that the historical roots of the phenomena being studied underlie and precede the behaviors and motivations of individuals and that there is no single version of events or universal solution (Flyvbjerg, 2001). This guiding philosophy of this research involves constructivist/interpretive paradigms, informed by the theoretical framework of its philosophical correlates: phenomenology, hermeneutics and idiography.

Phenomenology is a philosophical current first articulated by Husserl that studies human experience and the way consciousness perceives things, otherwise said, how people create, attribute and sustain meaning (Creswell, 2003; Giorgi, 2008). It rejects the naturalism and positivist subject-object dualism and instead argues that what is experienced and how it is experienced are inextricable. Things only enter our reality upon perceiving them, and our perception is relative to the position of the perceiver. Thus, phenomenological methods involve understanding a person's lived experience and how they relate to the event.

Moreover, hermeneutics is the philosophy of interpretation, and thus in research refers to the interpretative process of understanding phenomena through language (communicative texts), seeking to explore the meaning embedded in experiences. Interpretative (hermeneutic) phenomenology was developed by Heidegger as an extension of hermeneutics. In contrast to Husserlian frameworks, which are descriptive and ask researchers to suspend their preconceived notions about the phenomena, often through bracketing; interpretative phenomenology, according to Heideggerian frameworks, asserts that humans are embedded in their world, context, and temporality, and researchers are self-interpreting, and thus, views shared knowledge and experiences as central to the interpretation and understanding of a phenomenon (Polifroni & Welch, 1998). Heidegger (1962) refers to the "hermeneutic circle" as the harmonic and circular relationship between the parts and the whole; the interpretation and contextualization; the interpreter's way of being and the being revealed in language.

Furthermore, interpretative phenomenology requires researchers to perform a double hermeneutic interpretation as a process of intersubjective meaning-making, to gain insider-perspective, reflecting on how they themselves interpret subjects' interpretations (Smith et al., 2009). Interpretative phenomenology allows the researcher to delve into the complex and nuanced lived experiences of the target population through the contextual systems and structures in which they exist and the meaning they assign to said experiences. The approach is unique in that it seeks to ensure that readers empathetically understand the lived experiences of study participants (Shaw, 2001). Finally, idiography involves in-depth analysis of individual experience in the context in which it occurs, shifting researcher focus away from the universal, and emphasizing

instead the particular, studying each case on its own and illustrating an authentic understanding of participants' individual experience (Pietkiewicz & Smith, 2014).

Methodology Rationale

Congruent with the theoretical framework of interpretative (hermeneutic) phenomenology, we believed interpretative phenomenological analysis (IPA) was the best suited and most credible methodology for the intended purposes of this research. IPA is a qualitative thematic approach developed by Smith (1996) in the field of health psychology as a method capable of exploring idiographic subjective social experiences, particularly in the health professions. As a participant-oriented approach (Smith et al., 2009), it allowed us to understand the ways that intracommunity negative perceptions and attitudes towards psychotherapy are shaped and perpetuated in BIPOC populations and inform mental health services through direct responses of the participants who lived this experience. Moreover, based on their experiences, these voices also provided direct strategies on how to best adapt to better serve racial minority communities and increase service utilization.

Sample

The IPA methodology requires sample homogeneity and small sample sizes to ensure the study has idiographic character. It is considered crucial that each individual is personally familiar with the phenomenon under investigation, chiefly, by means of lived experience (Creswell, 2013). Homogeneity allows for richer and deeper understanding, by offering multiple accounts and perceptions of the same phenomenon. It allows the researcher, in hermeneutic tradition, to understand how people make sense of their experiences and consequently how that affects their identity and behavior. Therefore, in

line with the idiographic focus of IPA, the methodology does not necessitate data saturation for sampling. This study used a purposive sampling method to identify eligible participants. Individuals who consented to participate in this study were (a) based in the United States, (b) identified as Black, Indigenous, or a Person of Color (BIPOC), (c) at least 18 years of age, and (d) had participated in at least one session of individual counseling/therapy. Thus, our sample was homogenous in that all participants identified as people of color living in the United States and had experience with individual psychotherapy at some point in their lives. IPA does not delineate a concrete sample size, and instead suggests sample size should be small and contextual, depending on the scope and depth of the study (Smith et al, 2009). Commitment to idiography is what distinguishes IPA from other forms of thematic analysis and qualitative research, and thus, when it comes to samples, less is more (Reid et al., 2005). Depth of analysis should always be prioritized. For this reason, in line with the current body of literature (Conroy & de Visser, 2015; Motta & Larkin, 2023; Noon, 2018; Yardley, 2000), our sample was limited to five participants. Participants were purposefully recruited through social media channels (Instagram), where flyers advertising the study were posted and circulated (Appendix C).

Table 1
Participant Demographics

Pseudonym	Age	Gender	Race/Ethnicity	Highest level of Education
Alyssa	25	Woman	Black, Afro-Latina	Graduate Degree
Brianna	33	Woman	Black	Bachelor's degree
Ciara	32	Woman	Black	Bachelor's degree
Deja	28	Woman	Black & White	Bachelor's degree
Eden	36	Woman	Black & Hispanic	Graduate degree

Data Collection

After being recruited, participants signed the informed consent form. At a scheduled date and time, each participant met with the researcher over a videoconferencing platform. Prior to starting the interview, participants completed an intake survey regarding age, ethnicity, and prior experience as a psychotherapy patient to confirm eligibility. The survey also asked questions about location, education and income with the purpose of collecting demographic information. Once eligibility was confirmed and verbal consent was reiterated, the researcher conducted semi-structured interviews lasting 60 minutes maximum. The researcher started with warm-up questions to establish rapport and ensure that participants felt safe sharing their experiences. We contend that conducting interviews virtually fostered openness and a safe atmosphere for participants, given that they could meet with the researcher wherever they felt most comfortable, rather than in an unfamiliar location. Interview prompts consisted of questions regarding home and intracommunity attitudes towards psychotherapy and personal experiences with psychotherapy (Appendix A). As a semi-structured interview, researchers followed a carefully crafted schedule of open-ended questions, but probes were asked and varied according to the participants' responses to enable a more in-depth directed conversation. This allowed for free-flowing conversation, where participants could speak freely about their lived experiences and the meaning they ascribed to them. At the conclusion of the interview, participants were thanked for their participation, asked if they had any other questions and reminded that they would receive a copy of the preliminary data analysis to revise if desired to ensure that their experiences had been authentically reflected.

Interviews were audio-recorded through secure software, with the participants' consent, for transcription purposes.

Data Analysis

Interviews were automatically transcribed verbatim by a secure videoconferencing platform in compliance with IRB privacy policies, and then researchers listened to the recordings and manually edited the transcriptions, correcting any errors. All identifying information was removed from the transcripts and participants were given pseudonyms. After this process was complete, recordings were deleted.

Data collected from participants' interviews was coded according to the six-step guidelines of IPA set forth by Smith et al. (2009). Researchers re-read and annotated the transcripts to gain familiarity with the material. For each case, notes were made on the margins and included interpretative analysis of participants' experiences and narratives, focusing also on their use of language and the implicit meaning it might convey. These notes were broken down and coded into heuristic units. These emergent themes were then grouped into common themes, which were defined and named. This entire process was repeated for each participant. Once all the data was coded, peer-debriefing occurred, and themes were agreed upon by the researcher and supervisory team.

Table 2

Six Steps of IPA	Analytic Process
Step one	Reading and re-reading
Step two	Initial noting (descriptive, linguistic and conceptual comments)
Step three	Developing emergent themes
Step four	Searching for connections across emergent themes
Step five	Move to the next case
Step six	Look for patterns across cases

Researcher Reflexivity

This phenomenological qualitative research study relies on a constructivist paradigm, emphasizing the multiplicity of human experiences, in which realities are collected and articulated through the researcher's interpretation. To remain objective, one must be cognizant of their subjectivities; positionality exists in the space between as a way to bridge the gap between subjectivity and objectivity and refers to the position where one exists in relationship to the "other" (Freire, 2000; Merriam et al., 2001). Thus, prior to presenting the study's findings, I, as the author, deem it necessary to acknowledge the ontological and axiological paradigms and lens through which I view and process information and how it might, to an extent, influence this study. I recognize my standpoint as a US-born, woman of Black and Hispanic descent, and native speaker of English and Spanish. Relevantly, I, the researcher, also have experience as a client in psychotherapy. Sharing this lived experience, allowed me to better make sense of the participants as they made sense of their own experience. I offer my findings as one possible explanation for the observed realities. I have witnessed the ways that ethnic and cultural backgrounds shape attitudes toward mental health and the ways that mental healthcare services have been ill-equipped to serve BIPOC populations. Thus, this research seeks to contribute to ensuring racial justice and equity in mental healthcare contexts. I believe my experiences as a BIPOC, and consequent insider perspective, aided in establishing trust and rapport to enable open conversation and ultimately enabled the pursuit of nuanced insight into the unique experiences of other BIPOC regarding their perceptions of mental illness and psychotherapeutic care.

Rigor

Four main criteria establish rigor in qualitative research: credibility, transferability, confirmability, and dependability (Anfara, Mangione, & Brown, 2002; Carnevale, 2002). To ensure the trustworthiness of the results of this study, we took the following measures described here. The first author provided a positionality statement and continuously practiced reflexivity, taking note of any feelings, biases, and insights that may arise during interviews. Moreover, this study used peer debriefing, whereby the collected and analyzed data was checked by and compared with the supervisory team. We also provided a thorough description of the phenomena being studied, using quotes, anecdotes, and examples to highlight themes in our findings. Participants' own words were included in the final research through the inclusion of quotes. To further ensure credibility, and counteract any researcher bias, we used member checking (respondent validation), allowing participants to check whether the data analysis authentically reflected their accounts and experiences. The researcher established rapport and trust with participants before commencing the interviews, and regularly expressed empathy and support throughout interviews. Furthermore, participants were recruited using purposeful sampling, and in-depth demographic data was collected. Finally, we documented how and why each step of the data collection process was performed in detail.

Ethical Considerations

This study was submitted to the Institutional Review Board for ethics approval and was granted permission to be conducted. We gained signed informed consent forms (Appendix B) from all participants, including consent to be recorded, and participants were repeatedly made aware that their participation was voluntary, and they had the right

to withdraw from the study at any given time. Participants remained anonymous, and all identifying information was removed from the report. Pseudonyms were assigned to the sample.

Findings

As aforementioned, the research question for this study is to understand the role of attitudes, perceptions, and experiences on psychotherapeutic treatment-seeking tendencies in BIPOC communities, with specific attention to the role that negative experiences with culturally insensitive providers plays. Five salient themes emerged from the interviews reflecting participants' experiences as they relate to our research question (see Table 3).

Table 3
Themes and subthemes

Superordinate Themes	Subthemes
Pray it away	
Isolated and invisible	Personal Isolation Intracommunity Isolation Isolation in Therapy Isolation from Access Issues
Fear	Stigma: "They must be losing their mind" Institutional Racism: Locked up Privacy
Perceived importance of racial matching	Inherent cultural understanding Shared Language Perceived Hardship
Therapeutic experiences profoundly impact treatment-seeking	Cultural incompetence Cultural competence

Theme 1: Pray it away

This theme was at the root of participants' family and community's explicit attitudes and narratives towards mental illness and healthcare. Across the sample,

devotion to higher powers created taboos and strict rules around healthcare seeking. Although belonging to different cultural backgrounds and having different spiritual upbringings, participants emphasized the way that mental illness had always been considered a spiritual affliction whenever psychological struggles arose in their communities.

Despite clearly seeing people in their family struggle, it was never acknowledged as mental illness. Regarding a possible childhood ADHD diagnosis suggested by her teachers, Ciara, a Black woman in her early thirties who grew up immersed in a Senegambian community in the Midwest, recalled hearing her parents say: "in Africa we don't believe in that." Similarly, Eden, a Black Hispanic woman in her mid-thirties from Northern California, said that in her home, "depression, mental health was very much not real." The use of the words "real" and "believe" convey a juxtaposition between religion and mental healthcare, suggesting that intracommunity beliefs hold that professional help stands in opposition or defiance to religious devotion. Participants considered this a huge point of contention in their communities. Alyssa, who is an Afro-Latina woman in her mid-twenties who grew up in a large Latino-American community in Southern California, powerfully illustrates this reality with her account:

> I feel like psychology and religion have always been at war with each other. I think I saw that with my family and members of my community, that felt so strongly about their religion. God was their go to, or religion was their go to. They would just say things, like, "leave it in the hands of God, and he'll take care of it." Rather than seeking therapy or external help. One, it was seen as taboo, and two, we have God so why do we have to seek someone else.

As a consequence of this apparent zero-sum game, the women expressed feeling powerless to speak up about or even care for their personal struggles because those around them held that the power to change or improve their situation belonged only to God. Religious taboos forced silence, even between community members, as mental health was considered something between an individual and higher powers, nobody else. They were constantly told to "*pray it away*, and talk to God, he'll make you better," in the words of Ciara. Praying is considered to be a fix-all for issues relating to mental health. In times of struggle, one must ask God for help. Brianna, a Black woman from New York, also in her early thirties, delineated that in her Jamaican-American community it was believed that healing from mental health, as a spiritual affliction or attack coming from outside you, could only be achieved through prayer and ritual, not through therapy. When mental illness more than once led to tragic loss of life in the communities or families of these women, it was believed that the deceased must not have been praying hard enough, and thus succumbed to weakness (possession by evils). Eden candidly opened up about how this deeply impacted her family:

> I grew up in a very religious household, so you just had to pray. "You're not praying hard enough. You're not fasting enough. That's why you're experiencing those things. Just ask God to take it away." My mom definitely had some mental health issues, but never dealt with them because, you know, we're in church and we just got to pray about it. I actually lost 2 brothers to suicide. My dad dealt with it, like, "oh, well, they couldn't handle life, and they're not strong enough" type of thing.

These testimonies suggest that tragedies like these are not instigators of change; they did not shed light on intracommunity issues nor inspire anyone to seek professional help. In other words, mental health outcomes did not mediate the effect of devotion to prayer on treatment-seeking behavior. Witnessing an overreliance on religious devotion and under-reliance on healthcare professionals, participants felt sorrow and frustration. They felt like there must be another way than prayer on its own.

Theme 2: Isolated and Invisible

Personal Isolation

Being unable to speak up about mental health and forced to struggle in silence, with religious devotion as their only tool, participants frequently expressed feeling isolated and invisible, left to figure it all out on their own. Their environment (families and communities) rejected any mention of mental illness or professional help and were deeply uncomfortable with it. It was said that no one could see their pain or suffering, and they never felt like they could ask for help in difficult times. Ciara shared:

> I remember a few years ago my mom was like: "Oh sometimes you're just so anxious. I would just walk away from you because it was too much." So, at times when I thought nobody could tell [I was struggling], I think they just thought it was me being extra. Like they didn't know what to do with it. So, you just don't say anything.

Ciara's frustration was two-fold because she not only felt like she couldn't ask for help, but she also felt like her loved ones couldn't even see her struggling. The story

highlights how Ciara was made to feel isolated and invisible, because those around her actively chose to ignore and thus invalidate her struggles due to their own discomfort.

Intracommunity Isolation from the Outside

Communities relied on religion, other community members and/or substance abuse to cope with mental health struggles, so they were entirely isolated from the outside world. Again, Ciara emphasized the way that mental health was an "us versus them issue" in her community. When American teachers suggested seeking help, they were met with "no, no, no. They don't know better. We don't have that where we're from." Her family rejected the imposition of western values and medicine onto their children. Moreover, all participants expressed that no one in their community had ever sought therapy, and thus, they felt like therapy wasn't something for them, instead it was something for "rich White women," as it was depicted in media. So, there was a stark disparity in their perception of who therapy was made for. Deja, a biracial Black woman in her late twenties said:

> Not a lot of people in or of my background, or that I would say, racially or culturally identify with me, went to therapy at all. I went to a predominantly White school and so a lot of my friends in that circle, all went to therapy. I would say that none of my friends of color, at all, went to therapy.

Moreover, narratives suggested that those communities who did share some of their struggles with each other, weren't any more likely to seek help than those who never spoke of their issues. Alyssa spoke of how her immediate family was open about mental health and her larger community relied on each other in difficult times, though they considered mental health a taboo topic, yet she never saw anyone seek professional help,

nor did she feel comfortable seeking help herself. Perhaps then, reliance on community acts as another barrier to seeking treatment, in a similar way that religion does. Perhaps implicit biases might contradict explicit attitudes, and largely determine help seeking tendencies. In this way, communities isolated themselves.

This perhaps begs the question of whether a given community's conceptualization of a normal emotional state determines help seeking behavior. Deja remarked that "I feel like we're so used to plight as minorities." To what extent might this suggest that the trauma associated with being an ethnic minority breeds hyper-independence and isolation, evaluating high levels of stress and anxiety as normal and perhaps inevitable? People of color, like Deja, have always had to be strong and find ways to overcome adversity alone, so in that hyper-independence and self-reliance it can be hard to ask for help.

Brianna said: "all the women in my family have had one period of a clear distinct mental breakdown. So, we all know that it's hereditary to struggle. (…) Because of the history, we talk about it to an extent because we're all scared of it and know that we all struggle with it, but we don't necessarily know how to support each other with it. Therapy is not a thing in my family." The narrative suggests a level of normalization and feelings of inevitability, and perhaps most importantly, an intracommunity struggle experienced in isolation. Participants' families struggled with alcohol, drugs, food and TV addictions to try and cope with the isolation and hopelessness they feel. Professional help isn't seen as an option, so self-medication is seen over and over. All but one participant said their communities struggled heavily with addiction, which further

isolated them and took the lives of loved ones, worsening their communities' overall mental health.

Isolation in Therapy

The isolation theme extended into the therapeutic context. Several participants expressed feeling deeply misunderstood and invisible when working with White therapists. They reported that their therapists often lacked an understanding of the cultural and racial contexts that shaped their experiences – a reality that was particularly harsh when they were seeking therapeutic treatment for racism and race related trauma. This led to a sense of fragmentation, where they felt their therapists didn't see them as whole individuals. Consequently, participants expressed a strong desire for therapy with therapists from similar racial or ethnic backgrounds, believing that only a BIPOC therapist could truly understand and address their unique struggles, and lift them out of their isolation. We elaborate on these issues in the fourth and fifth themes.

Isolation from Access Issues

Finally, participants felt deeply isolated in their mental health struggles because they simply could not access the help they needed. This was due to extended wait times to see a therapist, an enormous lack of BIPOC therapists in the field, unfamiliarity with modalities, high cost of going to therapy, and an overall lack of resources. Brianna expressed with frustration: "I was paying, like, 1600 dollars' worth of therapy every month, for a couple of months. I was like damn that's rent! I was like, we're going to take a break on healing and then we'll start up again later. I think most of the people I know who are not going into [therapy] is because of the cost." Similarly, Deja said that it was incredibly disheartening to look for a BIPOC therapist and see that they were either not

accepting new clients, there was a 6 month wait or they didn't accept her insurance. "When you're at a breaking point, it's not fun to be let down" she said.

Eden talked about the fact that it's a risk try a White therapist who might or might not be culturally competent – a risk that not everyone is able to take.

> Even though I continued and was like, okay, well, I just, I guess I'll just find a White therapist, I do think I got really lucky, because I have heard these horror stories from other people. I'm sure other Black people would have stopped their search. Like, "there's no Black people available, so I guess it's not meant to be." And not everybody is going to give a White person a chance. So, I do think that there's a need for more people of color in the fields. And especially if they're not accepting new clients, it means that they're full.

This highlights the frustration and isolation that comes from finally being open to seeking help, despite having cards stacked against your favor, and not finding anyone that can help you.

Theme 3: Fear

<u>Fear of Stigma: "They must be losing their mind"</u>

In BIPOC communities there is a lot of fear surrounding the concept of mental health, rooted in a multitude of perceptions and experiences. One fear was related to being seen as ill, and consequently being stigmatized. This was largely expressed through narrative accounts of personal and family struggles. For instance, Alyssa shared:

> I remember even hearing that often, oh, "estás loca" or "that person's crazy" or like, in order for the, to go seek out a psychologist, they must be losing their mind. Right? All that stigma that surrounded mental health growing up didn't

allow for a lot of my relatives that needed and should have received help, it prohibited them from doing that because of stigma.

This stigmatized vision of mental health fosters an environment of fear. Individuals fear being stigmatized by their community, seen as mentally ill or "losing their mind." Thus, despite prevalent mental health struggles, individuals entirely avoid seeking professional help. In other words, the fear of stigmatization profoundly determined treatment-seeking behaviors.

Interestingly, Alyssa enthusiastically talked about the fact that her mom had an undergraduate degree in psychology, and thus her immediate family had always been open about mental health. Alyssa was taught that it's important to take care of your mental health and that "seeing a psychologist or seeing a therapist isn't, for crazies only, or at all." Alyssa said openness was something that she clearly appreciated about her household. However, she later emphasized that "no one to this day" has ever sought help in her family or community, despite seeing a lot of mental health issues growing up. This begs the question of where the disconnect lies between explicit attitudes towards mental health and treatment-seeking behavior. On the surface, one might assume that anyone who speaks positively about mental health would be significantly inclined to seek help, but this account illustrates the ways that intracommunity attitudes may be internalized and act as barriers to accessing treatment. Perhaps thus a fear of stigmatization in their community was more of a determinant than the narrative account initially suggests. In this way, cultural stigma can transform into self-stigma. In the member-checking process, Alyssa clarified:

> I think her seeking professional help maybe would've elicited a sense of shame about being an alcoholic that she wasn't prepared to actually face/accept? Maybe her denial/lack of acceptance made it too difficult for her to seek help, thus, causing her to succumb to the stigmas surrounding seeking help.

Her story highlights how nuanced and multifaceted these experiences can be. Treatment-seeking behavior isn't determined by mutually exclusive factors, the themes discussed in these findings occur in conjunction with each other. Sometimes they create cognitive dissonances like these. One might value mental health but simultaneously fear being perceived as mentally ill and stigmatized. Both realities can be true, as they don't necessarily negate each other. Fear and isolation make it incredibly hard to seek help, no matter the valence of one's beliefs.

Fear of Institutional Racism

Participants also told stories of their families and friends being afraid of being "locked up" in psychiatric institutions. In a country with such a long legacy of institutional racism, including in medicine, they feared that showing vulnerability regarding their mental health might put them in danger. Brianna said:

> I think there was a lot of fear [surrounding mental illness], because growing up we all heard whispers on my grandpa's side. All of his sister's ended up in, my family will refer to it as, the crazy house, in Jamaica, they all got sent there. (…) It sounded like "you're gonna get locked away if you don't get it together."

This narrative highlighted the generational trauma that is present in so many BIPOC, and more specifically, Black communities. The stories about her great aunts

transpired in the early 20th century, however, the fear of mental healthcare, indubitably has been inherited through generations.

Moreover, Deja said that an Asian American friend of hers shared that her cousin had been immediately sent to a mental health facility when she went to a therapist and spoke about not feeling well. The fear of getting "locked away" was actively preventing her friend from seeking help herself. There is a power inherent to being a mental healthcare provider, particularly a White one, and thus, when the power to involuntarily commit a person to a mental health institution is combined with the privilege and power of White people in society, institutionalization is ultimately experienced as an expression of structural racism and oppression. Ciara explicitly discussed how she felt the legacy of racism in medicine affected her community's attitude toward mental healthcare: "If you're dealing with [medical racism] constantly for decades and now people are like "oh, what about your brain?" It feels like somebody's trying to manipulate or get into your psyche." These narratives illustrate the way that that people of color, and more specifically Black people, have been harmed by institutional racism and how it fostered a distrust in healthcare, to the point that they entirely avoid seeking professional help.

Privacy:

Privacy is considered vital and is a cultural tradition for many communities. It could be argued that this need for privacy is an extension of the fears discussed in this theme. On one hand, the fear of being stigmatized and scrutinized by others in your community, being considered weak or not sufficiently devoted demanded privacy. On a larger scale, fear of being "locked up" or mistreated by White or western healthcare

professionals also demanded that individuals keep their struggles private. Ciara was very clear about how seriously her environment expected privacy:

> I feel like there's that shame of you not saying that you're okay, which is funny for a community that is always with each other, so it's like, we have that warmth, but then there's that sense of being guarded too, with people who are supposed to be super close to you. (…) People just kept it to themselves, and then you would hear somebody died of suicide of someone's going through it. It took a big situation for it to be talked about, but it seems like everybody just kept it to themselves and compartmentalized it.

Her family fears what others might think if anyone were to be perceived as unwell, and thus they feel the need to keep up appearances at all times. Ciara talks about how deeply important her community is to her, and how everybody is very close to each other and spends a lot of time together. However, that "warmth" doesn't translate to openness, as the term might suggest. They support each other when someone is struggling, without ever acknowledging mental illness in and of itself. In cases like Ciara and Eden's, community members didn't even share their experiences with each other, nothing was ever said out loud, because privacy was of the utmost importance.

Moreover, in other cases, the need for privacy stems from a fear of religious persecution. Eden's family felt that they needed to be incredibly private at all times, because if not they would be persecuted for their Christian beliefs. Any outside influence on the family's status quo was an attack:

> In church we were taught that we're persecuted, you know, people are out to get us. So, if we reach out for help, then CPS could come to our door and now we're

being persecuted. It's not like, “Hey, you're doing something wrong. You're abusing your children.” It’s like: “We’re being attacked by the enemy right now.” It was very much like “It's our household and God, and that's all that gets to know about anything.”

Professional help is seen as a threat to the family’s authority and judgment, and thus, they believe that absolute privacy will ensure them safety. This relates to the themes of religion, isolation and fear as principal determinants of help avoidance. Devotion to religion isolates the family, and fosters an environment of fear, for which only privacy can offer protection. Her family perceived that asking for help would put them in danger. Moreover, healthcare professionals are very explicitly referred to as the “enemy,” like a villainous figure that will take your children and threaten your wellbeing.

Ultimately, participants express needing support, but not knowing how to get it. They chronicle the struggle of trying to strike a balance between support and privacy, keeping up family image.

Theme 4: Perceived Importance of Racial Matching

Largely in response to these fears, and a need for safety in the therapeutic context, all participants stated that they explicitly searched for a BIPOC therapist. That was the most important quality they were looking for in a therapist. As aforementioned, they all felt that a White therapist wouldn’t understand them and wouldn’t be able to validate their experiences in the way they needed. And so, they considered it of utmost importance that they find a BIPOC therapist who could help them navigate their mental health struggles. This theme was underscored by three main desires, as explored in the following subthemes.

Inherent Cultural Understanding

Firstly, all five women repeatedly asserted that they necessitated a cultural connection or bond with their therapists. They believed this bond would allow them to feel safe in the psychotherapeutic context and ameliorate many of their earlier discussed fears. They expressed a desire for cultural behaviors to go without saying or disclaiming. They didn't want to explain their belief systems or cultural practices. "I feel like, if I told [a White person], some of the stuff that I know my family does, they'd be like: are you guys like, you know, witches? And it's like, no, that's just Jamaican culture." Like other participants, Brianna feels frustrated at the prospect of not being understood in the therapeutic context, in a society that already misunderstands and stigmatizes her heritage. She later commented on her experience with her (Black) therapist:

> I don't have to over explain myself with her. I think there's also a lot of unspoken things when it comes to culturally being a woman of color that I think she's going to get. I think she's lived a similar experience. She's able to like match what I'm saying, like, am I being crazy or is this my reality, you know? And I think without having the position of living that experience, it is really hard for you to give someone objective understanding. Well maybe not objective, I'm sure it has some bias to it, but she can give an understanding from that same seat that I'm at, which I think is important.

Even if they didn't share the exact same background, participants felt that a BIPOC therapist would understand what it meant to live as an ethnic minority and thus, would be able to read between the lines in a way that they felt a White therapist simply couldn't, at least not without immense amounts of education and commitment.

> Being Black and African American in this world and in this country, like, there are things and nuances that, I don't think a White, a White woman, or man could offer. Maybe they could offer sympathies (…) but it's like I don't want to explain things to someone. I shouldn't have to explain why colorism is bad. If I'm like, now teaching you or, like, having to deal with White guilt while I'm supposed to be healing, like. Now, I'm doing your job in a way, and I don't want to have to worry about that.

It's important for Ciara, as well as all other participants, to feel like she doesn't have to teach cultural difference and anti-racist theory to her therapist, particularly not when she's the one paying. The participants believe these things should go without saying, but because of a frequent lack of education on the part of White therapists, the responsibility to educate them seems to fall on BIPOC clients. If they're not educated, participants feel like they inevitably have to explain so they can be understood.

Shared Language

Similarly, having shared language with your therapist is something the participants expressed a desire for. Whether that means having a therapist who speaks your native language or is familiar with English dialects such as African American Vernacular English (AAVE), they felt it was vital for therapists to understand their mannerisms, expressions and vocabulary without having to "code switch" or translate. Having shared language helps patients feel much closer to their therapists. After all, language tells stories about who we are and where we come from. Alyssa was born and raised in California but has always spoken Spanish with her family and community.

Thus, although she considered seeing a Black woman therapist, she prioritized seeing a Latina who could speak Spanish, because it's where she feels most at home:

> Being Latina, being able to speak to her in Spanish, there's just certain phrases or certain things, that come more naturally to me in Spanish. Being able to understand and speak the same language back is so comforting. It's almost nurturing for me and so I think that has made like, a huge impact on my sensation of feeling like, safe, protected, like, she actually cares.

Breaking free of the aforementioned isolation and fear, finding a therapeutic space where she can feel protected and nurtured has played a huge role in her healing journey. Thus, both cultural connection and shared language are powerful tools. Ciara expressed a similar sentiment, emphasizing how being able to speak casually was a vital component in allowing her to feel comfortable in therapy and let her walls come down:

> You have to worry less about like, code switching too, and you can say or use AAVE, like, or use colloquialisms and not feel like you have to explain that too, because they get it. And then that kind of like façade drops, when you're like, "ugh, girl, blah, blah, blah." It's like, okay, they get it. And that makes me comfortable.

This is a reality that is not often discussed. It's not only a question of sharing a language, but also sharing a way of speaking and communicating. For Ciara, a Black therapist is the only one who could provide that.

<u>Perceived Hardship</u>

It was expressed by the participants that they needed a therapist who had experienced struggle or hardship. They believed someone who came from privilege

couldn’t possibly understand what it’s like to be them, to be oppressed in society. And thus, they wouldn’t have the tools necessary to help them process that trauma and that pain, specific to being an ethnic minority. Eden talked about what she was looking for when she began her search for a therapist:

> I just felt that for somebody to understand my experience, they needed to look like me. I thought that somebody who experienced no hardship or, had everything handed to them that they wouldn't understand.

In the same vein, in the therapeutic context, self-disclosure from fellow BIPOC therapists was highly appreciated. Hearing about their therapists’ hardships helped them feel more normal and less alone in their struggles. It could be argued that they were looking for empathy rather than sympathy. Alyssa expressed the following about her Latina therapist:

> She was very affirming and reassuring because I didn't feel like I was experiencing that alone, or I was like, the only one going through that. So, she was very much so able to empathize and understand and also be vulnerable enough to share her own experiences too, that allowed me to feel like again I wasn’t alone.

This links back to the theme of isolation. The participants desperately wanted to feel seen in the therapeutic context, in ways that they hadn’t felt in their homes and communities. The way many of them felt seen was through speaking to therapists with similar experiences and feeling a sense of community with them.

Theme 5: Therapeutic experiences profoundly impact treatment-seeking

Cultural Incompetence: *I would be shocked if she ever had a patient of color*

Participants shared their experiences with psychotherapy. Generally, experiences with White therapists were unhelpful at best and traumatizing at worst. Three participants had BIPOC therapists, and two participants had a White therapist. However, some of the individuals with BIPOC therapists had also at some point had a session or more with a White therapist.

Individuals voiced concerns that White therapists weren't culturally competent and weren't educated on issues pertaining to BIPOC people at all. They also clearly had a lack of exposure to BIPOC populations that impacted their ability to help non-White patients. Deja has had two therapists, both White, and strongly believes that her mental health outcomes were negatively impacted by her therapist's race, and more specifically, by their lack of cultural competence. Regarding her first therapist, she said:

> I might not have even done 2 sessions, but I went in and like, sat down and started to explain and just broke down. And I just remember her looking like, just there was just no way that she had ever, ever spoken to anybody about this. Like, I would be shocked if she had ever had a patient of color.

This statement is so impactful because it illustrates the reiterated isolation experienced by participants, even in the therapeutic context. Her therapist was so unaware that the client left feeling like her therapist must have never "ever, ever" discussed racism, especially not with a person of color, in her entire career. When asked if she felt like her therapist made an effort to be informed, she lamented:

> I don't think that she thought about it, before, or after our sessions. I think for her to fully grasp that, that's like, not something that you can just understand, I guess. You would have to do some background research. I don't think that that's something that she felt the need to do.

She later said she wished that therapists would be more cognizant of how their lack of education affects the care they're able to provide, but that she "truly feels it's something they're completely oblivious to." Ciara expressed a similar sentiment:

> I didn't feel she was like, trying to understand me and when I did bring like, of course, anxiety, general anxiety and sometimes the depression I feel… I was also, like, of course these last few years, especially as a Black woman. It's crazy. And I felt like at that point, like, she didn't know to say, kind of thing and I'm like, well, we might have sessions where [racism] is kind of what we talk about.

This experience highlights an overwhelming willing ignorance on the part of these therapists. BIPOC patients often have to overcome countless barriers to accessing treatment, and thus, to finally seek help and be met with complete ignorance is deeply traumatizing; the silence is invalidating. Deja herself said that her negative experiences made her much less inclined to start a search again for a new therapist.

Participants also expressed that therapists make assumptions about them as BIPOC clients and seem to struggle to understand why said patients feel uncomfortable in the therapeutic space. Deja was frustrated about the fact that her therapist had made huge assumptions about her life, assuming that she was "married to a wealth White man" without ever bothering to ask. The assumption was so ludicrous that she didn't feel

comfortable correcting her therapist. It seemed that her therapist had a clear vision of who Deja was in her mind, clearly influenced by her very White environment.

Ultimately, Deja and Ciara felt their White therapists weren't at all committed to understanding or learning. They didn't make any efforts to be more educated. They didn't ask questions or show any growth or even interest in learning more. And finally, they were shocked that their patients didn't want to see them anymore. Throughout the negative experiences shared with White therapists, it was said that race felt like an elephant in the room. Some therapists didn't address it at all and ignored it. Some therapists said they were holding space but were not effectively creating a safe space or making clients feel held or valid. And others handled it poorly, making it an uncomfortable experience for both parties. They simply weren't equipped to tackle the issue.

All participants asserted that White therapists must approach cross-racial therapy with extreme humility and commitment to understanding. It's not something that comes easy or can be figured out with a few google searches or even a single course. It's a long-term commitment to deconstructing White supremacist notions and learning anti-racist theory, as well as learning to understand differences in verbal and non-verbal cues across cultures. Brianna perfectly summed up this theme with the following:

> Therapy can be a helpful tool if you're with the right person, the right therapist, if you're with a therapist that understands you and your background, when you're from, I think it can be damaging if they don't. I think, White therapists have to be honest and sometimes say: "you know what? I don't know if I got that" or "I'm not committed to understanding this experience." If you are, that's amazing. I

think I would encourage White therapists to challenge themselves to be committed to understanding the Black experience enough to be able to provide them therapy. But that takes a lot of work! You've got to learn a whole 'nother world that most have not been exposed to or understand.

It makes it clear how whether your therapist is BIPOC or not, if your therapist isn't committed to understanding you holistically, therapy can do more harm than good and traumatize BIPOC patients.

Impact of Cultural Competence

Most importantly, the quality of one's experience in therapy was shown to have an enormous effect of treatment-seeking tendencies. Those who had had a negative experience with a White therapist were mistrusting and did not want to try again, whether in general or with another White therapist. However, seeing friends have positive experiences made them have hope.

It's also worth mentioning that a sole participant, Eden, said that she had had a positive experience with a White therapist. She emphasized how this therapeutic experience changed her life. Although seeing a White therapist was her last resort, in a moment of desperation, she attributed her positive experience to the fact that her therapist was "very aware of her privilege" and "extremely vocal about being an anti-racist ally" and made huge efforts to be informed and educated on issues that pertained to BIPOC populations, including updating her entire website to reflect these values. Eden felt like she could really talk about racism and police violence and how it was affecting her mental health with her therapist. She made her feel "normal." This positive experience had a huge impact on her attitudes toward mental health, treatment outcomes, and

treatment-seeking behavior. In fact, she talked about how her positive outcome motivated her to become a therapist herself and inspired her to put all her children in therapy at different points in their lives.

Alyssa shared a Latin background with her therapist and attributed her positive mental health outcomes largely to this fact. This scenario was interesting because it was an ethnic match, but not a racial match. Thus, we asked a probe seeking to explore whether her therapist was able to meet the challenge of holding space for her experiences specific to being a Black woman in addition to a Latina woman. Alyssa responded:

> I know she's not a Black woman, but I never felt like I was misunderstood. One thing I will say, I think this also plays a role in it too, is like something as simple as doing my hair, right? She knows my exact [wash and styling] process, not because she has similar hair but because she takes it upon herself to learn. She takes it upon herself to research and learn about different cultures.

This might initially suggest, as participants intuitively determined, that BIPOC are better equipped to work cross-racially because they already understand minority experience inherently. However, in the researcher's opinion, it importantly suggests that no matter one's background, explicit efforts must be made to educate oneself on cultures and experiences different than one's own. These cases highlight the power of cultural competency to deeply impact people's mental health outcomes. It also proves that cultural competence is an extremely feasible tool when one is committed to understanding. As exemplified by participants' experiences and narratives, the average White healthcare provider isn't adequately educated on cultural competency. Even the sole participant with a positive experience said she felt extremely lucky, and that her

experience was an outlier, because she had heard countless horror stories from other BIPOC people. Thus, they felt that to avoid a harmful encounter and be able to actually feel safe and supported in therapy, they had to seek out a BIPOC therapist.

Discussion

This study arose from a gap in current research regarding experiential accounts of intracommunity experiences with mental health and their effect on treatment-seeking behavior in BIPOC communities. Intracommunity attitudes and negative experiences with (mental) healthcare providers are often discussed by people of color on an anecdotal level, but the phenomenon hasn't been widely empirically studied, especially not as a determinant of treatment avoidance. We sought to investigate the role that intracommunity attitudes, perceptions and experiences play in determining BIPOC psychotherapeutic treatment-seeking behaviors. To achieve this, we conducted semi-structured interviews ranging between 40 and 60 minutes with five participants who were purposefully recruited through social media. All participants were Black women based in the United States who identified as BIPOC and had attended individual psychotherapy sessions. The qualitative methods employed in this study allowed us to gain detailed and nuanced insight into the experiences underlying racial disparities in psychotherapeutic treatment utilization rates, phenomenologically exploring how BIPOC individuals and communities make sense of mental health. Five superordinate themes were identified.

In the first theme, pray it away, participants felt that their spiritual upbringing was deeply tied to their cultural heritage. Research shows that both Black and Latino Americans demonstrate high religious involvement. 75% of Black Americans and 60% of Latino Americans indicate that religion is very important in their lives (Pew Research

Center, 2015). Religion exists not only as spiritual support but also as a cultural and social institution. For example, in Latino communities, religion has been found to facilitate the preservation of cultural identity and values and establishment of ethnic communities in the United States (Nguyen, 2020). Thus, it can be argued that spirituality is closely related to cultural identity, and thus plays a significant role in determining attitudes towards mental health, as it did for our participants.

Moreover, four of five participants emphasized the fact that, in their communities, mental illness was considered a spiritual affliction at its core and thus could only be healed through devotion to higher powers. This was a very frustrating reality for these participants, because it made mental healthcare and religion feel like a zero-sum game: the two simply could not co-exist in their homes. Mental health interventions inherently questioned the absolute powers of God. Seeking help meant questioning the will of what God intended for someone. This phenomenon has been observed in prior research and can be described as spiritual bypassing (Motiño et al., 2021). Spiritual bypassing occurs when individuals use religion dysfunctionally, as a coping mechanism to repress emotional and psychological distress (Masters, 2010). This is often accompanied by the magical thinking observed in our findings, that seemingly releases individuals from any personal responsibility or control over their well-being and instead waits for divine intervention (Picciotto & Fox, 2017). Furthermore, studies show that Black Americans frequently report that seeking mental healthcare implies a lack of religious devotion, and prayer is considered the most culturally accepted method to cope with mental health struggles (Conner et al., 2010). Other normative beliefs in Black communities reflected in this study and existing literature include the belief that depression is a crisis of faith and

BIPOC trust and believe in religion more than healthcare (Campbell & Long, 2014). There's a strong emphasis on the concept of "belief" throughout this theme. Participants repeatedly stated that their families didn't "believe" in therapy, thus framing psychotherapy as something "not real" that one shouldn't put their faith into. Faith should be directed towards God, in their eyes. Whenever one faces difficult times, the solution is to "pray it away." If the issue isn't solved, one must only pray harder, and never look to the outside for answers. Thus, the assertion that all can and must be prayed away, rooted in normative intracommunity beliefs was a primary determinant of treatment-seeking behavior in BIPOC communities.

In relation to needing to take all your problems to God, in theme 2, participants expressed feeling deeply isolated and invisible in their struggles. Their community's negative attitudes towards mental health meant that they had to struggle in silence. Because mental illness was considered "not real" in so many cases, individuals were constantly invalidated and even ignored, despite pleas for help. Another striking aspect of this theme is how said isolation also extended to their communities as a whole. Narratives illuminated how mental health was often framed as an "us versus them" issue, with Western values and medicine being rejected in favor of traditional community support systems. Normative beliefs about mental illness not being real, or something that only affects White people, contributed significantly to these feelings of isolation and avoidance of treatment-seeking. Research has shown that Black Americans often perceive mental illness as something that isn't meant to affect them, due to a historic lack of BIPOC representation in mental health research and practice (Njiwaji, 2012). Thus, this false notion causes BIPOC to deny or reject the value of mental health treatment

(Taylor & Kuo, 2019). They described relying on religion, fellow community members, or substance abuse as coping mechanisms for their mental health struggles, which effectively isolated them from the outside world. This resistance to external influence, while partly rooted in cultural preservation, seemed to contribute to the isolation experienced by our participants.

Access to mental health services emerged as a significant factor contributing to the isolation experienced by our participants. Extended wait times, a lack of BIPOC therapists, unfamiliarity with therapy modalities, high costs, and inadequate resources were reported as major obstacles to receiving the help they needed. The scarcity of BIPOC therapists compounded these difficulties, leaving many feeling abandoned by a system that failed to provide culturally competent care. The frustration of searching for a therapist who could relate to their experiences and the disappointment of encountering insurmountable barriers created a sense of isolation and desperation even when individuals were actively seeking help. This profound lack of BIPOC mental healthcare providers has been shown to negatively impact mental health treatment-seeking (Taylor & Kuo, 2019).

Furthermore, fear was a central component in determining treatment-seeking behavior, centering around intracommunity stigmatization and institutional/medical racism. In the case of the former, people feared being stigmatized, mostly within their own communities, for being mentally ill or seeking help. People didn't want to be seen as "losing their mind" or "crazy." Thus, being mentally ill came with an abundance of compounding struggles. Not only did people struggle with their symptoms, but also with the fear of being stigmatized and ostracized/isolated if they sought help or acknowledged

struggles as illness. Our sample consisted entirely of Black women, all of which expressed that no one in their communities had ever sought help. These findings align with research showing that Black Americans avoid seeking mental health treatment because they are highly concerned by the stigma associated with doing so (Ward et al., 2013). Moreover, Black Americans also frequently assert that having anxiety or depression would be seen as "crazy" in their communities, further stating that conversations about mental illness are not even acceptable between family members (Mental Health America, 2023). The participants' accounts mirrored this reality, showing how stigma and the fear of stigmatization was ever present when it came to mental health in BIPOC communities, and this stigma made it incredibly difficult for people to seek treatment. In fact, in some cases, fear of intracommunity stigmatization was more of a determinant of help seeking behavior than positive personal attitudes towards mental health. Thus, individuals who wish to seek treatment must confront countless barriers including shame a deep fear of being stigmatized by their community and the shame associated with that. Some participants believed their family members would have sought help and had better mental health outcomes if they hadn't been surrounded by stigma. The participants in this study all expressed being the first and only people in their families and communities to ever seek treatment, and only doing so when they were desperate and at a breaking point.

The other side of fear centered around medical racism and distrust. This theme reflects the long legacy of racism, embedded in healthcare infrastructure, in the US and other colonized lands in the American continent. One participant spoke of all her female relatives being "locked up" to insane asylums in Jamaica when they had a mental health

crisis. Towards the end of the 19th century, the British empire established asylums in Jamaica and legalized involuntary commitment and incarceration for the mentally ill (Hickling & Sorel, 2005). This was arguably experienced as an extension of slavery for descendants of enslaved Africans. Collis (1972) pointed to the extreme fear and avoidance that surrounded the issue of mental illness and the Lunatic Asylum in Jamaica. Thus, the fear of being institutionalized is rooted in very real events in history and has been inherited through generations. Presently, BIPOC are significantly more likely to be involuntarily committed to a mental health institution and diagnosed with a psychotic disorder (Shea et al., 2022). The inherent authority of mental healthcare providers, especially those who are White, becomes particularly significant when their ability to involuntarily commit someone to a mental health facility intersects with the societal privilege and influence of White individuals. In this context, institutionalization can be seen as a manifestation of structural racism and oppression.

Despite communities being close-knit and interconnected, participants said that privacy was highly regarded, as an extension of the aforementioned fears. To avoid bringing shame to oneself and family it was essential to stay quiet about issues pertaining to mental health. In some ways this could be a reflection of collectivist values that prioritize intragroup harmony, and thus, to disrupt privacy is to disrupt harmony and status quo. Privacy was a vital tool in avoiding fears becoming realized, being ostracized, stigmatized or even, institutionalized.

Tragically, the second leading cause of death among African American youth is suicide, being twice as likely as their White counterparts (Sheftall, 2023). The two participants who explicitly talked about seeing suicides in their family and community,

were also the two participants who said that their community members did not share their struggles with each other; in other words, they belonged to the most private communities of the sample. Thus, this might suggest, in line with previous research, that social support can be a protective factor and can decrease the likelihood of suicide (Kleinman & Liu, 2013). However, communities who did speak to each other, although not in mental health terms, experienced high rates of addiction and addiction related disease and death and were not any more likely to seek treatment. Suggesting that fear, particularly of stigma and mental healthcare, were significant deterrents. Social support can take many different forms, and only social support that directly addressed mental health issues affected treatment-seeking in this study. For our participants, that meant having friends who encouraged them to seek help or being exposed to affirming mental healthcare messaging on social media platforms.

To mitigate their fears participants all expressed that they had searched for a BIPOC therapist. They worried that a White therapist wouldn't be equipped to meet their needs, including validating their experiences and creating a safe space. When asked about what they searched for in a therapist, all participants solely spoke of race and ethnicity. These findings are particularly cogent in the context of our sample's demographics. People with stronger ties to Black identity and culture frequently place higher importance on racial matching (Ward, 2005). Thus, given that our sample consisted of five Black women who discussed strongly identifying with their Blackness, racial matching, logically, was a central theme throughout the interviews.

All participants discussed the importance of finding a therapist who mirrored themselves but did not significantly discuss the quality of their therapists. This aligns with research

showing that during a first psychotherapy session, Black clients primarily assessed their therapists' race, above any other quality or characteristic about them; upon confirming that their race matched their own, they assessed other characteristics about their providers (Ward, 2005). Furthermore, many studies show that racial matching in the psychotherapeutic context is linked to better treatment adherence, outcomes and patient satisfaction (Flicker et al., 2002; LaVeist & Nuru-Jeter, 2002).

When searching for a therapist, participants first and foremost sought inherent cultural understanding. They wanted to have a racial match because it would allow for cultural nuance to go unsaid and unexplained. In other words, they were tired of having to explain and translate their realities and were scared of being stigmatized by their own therapist. It was clear to them through experience and anecdote, that the average White therapist was not nearly culturally competent, and so the way to bypass that issue was to seek a BIPOC therapist, under the assumption that a person of color would inherently understand cultural nuance in a way that does not come naturally or easily to a White therapist. Participants didn't want to gamble on the cultural competence of a White therapist, particularly not when they were at a breaking point. Similarly, participants prioritized shared language, seeking to be understood on a literal level as well. Whether it was Spanish or AAVE, being able to speak their native language or in a way that was natural to them was vital. Lastly, perceived hardship was important. Participants believed that someone who didn't understand what it meant to struggle or experience hardship wouldn't be able to hold space for them. They deeply desired empathy, relatedness and kinship, above mere sympathy. However, BIPOC therapists are severely underrepresented, as approximately 83% of the US psychology work force is White

(Huff, 2021), and thus, participants struggled to find someone who met their needs. This profound lack of therapists who can provide culturally competent and humble care, and therapists with whom patients can share cultural, ethnic and linguistic bonds, distrust of mental health professionals is this way perpetuated in BIPOC communities (Nicolaidis et al., 2010).

The final theme related to the direct effect of cultural competence on treatment-seeking behavior. Our findings suggest, in line with previous research (Constantine, 2002), that perceived cultural competence or lack thereof played a primary role in determining patient satisfaction and future treatment-seeking behaviors. The sentiment expressed by participants was that therapy is only helpful and useful if your therapist understands your background. Thus, cultural competence was viewed as crucial to establishing a successful therapeutic alliance. More specifically, a lack thereof was believed to be damaging, doing more harm than good. Only a provider who displayed cultural competence and humility could effectively create the supportive environment, characteristic of the definition of psychotherapy, that allows for open and nonjudgmental exchange.

In their experiences with culturally insensitive therapists, participants reported feeling like their therapeutic relationship mirrored their outside realities, negatively. These therapists seemingly made no efforts to understand BIPOC patients or become informed on cultural issues possibly affecting these populations. They felt like their therapist had never had another BIPOC patient or ever discussed racism, and thus felt extremely alienated and foreign in a place (therapy) that was supposed to be safe and made for them. This is a significant finding that underscores the apparent willful

ignorance often displayed by healthcare providers in Western contexts. It is crucial to consider the implications of this discovery within the broader context of our study. As we have observed, BIPOC patients often face numerous hurdles when seeking access to treatment. Consequently, encountering such ignorance during this process can have long-lasting and deeply traumatizing effects on people's perception of mental healthcare and their future treatment-seeking behaviors.

Prior studies exploring the role of racial matching and multicultural competence have shown that a majority of BIPOC patients assert that White therapists, in their experience, have been unable to understand key cultural or racial aspects of their realities, and have thus avoided tackling issues of race entirely (Chang & Yoon, 2011). In populations of Black women, data shows that willingness to seek care is actually more significantly determined by prior experiences with mental healthcare than by stigma (Ward et al., 2013). These findings suggest that in no way is help seeking solely determined by intracommunity attitudes, beliefs and experiences, rather negative experiences with mental healthcare have a profound ripple effect that perpetuates fears and treatment avoidance in BIPOC populations.

In contrast, cultural competence allowed patients to feel like they could be their whole selves in this room, without needing to "translate" their realities. Further, it allowed patients to feel safe and nurtured, like they could finally be seen and understood, and their struggles mattered. At their core, participants wanted to feel like their therapist understood them. An effective strategy to meet this need, was self-disclosure. In the case of BIPOC therapists, it meant having your therapist disclose their own struggles and similar experiences, to validate those of the client. In the case of White therapists,

effective self-disclosure meant being self-aware of one's privilege and taking a strong stance against racism. Neutrality was to be avoided when discussing racism and oppression. Culturally incompetent therapists will often deflect questions about their beliefs and avoid taking a stance. Similarly, "colorblind" approaches also prevent therapists from understanding the experiences of BIPOC patients and severely minimize the issue of racism (Neville et al., 2013). This professed neutrality is experienced as invalidating and serves to reinforce the therapist/patient and White/minority power dynamic. Understanding this, we might reconsider the aforementioned APA definition of psychology, that portrayed therapists as "neutral" and witness how the language of the discipline reflects and upholds archaic Eurocentric standards of practice unsuited for diverse populations.

Furthermore, research shows that self-disclosing emotional reactions to clients' racist experiences is a powerful tool in bridging cross-racial therapeutic relationships (Burkard et al., 2006). Thus, beyond race, shared values were arguably an integral part of effective cross-racial therapeutic experience. This aligns with Atkinson and Thompson (1992), who observed that (shared) racial worldviews impacted the therapeutic process significantly more than race. Participants said that being able to discuss personal experiences with race and racism, as well as large-scale racist issues, including current events, positively impacted their satisfaction and treatment outcomes. These findings are in agreeance with studies showing that concerns about racial and cultural differences are ameliorated when therapists are compassionate and display willingness to discuss said differences (Arora et al., 2022). Moreover, open conversations about race and racial

differences foster feelings of safety and trust and largely contribute to building a strong therapeutic alliance (Owen et al., 2014).

Implications

There is no singular or monolithic BIPOC reality. Even in this homogenous sample, participants sought and valued different things in therapy. Some wanted a therapist who would be more confrontational, some wanted their therapist to be more open to the idea of medication, and others entirely rejected a therapist's suggestions that they might need medication. These experiences represent the multiplicity of BIPOC experiences. Therapists will never be one size fits all; every person is uniquely multifaceted, and commonality doesn't guarantee connection. However, ensuring that all therapists are equipped to meet the needs of racially diverse clients is the bare minimum. Current psychotherapeutic disciplines are based on Eurocentric frameworks, and thus, a majority of therapists are largely unequipped to serve marginalized BIPOC patients. Although different barriers to accessing treatment are unfortunately common across all racial demographics, White people in the United States aren't forced to reckon with the issue of racism and cultural insensitivity when searching for a therapist, and thus, are more likely to have the privilege of interviewing therapists to find one that best matches their personality and understands them as person. In contrast, BIPOC clients have long felt the need to find a therapist who closely mirrors themselves in order to feel safe; scared of experiencing dynamics with White therapists that mirror their racist experiences with White people in society. Given the lack of BIPOC therapists, many clients give up on their search and either abandon the idea of therapy or have to make it work with a culturally insensitive therapist that they don't feel safe with.

Racial matching should always be an option, and thus educational pipelines must be amended to increase representation of BIPOC in the psychotherapeutic field. However, cultural competence should be the baseline of care, not the holy grail. It should be a non-negotiable part of therapists' training and quality of care, rather than something exceptionally committed therapists opt into. This way, when BIPOC clients seek help, they can focus their energies onto the quality and character of their potential therapists; choosing a therapist from a place of curiosity rather than protection. Cultural competence is a journey, a plant that must be regularly watered. There is no single answer to what it should entail, but the results unequivocally suggest that cultural humility and commitment to learning are vital.

Limitations and Future Directions

The sample for this study was small and homogenous as is typical for an IPA study. The methodology does not necessitate data saturation for sampling, and thus, we acknowledge limited transferability of these results. We do not intend to portray these findings as universal or objective truths. Instead, these accounts offer insight into individual experiences with mental health in BIPOC communities. However, commonalities shown across interviews, reflected in the themes discussed, suggest that our sample had similar lived experiences, determined by their cultural and ethnic background. Our findings illustrate a rich and contextual understanding of participants' experience; however, we do not draw causal relationships and thus, future research might employ quantitative or mixed-methods with larger samples to investigate the correlation between the phenomena explored in this study.

We acknowledge that although reflexivity was practiced throughout this study, including through the use of a reflective journal, it is inevitable that the researcher's own attitudes might have influenced the accounts participants were willing to share. The researcher's attitudes might have also impacted data analysis, although member-checking and peer debriefing sought to mitigate this potential bias. We believe that the researcher sharing a similar ethnicity with the sample, positively impacted participants' feelings of safety and perceived researcher trustworthiness, allowing more in-depth conversation and proportioning insider perspective throughout data collection and analysis.

Sampling and self-selection bias may have contributed to our sample solely consisting of Black women, perhaps suggesting that this might be the demographic most deeply impacted by the phenomena described in this study. Given that all participants identified as Black women, we cannot know the extent to which these findings may or may not transfer to other BIPOC populations or even other genders. Future research may employ a larger and more diverse sample or within other ethnic groups, to provide a more comprehensive understanding of how intracommunity attitudes and experiences affect treatment-seeking tendencies, and the degree to which other BIPOC populations feel misunderstood in the therapeutic context and seek racial matches. Moreover, participants in this study either had a racial/ethnic match with their therapist or had a White therapist. We did not collect any data on non-White cross-racial therapeutic pairings; thus, future research might further explore the cultural competence skills of BIPOC therapists in the absence of a racial or ethnic match.

Our findings showed that participants struggled to find a BIPOC therapist, despite living in metropolitan areas in the United States. Participants emphasized the importance

of having more BIPOC professionals in the mental health field and education, as well as the importance of community mental healthcare and outreach. Thus, future research might also investigate the BIPOC educational pipeline and the dearth of BIPOC professionals in the psychology and psychotherapeutic fields. Perhaps most importantly, future research should work with patients and therapists to develop a more comprehensive and evidence-based framework of cultural competence.

In the communities across our sample, it was believed that mental illness was largely inevitable, due to heredity and the will of higher powers, and thus, not curable by healthcare professionals. Throughout the study it was implied that therapy was only for the most severe of mental illnesses. In fact, the participants, who were all the first to seek therapy in their communities, only did so when they felt they had no other option, facing severe depression and anxiety. This begs the question of how changing that perception of mental healthcare would change help-seeking behavior and positively shape generational dynamics. It was suggested that community mental health initiatives are vital to familiarizing marginalized communities with mental healthcare professionals. Diversifying the field and increasing cultural competence, could increase positive experiences with therapists and patient satisfaction. Consequently, this could have a ripple effect and allow normative beliefs about therapy and mental health in BIPOC communities to be slowly shifted, so therapy could begin to be seen as something "for everyone." Ultimately, increasing treatment-seeking behavior entails more than seeking care when one is ill, it also entails utilizing preventative services, addressing the issue before the symptom.

Finally, we must emphasize that this study was conducted in the United States, where mental healthcare is a privilege of the few, and access to resources is profoundly disparate. This study focused on attitudinal and experiential barriers to treatment-seeking without delving into other contextual factors such as socioeconomic status, but future studies might explore this phenomenon in countries with universal healthcare and measure the extent to which access to resources influences treatment-seeking relative to the barriers discussed in this study.

Conclusion

This research found that intracommunity attitudes and negative experiences with mental healthcare profoundly impact treatment-seeking in BIPOC populations. In terms of attitudinal barriers, lack of treatment-seeking behavior was determined by overreliance on religion for unhealthy coping, constructs of mental illness characterized by inevitability, pervasive feelings of isolation, and fear of stigma. With respect to experiential barriers, treatment avoidance was shaped by transgenerational trauma and fear of structural racism in healthcare, the inability to find a BIPOC provider, and lastly, adverse encounters with culturally insensitive therapists, which in turn perpetuated negative intracommunity attitudes. These findings emphasize the urgency of diversifying the field, as well as crafting and implementing cultural competence interventions to improve psychotherapeutic utilization rates and, consequently, mental health outcomes in BIPOC communities.

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Appendix A ***Interview Guide***

1- Introduction questions to establish rapport and gather contextual information:

   a. *Where are you from? Tell me a little about your family background. To what extent, if at all, does culture and ethnicity play a large role in your personal identity? How?*

2- Questions about intracommunity attitudes toward mental illness and therapy*:*

   a. *What were the perceptions of mental illness in your family/community?* (Provide definition of community)

      i. *While growing up, what were the narratives surrounding it?* (Seeking to evaluate to what extent these were dictated by negative lived experiences, intracommunity scripts and transgenerational trauma, mistrust towards healthcare providers, cultural values)

   b. *What are your personal feelings towards mental illness? To what extent do you think therapy is a good/helpful tool for mental health?*

   c. *Have you ever struggled with mental health, and if so, did you feel comfortable asking for help?*

   d. *While growing up, did the people around you ever seek help for mental health issues?*

      i. *If not, which was the preferred coping method?*

      ii. *If so, what was their attitude or what did you notice about what they said or how they responded to their experiences with mental health services?*

3- Questions about therapeutic experiences:

a. *Tell me a bit about your experience in therapy. What were some of the shining moments? What were some of the disappointments? How long did the therapeutic relationship last? To what extent do you think therapy is a helpful tool for mental health?*

b. *Was your therapist a person of color? Did you purposefully seek out a BIPOC therapist? If so, why? To what extent did their ethnicity play a role in your experience, if at all?*

c. *To what extent did your therapist understand and hold space for your experiences specific to being a BIPOC, if at all*?

d. *Tell me about your therapist's shortcomings. What are some specific ways that they were/came across as culturally or racially insensitive?* (Lack of education/exposure, microaggressions, overt prejudice…)

    1. *Do you feel that if your therapist had been more informed about other cultural backgrounds your experience would have been different? How so? How would that have made a difference?*

e. *What difference, if any, did your therapist's ethnicity/identity make in your overall mental health outcomes?*

4- Closing questions

a. *What do you think played the largest role in shaping your attitudes toward mental health? What about your community's attitudes?*

b. *In what ways could your therapist have better met your needs? How can therapists be better equipped to better treat BIPOC patients? What needs*

to change so that other people don't have experiences like yours in therapy?

c. *To what extent has your attitude towards mental health and therapy shifted due to your experience in therapy? In what ways? Is it more positive or negative now?*

d. *Would more positive experiences in therapy lead to widespread change in attitudes toward therapy in your community? How?*

e. *Do you have any other thoughts you have about (RQ) that I haven't asked that are important for me to know?*

Appendix B *Informed Consent*

TITLE OF STUDY: A Phenomenological Exploration of Intracommunity Attitudinal and Experiential Barriers to the Utilization of Psychotherapeutic Services in BIPOC Populations

INVESTIGATOR(S): Katherine M. Hertlein, Jade B. Turner For questions or concerns about the study, you may contact Jade Turner at turnej14@unlv.nevada.edu. For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted, contact the UNLV Office of Research Integrity – Human Subjects at 702-895-2794, toll free at 888-581-2794 or via email at IRB@unlv.edu.

Purpose of the Study
You are invited to participate in a research study. The purpose of this study is to explore the role of attitudes, perceptions, and experiences on mental health treatment-seeking tendencies in BIPOC communities.

Participants
You are being asked to participate in the study because you fit the following criteria: You are over the age of 18, identify as Black, Indigenous or other Person of Color (BIPOC), and have participated in at least one session of individual counseling/therapy.

Procedures
If you volunteer to participate in this study, you will be asked to do the following: answer some interview questions about your attitudes towards mental illness and experiences in psychotherapy. The interview is estimated to last no more than 60 minutes. The interview will be conducted over WebEx and will be audio-recorded, though participants may also choose to have the video on during the interview. In addition, you will be asked to complete a brief demographic survey prior to beginning the interview, which will take no longer that 5 minutes. Therefore, the total participation time is no more than 65 minutes.

Benefits of Participation
There may not be direct benefits to you as a participant in this study. However, we hope to gain insight into how attitudes and experiences in psychotherapy shape mental healthcare seeking tendencies in BIPOC populations.

Risks of Participation
There are risks involved in all research studies. This study may include only minimal risks. It is not likely that any harm will occur. If it does occur, it will likely be minimal and can be reversible through reframing some of the conversation or allowing the participant to terminate the interview at no consequence.

Cost /Compensation

There is no financial cost to you to participate in this study. You will not be compensated for your time.

Confidentiality
All information gathered in this study will be kept as confidential as possible. No reference will be made in written or oral materials that could link you to this study. Audio recordings will be immediately transcribed and deleted. Participants will be assigned pseudonyms and all identifying information will be removed from the report. Transcripts will be stored in a password protected UNLV online storage drive for 10 years after completion of the study. After the storage time the information gathered will be deleted.

Voluntary Participation
Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with UNLV. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Participant Consent: I have read the above information and agree to participate in this study. I have been able to ask questions about the research study. I am at least 18 years of age. A copy of this form has been given to me.

Appendix C *Recruitment Flyer*