Behavioral Health Professionals’ Perception of Anxiety Disorders Amongst African American Clients

Chantel K. Gant
University of New Orleans, ckgant@uno.edu

Follow this and additional works at: https://scholarworks.uno.edu/td

Part of the Counselor Education Commons, Other Mental and Social Health Commons, and the Student Counseling and Personnel Services Commons

Recommended Citation
Gant, Chantel K., "Behavioral Health Professionals' Perception of Anxiety Disorders Amongst African American Clients" (2024). University of New Orleans Theses and Dissertations. 3171.
https://scholarworks.uno.edu/td/3171

This Dissertation is protected by copyright and/or related rights. It has been brought to you by ScholarWorks@UNO with permission from the rights-holder(s). You are free to use this Dissertation in any way that is permitted by the copyright and related rights legislation that applies to your use. For other uses you need to obtain permission from the rights-holder(s) directly, unless additional rights are indicated by a Creative Commons license in the record and/or on the work itself.

This Dissertation has been accepted for inclusion in University of New Orleans Theses and Dissertations by an authorized administrator of ScholarWorks@UNO. For more information, please contact scholarworks@uno.edu.
Behavioral Health Professionals’ Perception of Anxiety Disorders Amongst African American Clients

A Dissertation

Submitted to the Graduate Faculty of the University of New Orleans in partial fulfilment of the requirements for the degree of

Doctor of Philosophy in Counselor Education

by

Chantel K. Gant

B.S., Xavier University of Louisiana, 2006

M. E.d., University of Georgia, 2008

May 2024
Copyright, 2024, Chantel K. Gant
Dedication

I dedicate this dissertation to my wonderful parents who have encouraged me since birth who provided me with guidance, support, love, and care and who have exemplified care for others. I dedicate this dissertation to the best grandfather in the world for being an example of a loving, smart, and caring man. Thank you to my uncle who was ecstatic to find out he would have a niece and has shown care for me. This dissertation is in honor of my witty and stylish maternal grandmother Carrie who passed away but always believed in her granddaughter and showed me endless love and to my paternal grandmother Mary who had a quiet spirit and intellect.
Acknowledgements

Thank you to God first for all you have blessed me with and for helping me to complete my dissertation journey. Thank you, God, for filling me with a passion for learning, reading, and caring for people. I thank you God for giving me a purpose where I plan to continue to encourage others.

I want to thank my ancestors who had to overcome from the 1700s in Vacherie, and Edgard, Louisiana where your memory and history are immeasurable. I love and am eternally grateful for my parents who have wanted the best for me and there are not enough pages to express how thankful I am for having you in my life. I would not have reached this point in my academic journey without my parent’s guidance, dedication, time and observation of how you help people and continue to help with sincerity. [Mom]: I am grateful for your compassion, kindness, daily inspiring words, and heart full of love. Thank you for sitting with me at the kitchen table in kindergarten where you would teach me after school and ensured that I would be prepared ahead of time for my course assignments. You have a gift for writing. [Dad]: Thank you for your consistent supportiveness, presence, and your willingness to get me anywhere I needed to go and for helping me early on with math. [Grandfather]: You are a true inspiration from building your physical home, lots of stories, and the fact that many people look up to you including myself for the man of character that you are. [Uncle]: Thank you for being supportive of me. [Grandmothers]: [Carrie]: You were my loving, fun-spirited grandmother with a distinct laugh, joy for cooking, stylishness, deep care for me and ability to use your voice. Grandmother [Mary]-Your quietness showed me that it is ok to sit, reflect, and observe and your smile will always be remembered.
Thank you to my dissertation committee. I want to thank my chair Dr. Belser for his willingness to work with me on this journey, his constant encouragement of us as graduate students, and thoroughness of our advanced theories course. I appreciated your balanced dissertation feedback that was considerate and encouraging as well as your feedback on anxiety assessments that helped me to expand that area of my literature review. Thank you, Dr. Jeffers, for the wonderful book and article recommendations that helped expand my methodological approach and theoretical framework in lieu of imperative cultural considerations. I appreciated your comprehensive research classes that allowed me to think about different research approaches. Thank you to Dr. Watson for addressing the ethnic identity frameworks, focusing on critical thinking with case consultations, feedback on recruitment and helping me to recognize that a peer debriefer would be important. Thank you to Dr. Mifsud for your continual thoughtfulness, encouragement, passion for the counseling field, regard for students, and exemplifying the qualities of effective supervision in doctoral supervision group.

I am grateful for my peer debriefer who was gracious to serve in the process as your feedback and thoughtfulness was key. It helped to have you as a peer debriefer to process how I was thinking about my research, reflecting, and conceptualizing particularly during the post-transcription and coding process.

I am appreciative of my two best friends who are smart, passionate, and ambitious women who will continue to make a positive impact.

I appreciate meeting different peers in the doctoral program in supervision group and courses and the helpful feedback. I appreciate the thoughtfulness and kindness of Brittney.

I am grateful for working as a counselor to advocate for and encourage clients whose life experiences and willingness to seek help is pivotal.
Last and not least, I am grateful for all the participants and esteemed behavioral health professionals who were willing to be a part of this research study. Each participant was an inspiration as their words, thoughtfulness, attention to care, regard for clients, passion for anxiety disorders and mental health helped this to be an enriching research process for me.
Table of Contents

List of Tables .................................................................................................................... xiii
Abstract ............................................................................................................................. xiv
Chapter 1 ............................................................................................................................. 1
   Introduction ...................................................................................................................... 1
      Overview of the Study .................................................................................................. 1
      Problem Statement ..................................................................................................... 4
      Purpose of the Study .................................................................................................. 11
      Significance of the Study ............................................................................................ 11
      Conceptual Frameworks .............................................................................................. 13
         Anxiety Model in African Americans ..................................................................... 13
         Black Feminist Thought .......................................................................................... 15
      Overview of Methods .................................................................................................. 17
      Research Questions ..................................................................................................... 18
      Positionality ................................................................................................................. 18
      Limitations and Delimitations .................................................................................... 19
      Assumptions of the Study .......................................................................................... 21
      Definition of Terms .................................................................................................... 21
Chapter 2 ........................................................................................................................... 28
   Literature Review .......................................................................................................... 28
      Occurrence of Anxiety Disorders in African Americans ........................................... 29
         Anxiety Disorders in African American Women ..................................................... 31
         Anxiety Disorders in African American Men ......................................................... 32
         Anxiety Disorders in African American College Students .................................... 33
      Anxiety Symptoms in African American Adults ...................................................... 34
      Contributing Factors to Anxiety Disorders in African Americans .......................... 35
         Discrimination ......................................................................................................... 35
         In-Group Bias ........................................................................................................... 39
         Cultural Factors ....................................................................................................... 39
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Influences</td>
<td>40</td>
</tr>
<tr>
<td>Environmental Factors</td>
<td>42</td>
</tr>
<tr>
<td>Notion of Strength in African American Women</td>
<td>43</td>
</tr>
<tr>
<td>Social Factors</td>
<td>44</td>
</tr>
<tr>
<td>Protective Factors for Anxiety and Anxiety Disorders in African Americans</td>
<td>45</td>
</tr>
<tr>
<td>Impact of Anxiety Disorders on African American Adults</td>
<td>46</td>
</tr>
<tr>
<td>Coping with Anxiety for African American Adults</td>
<td>48</td>
</tr>
<tr>
<td>Faith and Spirituality</td>
<td>48</td>
</tr>
<tr>
<td>Immediate Support Circle</td>
<td>50</td>
</tr>
<tr>
<td>African Americans’ Receptivity to Anxiety Disorder Treatment</td>
<td>51</td>
</tr>
<tr>
<td>Assessments of Anxiety Disorders in African American Adults</td>
<td>53</td>
</tr>
<tr>
<td>Anxiety Assessments</td>
<td>53</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder and Symptom Assessments</td>
<td>65</td>
</tr>
<tr>
<td>Assessments for Panic Disorder</td>
<td>69</td>
</tr>
<tr>
<td>Assessments for Social Anxiety Disorder</td>
<td>69</td>
</tr>
<tr>
<td>Assessments for Specific Phobia</td>
<td>72</td>
</tr>
<tr>
<td>Assessments for State-Trat Anxiety</td>
<td>73</td>
</tr>
<tr>
<td>Effectiveness of Treatment for African Americans with Anxiety Disorders</td>
<td>74</td>
</tr>
<tr>
<td>Treatment Issues for African Americans with Anxiety Disorders</td>
<td>76</td>
</tr>
<tr>
<td>Overlooking Anxiety Symptoms in African American Community</td>
<td>77</td>
</tr>
<tr>
<td>Health Professionals Perception of Treating African Americans with Anxiety Disorder</td>
<td>79</td>
</tr>
<tr>
<td>Summary</td>
<td>83</td>
</tr>
<tr>
<td>Chapter 3</td>
<td>85</td>
</tr>
<tr>
<td>Methodology</td>
<td>85</td>
</tr>
<tr>
<td>Research Questions</td>
<td>85</td>
</tr>
<tr>
<td>Rationale</td>
<td>86</td>
</tr>
<tr>
<td>Research Design</td>
<td>86</td>
</tr>
<tr>
<td>Hermeneutic Phenomenology</td>
<td>86</td>
</tr>
<tr>
<td>Sociogenic Phenomenology</td>
<td>90</td>
</tr>
<tr>
<td>Sample</td>
<td>91</td>
</tr>
<tr>
<td>Sample Size and Criteria</td>
<td>91</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>“Contributing Factors” to Anxiety Disorders for African Americans</td>
<td>135</td>
</tr>
<tr>
<td>African American Women, Responsibilities, and Anxiety Factors</td>
<td>135</td>
</tr>
<tr>
<td>Socioenvironmental Factors</td>
<td>135</td>
</tr>
<tr>
<td>Health/Counseling-Related Factors</td>
<td>137</td>
</tr>
<tr>
<td>“Surprises” vs. “No Surprises” Regarding Anxiety Disorder Presentation</td>
<td>151</td>
</tr>
<tr>
<td>Experiencing “No Surprises”</td>
<td>151</td>
</tr>
<tr>
<td>Experiencing “Surprise”</td>
<td>151</td>
</tr>
<tr>
<td>Pervasiveness of Anxiety for African Americans</td>
<td>153</td>
</tr>
<tr>
<td>Major Themes for Research Question Two</td>
<td>154</td>
</tr>
<tr>
<td>Comprehensive Preparation and Clinical Experiences</td>
<td>155</td>
</tr>
<tr>
<td>Levels of Readiness</td>
<td>155</td>
</tr>
<tr>
<td>Educational Experiences</td>
<td>158</td>
</tr>
<tr>
<td>Resources</td>
<td>163</td>
</tr>
<tr>
<td>Providing Presentations</td>
<td>165</td>
</tr>
<tr>
<td>Clinical Experiences/ “Nature of the Work that I Did”</td>
<td>166</td>
</tr>
<tr>
<td>“Do this Research”</td>
<td>171</td>
</tr>
<tr>
<td>Having Specific Mentors vs. Not Having Specific Mentors</td>
<td>171</td>
</tr>
<tr>
<td>Diagnostic Process</td>
<td>172</td>
</tr>
<tr>
<td>Utilizing Assessment</td>
<td>172</td>
</tr>
<tr>
<td>“Develop A Diagnosis”</td>
<td>174</td>
</tr>
<tr>
<td>Using the DSM and DSM-5</td>
<td>178</td>
</tr>
<tr>
<td>Life and Familial Experiences</td>
<td>179</td>
</tr>
<tr>
<td>Importance of Life and Familial Experiences</td>
<td>179</td>
</tr>
<tr>
<td>“Try to stay neutral”</td>
<td>183</td>
</tr>
<tr>
<td>“Feelings” vs. No Feelings Regarding Anxiety Diagnosis</td>
<td>184</td>
</tr>
<tr>
<td>No Feelings</td>
<td>184</td>
</tr>
<tr>
<td>Experiencing Challenging Emotions</td>
<td>184</td>
</tr>
<tr>
<td>Behavioral Health Professionals’ Perception of their Clients Reaction to Anxiety Diagnosis</td>
<td>185</td>
</tr>
<tr>
<td>“Stigma of Mental Health”/Negative Reaction</td>
<td>185</td>
</tr>
<tr>
<td>Receptivity to Diagnosis</td>
<td>188</td>
</tr>
</tbody>
</table>
List of Tables

Table 1 Participant Demographic Information.........................................................94
Table 2 Major Themes and Subthemes for Research Question 1...............................122
Table 3 Major Themes and Subthemes for Research Question 2...............................154
Abstract

Anxiety disorders are frequent and increasing across the United States including for ethnically diverse populations (Carter et al., 2012). There is a need for education in the community on anxiety disorders about indicators of anxiety, severity and therapeutic approaches that would be beneficial (Johnson & Coles, 2013). It is imperative to know the variation in anxiety for African Americans to aid in therapeutic resources and counseling designed for this population (Hopkins & Shook, 2017). Prior research includes more of a focus on behavioral health professionals’ perspectives in conjectural situations rather than actual clinical practice (Joy & Bartholomew, 2021; Lawrence et al., 2015). The purpose of my hermeneutical phenomenological study of nine behavioral health professionals was to gather the meaning of these professionals’ identification of anxiety disorder symptom presentation, diagnostic process, use of screenings and assessments and therapeutic lens regarding African American clients with anxiety disorders (Gadamer, 1975/2013; Heidegger, 1962/2013). The key focus of this study the interview approach to focus on the behavioral health professional’s perception of anxiety disorder presentation across socioeconomic status and gender and how their positionality influences their perception for African American clients. The results of this study have important implications for behavioral health professionals in general and at university and college counseling centers, for health and wellness outreach, and for curriculum and cultural considerations in behavioral health graduate programs. This research study will be instrumental for enhanced training on anxiety disorders for African Americans in diagnostic coursework, trainings, and for the overall provision of counseling.

Key Words: African American, Anxiety Disorders, Behavioral Health Professionals
Introduction

Overview of the Study

Anxiety disorder symptomatology for African Americans increased significantly weekly from 8.2% in June of 2019 to 35.8% in June of 2020 during the COVID-19 pandemic with continual increases (National Center for Health Statistics [NCHC] et al., 2020) & NCHC & (Centers for Disease Control and Prevention [CDC], 2020). 40% of African American college students and 36% of African American graduate students presented with a generalized anxiety disorder during the COVID-19 pandemic in a survey of nine public universities (Chirikov et al., 2020). 39% of Historically Black College & University (HBCU) students in a study of one HBCU with 83% African American college students and 8% Latino and Black college students experienced anxiety during the COVID-19 pandemic (Wang & Goodman, 2022). Before the COVID-19 pandemic, there were increases in anxiety disorders among African American populations, women, and adults in general (Jones et al., 2020; Lacey et al., 2015; Louie & Wheaton, 2018; Simning et al., 2011). In addition, there were increases in anxiety disorders among African American young adults (Himle et al., 2009). The ability of behavioral health professionals to grasp more about how anxiety disorders present and progress for African American young adults to older adults is a significant health imperative for behavioral health professionals (Carter et al., 1996; Himle et al., 2009; Hunter & Schmidt, 2010; Sibrava et al., 2013).

Increasingly, ethnically diverse populations in the United States (U.S.) are experiencing anxiety disorders (Carter et al., 2012). Anxiety disorders are a prevailing concern for African American and Caucasian populations in the U.S. (Himle et al., 2009). A comprehensive review of 114 articles found that anxiety was the second most prevalent health issue for African
American families (Ellis et al., 2020). LGBT-Q individuals within communities of color who receive a lack of acceptance from their social networks, face bias from their jobs, significant others, and people are more likely to experience anxiety (Sutter & Perrin, 2016). Anxiety disorders are frequent behavioral health diagnoses (Contreras et al., 2004; Hofmann & Hinton, 2014; Neal-Barnett & Crowther, 2000; Vanderminden & Esala, 2019). Frequently occurring mental health disorders outside of major depressive disorder are specific phobia at 15.6% and social phobia at 10.7% for individuals in the United States (Kessler et al., 2012). The most prevalent anxiety disorder diagnoses for African American women were specific and social phobia (Petrie et al., 2013). An anxiety disorder that often presents for African Americans is a particular phobia from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) referenced as a simple phobia in DSM-3-R (American Psychiatric Association [APA], 1987, 2013; Last & Perrin, 1993; Neal-Barnett & Crowther, 2000). Specific phobia includes a person taking steps to not engage with objects or circumstances that cause extreme tension connected to fears of nature, animals, situations, or blood work (APA, 2013; Chapman et al., 2015a). Specific phobia for African Americans presents social and animal-based apprehension connected to heights and water-related concerns (Chapman et al., 2008, 2011). Due to limited research, there is a need-to-know further information regarding specific phobias and African Americans (Hunter & Schmidt, 2010).

Anxiety disorders can be incredibly stressful (APA, 2013; Hofmann & Hinton, 2014; Vanderminden & Esala, 2019; Williams et al., 2013). Anxiety disorders can have a long duration and significantly impact individuals (Coles et al., 2014). Anxiety and anxiety disorders present in African Americans with physical symptoms (Gordon et al., 2015; Heurtin-Roberts et al., 1997; Hunter & Schmidt, 2010; Neal-Barnett et al., 2011a; Vanderminden & Esala, 2019). Specifically,
African Americans with anxiety disorders are more likely to have allergies and infections (Oh et al., 2022). In contrast, post-traumatic stress disorder (PTSD) in the prior study is not representative of anxiety diagnoses in the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) for the DSM-5 or the current DSM-5-TR (American Psychiatric Association, 2013, 2022; Oh et al., 2022). African Americans experience heightened symptoms when diagnosed with anxiety disorders that can lead to disability and fewer salary earnings (Moitra et al., 2014; Sibrava et al., 2013). There was variation between some African Americans in therapy for anxiety, having more chronic features, and some not having treatment interventions experiencing debilitating symptoms (Moitra et al., 2014; Sibrava et al., 2013; Vanderminden & Esala, 2019). Neal-Barnett (2003) highlights that anxiety takes a significant strain on Black women’s bodies, beliefs and feelings and can lead to alcohol use, binge drinking, and substance use. There is a need to explore how often anxiety disorders present for African Americans, considering the common occurrence across Americans (Brown et al., 1999; Himle et al., 2009; Neal & Turner, 1991; Sibrava et al., 2013; Williams et al., 2013). It is imperative to know more about the concept of fear with specific phobia and social phobia for African Americans (Petrie et al., 2013). It will help to understand the subtleties of anxiety disorders presentation for African Americans across “gender, age group, and socioeconomic status” from behavioral health professionals’ perspectives (Himle et al., 2009; Hunter & Schmidt, 2010, p. 230).

In this chapter, I focus on an overview of the research study to provide a context of the state of anxiety disorders in the United States, specifically for African Americans. First, I explored the problem statement regarding limited research on anxiety disorders among African American adult populations (Gordon et al., 2015; Hopkins & Shook, 2017; Hunter & Schmidt, 2010). Next, I focus on the purpose of the study in terms of adding to the absence of literature
that currently exists about anxiety disorders and African Americans. Next, I focus on how this study will add to the current knowledge on anxiety disorder presentation for African American adult clients that may benefit current graduate students in behavioral health and behavioral health professionals. Furthermore, there is a discussion of the applicability of A Sociocultural Model of Anxiety for African Americans in connection to the topic of study (Hunter & Schmidt, 2010). I have included the research questions and hermeneutic phenomenological approach utilized for the study (Gadamer, 1975/2013; Heidegger, 1962/2013). Finally, I included the study’s limitations regarding potential gaps in the research study, what is potentially missing from the analysis, and assumptions of the study in terms of potential gaps.

**Problem Statement**

The underrepresentation of African Americans in anxiety disorders research leads to researchers having difficulty in understanding how varied types of anxiety disorders may present differently amongst this population (Brown et al., 1999; Carter et al., 1996; Hopkins & Shook, 2017; Hunter & Schmidt, 2010; Mendoza et al., 2012; Moitra et al., 2014; Neal-Barnett & Crowther, 2000; Neal & Turner, 1991; Williams et al., 2013). The rationale for African Americans missing from anxiety disorder studies includes *cultural mistrust* (Hunter & Schmidt, 2010; Neal & Turner, 1991; Williams et al., 2013). Additional issues with African Americans in anxiety disorder studies are researcher indifference (Mendoza et al., 2012; Neal & Turner, 1991; Williams et al., 2013). Stigma is another factor in why African Americans potentially do not participate in research studies on anxiety (Hunter & Schmidt, 2010). Most research on African Americans and anxiety disorders focuses on panic disorder with agoraphobia and no other anxiety disorders (Carter et al., 1996; Hunter & Schmidt, 2010). However, there is research on panic disorders that focuses exclusively on White clients or does not even identify the client’s
race (Friedman et al., 1994). There are gaps in exploring variations across gender for different types of anxiety disorders (Brenes et al., 2008; Chapman et al., 2008). African American adults aged 50 and older are often not found in research on anxiety and worry (Conti et al., 2017). Most studies on African American college students and anxiety are of largely African American women with a few African American men in the studies (Lee et al., 2015; Manning et al., 2017; West et al., 2013). Issues include not knowing how often different anxiety disorders present in African American men due to this population not frequently appearing in the research literature (Chapman et al., 2011, 2012, 2015b; Durkee & Williams, 2015; Markell et al., 2014; Perkins et al., 2022). It is speculative whether African American men experience lower anxiety levels or heightened symptoms (Carter & Walker, 2014). The lack of African Americans in anxiety disorders research impacts behavioral health professionals identifying the specific symptoms for diagnosis and assessment that may look different than Caucasian American populations (Chapman et al., 2012; Himle et al., 2009; Hopkins & Shook, 2017). Specifically, the lack of information on African American women and anxiety disorders, despite being more likely to have anxiety disorders, has implications for the conceptualization of anxiety disorders for this group and interventions (Neal-Barnett & Crowther, 2000). All African American adults are not monolithic regarding anxiety (Lee et al., 2015).

There are some challenges with existing research on anxiety disorders and African American populations. There is no consensus regarding anxiety research for African Americans (Chapman et al., 2009). Significant issues with research data for African Americans and anxiety disorders include obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) in studies, whereas these diagnoses are no longer part of the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM-5 or the DSM-5-TR (American Psychiatric
Association (APA), 1994, 2013, 2022; Brown et al., 1999; Jackson et al., 2004; Jones et al.,
2020; Lacey et al., 2015, 2021; Simning et al., 2011). Additionally, research studies on anxiety
disorders and African Americans include PTSD as an anxiety disorder that is irrelevant for
anxiety disorder diagnoses in the DSM-5 or DSM-5-TR (APA, 2013, 2022; Hodge et al., 2022;
Hunt et al., 2013). Furthermore, when there is research on African Americans and anxiety
disorders, the study population is from outdated samples across research studies, namely Jackson
et al. 2004 National Survey of American Life (Assari et al., 2013; Bijou & Colen, 2022; Carden
et al., 2022; Himle et al., 2009; Hodge et al., 2022; Johnson-Lawrence et al., 2013; Jones et al.,
2020; Lacey et al., 2015, 2021; Levine et al., 2015; Mays et al., 2018; Mouzon et al., 2017; Oh et
al., 2017, 2021, 2022; Soto et al., 2011; Taylor et al., 2021). Further issues with the research
literature on anxiety and African Americans were that some studies focus on African Americans
in particular cities and states and not across the United States of America (Assari et al., 2018;
Augustine et al., 2022; Jonassaint et al., 2017; Wang & Goodman, 2022). Some research on
African Americans and their anxiety symptoms are on African Americans in the south and
Midwest from a 2005-2006 Family and Community Health Study of participants in Georgia and
Iowa (Carter et al., 2016). The central focus of anxiety and African American college and or
graduate students often highlights a single university population and not a diversity of
universities across research studies (Chapman & Woodruff-Borden, 2009; Donovan & West,
2015; Lee et al., 2015; Lindsey, 2014; Manning et al., 2017; Mounts et al., 2006; Salami &
Walker, 2014; Singleton et al., 2022; Wang & Goodman, 2022; Watson & Hunter, 2015; West et
al., 2013). Overall, anxiety disorder research with African Americans mostly has a central
location in the Midwest that is not reflective of all African American college students in the
United States (Chapman & Woodruff-Borden, 2009; Manning et al., 2017; Mounts et al., 2006;
Salami & Walker, 2014; Watson & Hunter, 2015). Other studies on African American college students and anxiety focus on universities in the southern region of the United States (Carter & Walker, 2014; Lee et al., 2015; Lindsey, 2014). Other studies highlight African American women college students in New England (Donovan & West, 2015). Concerns include assumptions that research on anxiety and African American college students at predominantly White institutions (PWI’s) apply to African American college students at Historically Black Colleges & Universities (HBCUs) (Chao et al., 2012; Cokley et al., 2013; Salami & Walker, 2014). Furthermore, research on discrimination and anxiety among Black Americans, primarily African Americans, are at PWIs, where they do not know their experiences with discrimination external to other universities (Perkins, 2022). There were only two studies on experiences of anxiety for African American college students at HBCUs (Singleton et al., 2022; Wang & Goodman, 2022). There are not enough healthcare professionals or researchers from communities of color in the research area of anxiety disorders (Carter et al., 2012). It will be helpful to have longitudinal studies focusing on the cognitive, emotional, or physical presentations of anxiety disorders in African Americans and their progression (Beidel et al., 1994; Sibrava et al., 2013; Weisberg et al., 2012).

African Americans face not having anxiety disorders diagnosed properly due to misconceptions about how anxiety symptoms present amongst this population, issues with behavioral health resources, and behavioral health professionals’ misdiagnosis of symptoms (Hunter & Schmidt, 2010; Last & Perrin, 1993; Stockdale et al., 2008; Vanderminden & Esala, 2019; Williams et al., 2013). Further issues include those studies on behavioral health and healthcare professionals’ perceptions of an anxiety disorder, including hypothetical examples and not the behavioral or healthcare professionals’ experiences with actual clients (Joy &
Bartholomew, 2021; Lawrence et al., 2015). Most of the behavioral health professionals who provided their perceptions of anxiety disorders were White (Joy & Bartholomew, 2021). Only seven percent of psychiatrists were Black, with 64% of White psychiatrists in one study focused on diagnosing clients with anxiety in hypothetical cases (Lawrence et al., 2015). Only twenty percent of African Americans were able to identify anxiety disorder symptoms demonstrating an apparent struggle to understand anxiety symptoms (Coles et al., 2014). African Americans with anxiety symptoms are less likely to seek treatment for possible reasons: including normalizing symptoms, *acculturation* to the majority culture, ignoring thoughts or feelings indicative of anxiety presentation, or no available treatment (Carter et al., 1996; Neal-Barnett & Crowther, 2000; Sibrava et al., 2013). Stigma impacts African Americans expressing their anxiety symptoms or meeting with health professionals (Hopkins & Shook, 2017; Hunter & Schmidt, 2010; Johnson et al., 2009). Stigma for African Americans regarding disclosing anxiety symptoms can lead to less diagnosis of generalized anxiety disorder and social anxiety disorder (Hunter & Schmidt, 2010). A reason for African Americans not being diagnosed with anxiety disorders includes their interpretation of physical indicators of anxiety as heart-related or other medical ailments, leading to not receiving counseling or medication management (Carter et al., 1996; Hunter & Schmidt, 2010). On the other hand, there is no certainty of African Americans’ perception of anxiety within their cultural group or support networks (Neal & Turner, 1991). There are several unanswered questions, including whether people can identify the symptoms of anxiety disorders, get treatment sooner, seek help from a clinician, or receive the proper diagnosis from a medical provider (Coles et al., 2014). Health professionals are likely to inaccurately diagnose African Americans with physical health or other psychiatric conditions when they have anxiety symptoms (Hunter & Schmidt, 2010; Vanderminden & Esala, 2019).
Researchers examined that African Americans are more likely to seek treatment for anxiety from medical professionals than behavioral health professionals (Brenes et al., 2008; Brown et al., 1999; Gordon et al., 2015; Lagomasino et al., 2011). A limitation is that researchers focused exclusively on generalized anxiety disorder (GAD) treatment for African Americans in medical settings with doctors and not in behavioral health settings (Brenes et al., 2008). There is no plausible explanation if anxiety diagnosis link to meeting with medical rather than behavioral health professionals.

Behavioral health professionals utilize anxiety assessments that fail to accurately assess the “culture” of African American Americans (Carter & Sbrocco, 2018, p. 180; Gordon et al., 2015; Johnson et al., 2007; Parkerson et al., 2015). Not many anxiety assessment tools have been studied amongst African Americans or have a theoretical basis for this community (Carter & Sbrocco, 2018). There is a need for diagnostic tools that provide the proper fit for anxiety disorder presentation in African Americans (Lee et al., 2015). Anxiety disorder assessments in the United States or often designated from a majority culture White lens and not for communities of color (Mendoza et al., 2012). The issues with several anxiety disorder assessments include if behavioral health professionals can utilize these assessments to measure anxiety precisely for African Americans (Johnson et al., 2007; West et al., 2013). The Anxiety Sensitivity Index (ASI; Reiss, Peterson, Gursky, & McNally, 1986) normed on Caucasian Americans (Hunter et al., 2012). Different assessments for social anxiety, like the Social Phobia Scale (SPS; Mattick & Clarke, 1998) and Social Anxiety Interaction Scale (SIAS; Mattick & Clarke, 1998), have not been utilized or normed enough for African American adults (Carter et al., 2014). There was no prior research to understand the specific aspects of the Beck Anxiety Inventory (BAI; Beck & Steer) measure except for this study (Chapman et al., 2009). There were no prior studies focused
on the specific construct of the Hamilton Anxiety scale for African Americans (Marks et al., 2022). There is no research support for various anxiety disorder diagnostic measures for African Americans (Chapman et al., 2015a).

There is limited research on therapeutics and therapeutic interventions for African Americans with anxiety (Neal-Barnett et al., 2011b). Furthermore, there is little research on the effectiveness of specific therapies for African Americans with anxiety disorders (Markell et al., 2014). Researchers need to explore more about treating anxiety in communities of color rather than focusing only on Caucasian populations (Carter et al., 2012). Some research includes singular case studies of one client, namely an African American woman with social phobia or panic disorder, which is helpful to focus on specified treatment; however, the research is not representative of the totality of African American women with anxiety (Fink et al., 1996; Gore & Carter, 2003; Johnson, 2006; Wallace et al., 2021). It is imperative to explore the course of anxiety and therapeutic interventions for African Americans (West et al., 2013).

Anxiety disorders are increasing among African Americans, and it will be essential that behavioral health professionals have greater context regarding the presentation of anxiety disorders for this population will be paramount for assessment and diagnosis after the COVID-19 pandemic (CDC, 2020; Chirikov et al., 2020; NCHC et al., 2020). It will be essential for behavioral health professionals to work with African American sexual minority male clients to decrease negative perceptions of their sexuality, circumvent discrimination and harassment, and know how anxiety presents in this population (Graham et al., 2011). Only one qualitative study explores clinicians’ perception of anxiety disorders from a treatment lens rather than presenting anxiety symptoms (Stout & Maldonado, 2017). In addition, some behavioral health professionals’ perceptions have not considered the client’s race and gender in prior research.
(Lawrence et al., 2015; Stout & Maldonado, 2017). The ability to add knowledge to clear misunderstandings for what equates anxiety symptoms for African Americans may assist with the diagnostic bias that may extend to behavioral health professionals underdiagnosing African Americans with anxiety disorders (Hunter & Schmidt, 2010; Last & Perrin, 1993; Vanderminden & Esala, 2019).

**Purpose of the Study**

The research study’s purpose is to explore the value of the participant and researcher grasping the phenomena of behavioral health professionals working with African American clients with anxiety disorders (Gadamer, 1975/2013; Heidegger, 1962/2013). There is a lack of extensive prior studies or qualitative research on behavioral health professionals’ perception of anxiety disorders amongst solely African American clients to provide another viewpoint on anxiety disorders amongst this population in terms of diagnosis and treatment. It is essential to have qualitative research to explore behavioral health professionals’ perspectives on grasping anxiety symptoms for African American clients and how their viewpoint influences their strategies and treatment (Heurtn-Roberts et al., 1997; Joy & Bartholomew, 2021). This study will add to the literature considering that only one qualitative research study focuses on clinicians’ perception of anxiety disorders from clinical practice, namely a thesis, *Clinician’s Perspectives When Treating Adults in Poverty Living with Anxiety Disorders* (Stout & Maldonado, 2017). This study will aid in further understanding behavioral health professionals’ perceptions of anxiety disorders in African Americans in their clinical practice.

**Significance of the Study**

This research study will help graduate students in counseling, social work, nursing, psychology, and psychiatry medical students expand their grasp of anxiety to include
sociocultural factors and environment for African American clients for diagnosis, counseling, and treatment (Carter & Sbrocco, 2018; Chapman et al., 2012, 2013, 2015a; Hopkins & Shook, 2017; Sibrava et al., 2013; Soto et al., 2011; Vanderminden & Esala, 2019). It is essential to look at sociocultural variation in anxiety sensitivity for African Americans (Hunter et al., 2012). In addition, a qualitative research study is instrumental in investigating the discrepancy between African Americans presenting with anxiety symptoms and still not being diagnosed with anxiety by their healthcare professionals (Hunter & Schmidt, 2010; Stockdale et al., 2008; Vanderminden & Esala, 2019). There is a need for qualitative research regarding African Americans with “racism, anxiety, and mindfulness” (West et al., 2013, p. 339). There is a need for assessments that accurately measure anxiety for African Americans (Lee et al., 2015).

Potentially, students in counselor education, psychology, and psychiatry programs can focus more on “cultural factors” in anxiety diagnosis and treatment in psycho-diagnosis courses in graduate programs, considering the focus on culture in anxiety disorder research for African Americans (Carter & Sbrocco, 2018, p. 180; Chapman et al., 2011; Gordon & Teachman, 2008; Joy & Bartholomew, 2021). Master’s-level, doctoral-level, and medical students in counseling and mental health professions will be aware of their positionality in evaluating, diagnosing, or counseling African Americans with anxiety disorders (Chapman et al., 2013; Parkerson et al., 2015; Vanderminden & Esala, 2019).

Counselors, psychologists, psychiatrists, psychiatric nurse practitioners, and social workers can focus on sociocultural factors, home environment, and triggers that may present with African American clients in assessment, diagnosis, and treatment (Carter & Sbrocco, 2018; Chapman et al., 2012, 2013, 2015a; Hopkins & Shook, 2017; Lacey et al., 2015; Sibrava et al., 2013; Soto et al., 2011; Vanderminden & Esala, 2019). This research study may help providers
explore if they are utilizing “culturally” significant screening measures to assess African American clients (Carter & Sbrocco, 2018; Chapman et al., 2015a, 2015b, p. 9; Johnson et al., 2007, p. 294, Parkerson et al., 2015, p. 41). Expanding learning about anxiety symptomatology for African Americans will enhance behavioral health professionals’ clinical insight (Brenes et al., 2008; Gordon et al., 2015; Hunter & Schmidt, 201; Last & Perrin, 1993; Vanderminden & Esala, 2019). It will be beneficial for African Americans to know the symptoms of anxiety disorders to aid in receiving treatment and decrease the impact of anxiety disorders (Coles et al., 2014). It is instrumental in having qualitative research to investigate the discrepancy between African Americans presenting with anxiety symptoms and still not having an anxiety diagnosis by their healthcare professionals (Vanderminden & Esala, 2019). It is imperative to know how anxiety disorders and anxiety relate to physical health conditions for clients, physicians, and the medical community to understand better (Roy-Byrne et al., 2008).

**Conceptual Frameworks**

There will be two conceptual frameworks for this research study, including A Sociocultural Model of Anxiety in African Americans (Hunter and Schmidt, 2010) and Black Feminist Thought (Collins, 2022). Researchers need to explore the theoretical conceptualization of anxiety disorders for African Americans (Carter et al., 1996; Carter & Sbrocco, 2018; Chapman et al., 2015a). Future research involving theory can help to decipher how anxiety presents in African American college students (Manning et al., 2017).

**Anxiety Model in African Americans**

Hunter and Schmidt’s (2010) A Sociocultural Model of Anxiety in African Americans will be the framework of this study to interview behavioral health professionals with a focus on the sociocultural factors (racism, stigma, the significance of physical health, emotionality, and
thoughts) regarding their experiences evaluating, counseling, and or prescribing medication for
African American clients with anxiety disorders (Carter & Sbrocco, 2018; Chapman et al., 2012,
2013, 2015a; Hopkins & Shook, 2017; Sibrava et al., 2013; Soto et al., 2011; Vanderminden &
Esala, 2019). Hunter and Schmidt’s (2010) model connects marginalized populations feeling
* cultural mistrust* and unwillingness to express their anxiety symptoms or thoughts. African
Americans may generalize physical symptoms of anxiety as severe medical issues (Carter et al.,
1996; Hunter & Schmidt, 2010; Neal-Barnett et al., 2011a). Per Hunter and Schmidt’s 2010
model, behavioral health professionals assume that physical indicators of anxiety in African
Americans are due to physical health issues rather than anxiety disorders (Vanderminden &
Esala, 2019). Hunter and Schmidt’s (2010) model connects to how African Americans have
more fears regarding their anxiety and potential health-affiliated issues (Gordon & Teachman,
2008). The hope is that African Americans would know their physical symptoms of anxiety as
well as their behavioral health professionals identify their client’s anxiety rather assume a
medical affiliated justification considering more physical anxiety symptoms for African
Americans (Brenes et al., 2008; Hunter & Schmidt, 2010; Vanderminden & Esala, 2019). I asked
the behavioral health professionals if they focused on their client’s background including
ethnicity, socioeconomic status and gender identity with treatment decisions aligned with Hunter
and Schmidt’s (2010) model (Carter & Sbrocco, 2018; Chapman et al., 2012, 2013, 2015a;
Hopkins & Shook, 2017; Lacey et al., 2015; Sibrava et al., 2013; Soto et al., 2011;
Vanderminden & Esala, 2019).

Hunter and Schmidt’s (2010) *A Sociocultural Model for Anxiety in African Americans*
will help behavioral health professionals listen to and use the *sociocultural factors* to discuss
discrimination, health concerns, and perception of meeting with a counselor to promote
transparency and cultural competency. Counselors can ask specific questions to explore a wide range of symptoms of anxiety with African Americans, considering that this population may not have common symptoms of anxiety, not to miss essential indicators of anxiety (Brenes et al., 2008; Hunter & Schmidt, 2010; Johnson et al., 2007; Vanderminden & Esala, 2019). Furthermore, counselors can explore a broader scope of sociocultural factors, including a client’s upbringing, in their diagnostic assessment, theoretical approaches, treatment planning, and counseling interventions with African American clients (Carter & Sbrocco, 2018; Chapman et al., 2012, 2013, 2015a; Hopkins & Shook, 2017; Lacey et al., 2015; Sibrava et al., 2013; Soto et al., 2011; Vanderminden & Esala, 2019). Furthermore, Hunter and Schmidt’s (2010) model can serve as the impetus for counselors to have open conversations regarding anxiety and that it is acceptable to seek help and to ask clients what it means to be African American in the United States (Banks et al., 2006; Samander & Harman, 2022).

**Black Feminist Thought**

It is imperative to incorporate Black feminist thought in this research study to uplift the voices of the research participant and myself as researchers and those impacted by the study (Few et al., 2003). Black feminist thought is a “critical social theory” to promote fairness and equity regarding “Black women” in America and marginalized communities (Collins, 2022, pp. 13, 16, 22, 30, 41). Black feminist thought grew out of theories including critical race and feminism (Few et al., 2003). Black feminist thought aligns with “Black women’s lived experiences,” similar to hermeneutic phenomenology (Collins, 2022, p. 41; Damsgaard, 2021; Flood et al., 2019). Black feminist thought focuses on the perspectives and affirmation of Black women with a focus on their “race, gender, and class” (Collins, 2022, pp. 17, 317; Hamilton-Mason et al., 2009). “Race, gender, class, and sexuality” are core areas of bias against
African Americans in the U.S. exist under those that have more authority and access (Collins, 2022, pp. 29, 164-165, 260, 349). Black feminist thought exists to lift African American women and to go against systemic barriers and inequities in society (Collins, 2022). Black women’s voices are respected and heard, and the uniqueness of their experiences receives support through Black feminist thought (Few et al., 2003). Black women are foundational to Black feminist theory; however, the theory includes other communities (Collins, 2022). Black men can identify with aspects of Black feminist thought (Collins, 2022). Typically, Black feminism is open to Black men due to the focus on race, social class, and background (Adu-Poku, 2001).

Aspect one of Black feminist thought is that African American women experience similar inequities and systemic barriers (Collins, 2022). The second aspect of Black feminist thought is that African American women have shared barriers with divergent life narratives and awareness of personal situations (Collins, 2022). Furthermore, Black women are not singular in perspective, and it is essential to include their past experiences and financial, societal, and governmental impacts on their lives (Few et al., 2003). Aspect two of Black feminist thought will be helpful in this study to explore how behavioral health professionals may highlight diverse manners in which they treat African Americans with anxiety disorders in terms of counseling and assessment, even amongst African American women who are behavioral health professionals (Collins, 2022). No one Black women are symbolic of all Black women’s experiences will help this research study to show that there is not a universal perception of treating African America adults with anxiety disorders (Collins, 2022). Therefore, it is essential to gather a “Black woman’s standpoint” to grasp the inequities they face in connection to their life encounters, including the experiences of varied Black women (Collins, 2022, pp. 25, 37, 42, 130). Aspect three of Black feminist thought is that Black women in the United States, through mutual
experiences of inequities, encourage civic engagement against barriers to impact progression (Collins, 2022). Aspect four of the Black feminist thought is to look at what Black women have added regarding their grasping of anxiety disorders from their perspective as behavioral health professionals and how it impacts their advocacy for African American clients (Collins, 2022). Aspect five of Black feminist thought is that it is a fluid process where there must be progress in information and awareness (Collins, 2022). Aspect six of Black feminist thought is the connection to equity for all people and “social justice,” which is central to this study to explore how behavioral health professionals consider their positionality in their perception of working with African American clients with anxiety disorders (Collins, 2022, pp. 54, 346).

Thus, Black feminist thought as the conceptual framework will be instrumental to exploring equity with the behavioral health professionals in this research study in the assessment, diagnosis, and treatment of African American clients with anxiety disorders. African American women in terms of behavioral health professionals and the experiences and viewpoints of behavioral health professionals working with African American women with anxiety disorders will be integral to this research study (Collins, 2022).

**Overview of Methods**

Hermeneutic phenomenology will be an instrumental qualitative methodology to explore my research questions on what behavioral health professional’s experiences and positionality are working with African American adults with anxiety disorders (Alsaigh & Coyne, 2021; Bynum & Varpio, 2018; Gadamer, 1975/2013; Heidegger, 1962/2013; Vandermause & Fleming, 2011; van Manen, 2016). There will be purposive sampling with three to 12 licensed behavioral health professionals with at least a master's degree in the behavioral health field (counseling, social work, psychology, psychiatry) with experience with the phenomenon of working with African
American clients with anxiety disorders (Flood et al., 2019; Moustakas, 1994; Patton, 1990; Pathak, 2017; Vandermause & Fleming, 2011).

Research participants will include behavioral health professionals from university counseling centers at Historically Black Colleges and Universities (HBCUs) and community mental health centers (Joy & Bartholomew, 2021). In addition, I plan to conduct semi-structured interviews with an interview guide that I created using the sociocultural factors in the Sociocultural Model of Anxiety in African Americans (Hunter & Schmidt, 2010; Rubin & Rubin, 2011).

**Research Questions**

This study will explore the following research questions (1) How do behavioral health professionals’ perceive the presentation of anxiety disorders among African American adult clients across socioeconomic status and gender? The second central question: (2) How does behavioral health professionals’ positionality influence their perception of the presentation of anxiety disorders amongst African American adult clients?

**Positionality**

Positionality can consist of diverse layers and the recognizability is different because it is more how a person grasps their perception than is measurable (Jacobson & Mustafa, 2019). “Positionalities” can include “race, class, and gender” where one can grasp in divergent ways and is essential for counselors to have awareness when providing clinical services (Harley et al., 2002, pp. 216, 220, 234). There is significance with family therapy graduate students having knowledge about positionality in terms of self-context and in the clinical dynamic (McGeorge & Carlson, 2010). Positionality from the researcher’s lens is how the individual dialogue with participants and how connect with the research (Boveda & Annamma, 2023). Positionality is not
a mere collected group of terms; however, it is an experience of how the researcher encounters the data (Boveda & Annamma, 2023). It is essential for the researcher to gain deeper insight about the behavioral health professionals’ backgrounds and their perceptions of their African American client’s backgrounds as well as my background (Milner, 2007). An ethical imperative is to grasp the “racialized positionality” of the behavioral health professionals and researcher (Milner, 2007, p. 388). My positionality as an African American was evident in the structure of my introduction, focus on the literature review, methodology including my role as researcher, data collection, and analysis throughout the development of the dissertation. (Boveda & Annamma, 2023; Jacobson & Mustafa, 2019; Milner, 2007).

**Limitations and Delimitations**

**Limitations**

A limitation of the research study is that the interview guide I created for the research study was not normed on a prior sample or population. A drawback of the research not knowing the experiences of African American clients with anxiety disorders (Lauterbach, 2018). This study’s research will include not having African American clients with anxiety disorders detailing their experiences with behavioral health professionals being multiculturally competent (Hunter & Schmidt, 2010; Johnson et al., 2009). An issue is that this research study’s African American behavioral health professionals may not have a perception similar to other African American behavioral health professionals (Summers & Lassiter, 2022). A research concern is if behavioral health professionals in the study would disclose if they engaged in bias in their diagnosis, evaluation, counseling, or prescribing medications for African American adult clients with anxiety disorders (ACA, 2014, Sections A.2.c and A.7.a). I must recognize that being African American and a woman could impact my participant’s responses (Summers & Lassiter,
A limitation is that I have perceptions of anxiety disorders through my experience of counseling African American clients for over 13 years and facilitating an anxiety support group that will influence my interview guide and questions (Rubin & Rubin, 2011). A concern is that I will not have co-researchers who are usually integral to the phenomenological research (Hycner, 1985; Moustakas, 1994). Co-researchers would have provided me with feedback regarding the validity of the research methodology (Hycner, 1985). Co-researchers will not be part of the research process due to time constraints and the need for consent from research participants to support the confidentiality of the research.

**Delimitations**

I focused exclusively on African American adults and not youth which may prevent understanding how anxiety disorders progress from childhood to adulthood. Furthermore, the study participants are behavioral health professionals, which is a limitation in not knowing the perceptions of healthcare professionals like doctors, physician assistants or nurses in internal medicine, family medicine, or primary care who treat and prescribe medication for African Americans with anxiety disorders. Additionally, I will be unable to know if current graduate students in behavioral health fields are receiving training in working with African American adult clients with anxiety disorders. Finally, the focus on behavioral health professionals will exclude primary care doctors who provide some African Americans with anxiety disorders with medication management (Brenes et al., 2008; Kingery et al., 2007; Lagomosino et al., 2011 Manseau & Case, 2014; Stockdale et al., 2008). A further research issue is that the purposive sampling included African American adults in the southeast and not African Americans across the United States of America. African Americans living in the Southern region of the United States have variations in lifestyle compared to Americans who live in the southern regions of the
U.S. (Summers & Lassiter, 2022). Research participants may have varying definitions of African American race in the United States and who is in this group (Hunter & Schmidt, 2010). Therefore, a potential delimitation is not interviewing behavioral health professionals who work with African American clients with anxiety disorders at urban universities with a more diverse study body, PWIs, or general community to understand varied perceptions.

Assumptions of the Study

Assumptions of the study are that the behavioral health professionals in this research study have experience evaluating, counseling, or prescribing medication for African American adult clients with anxiety disorders. My perspective is that the interview guide for this research study would be suitable for exploring the behavioral health professionals’ perceptions of anxiety disorders for African American clients, including their cultural background, positionality, and prior experience. A further presumption is to consider the behavioral health professional’s perspective with no corroborating evidence from client feedback regarding their behavioral health professional’s multicultural experience working with African American clients with anxiety disorders. Finally, I assumed that graduate students and professionals in behavioral health would want further training and support in treating African American adult clients with anxiety disorders.

Definitions of Terms

The terms below were used in the research study:

African American

A person who is Black or has African Ancestry and origin is in the United States of America (Carden et al., 2022; Neal-Barnett & Crowther, 2000; Taylor et al., 2021). This term relates to individuals “whose parents and grandparents were born in the U. S.”
A person who is African American and lives in the United States (McCall et al., 2020). Black is another term that is interchangeable for African Americans (Durkee & Williams, 2015; Kim et al., 2022; Jerald et al., 2017; Mendoza et al., 2018).

**Agoraphobia**

This mental health diagnosis includes apprehension and tension across encounters attending a large gathering, whether in large or tight places, transport with groups of other people, or being in an unfamiliar place where one may be unable to leave or receive assistance when experiencing anxiety or humiliation (APA, 2013, 2022).

**Anxiety**

Worry, dread and fear are ways to describe anxiety (Sosoo et al., 2020). Neal-Barnett (2003) describes anxiety as a sense of attentiveness of an improbable danger.

**Anxiety Disorders**

Anxiety disorders consist of extreme trepidation expecting impending distressful situations, changes in physiological state, issues in the thinking process, and non-engagement per the *Diagnostic and Statistical Manual of Mental Disorders (DSM 5 and DSM-5-TR)* (American Psychiatric Association, 2013, 2022). Anxiety disorders include *anxiety disorder due to general medical condition, agoraphobia, generalized anxiety disorder, other specified anxiety disorder, panic attack, panic disorder, selective mutism, social anxiety disorder* formerly *social phobia in DSM-5, specific phobia, substance medication-induced anxiety disorder, unspecified anxiety disorder* (APA, 2013, 2022). The anxiety disorder duration is usually six months or longer (APA, 2013, 2022). The
symptoms have no connection to the use of a medicine or substance, alternate mental 
health diagnosis, or physical health illness (APA, 2013, 2022).

*Behavioral Health Professionals*

Clinicians include counselors, social workers, psychologists, psychiatrists, and other 

*Generalized Anxiety Disorder*

A mental health diagnosis involving increased angst and tension for six months or more 
where unable to stop the apprehension (APA, 2013, 2022). Generalized anxiety disorder 
includes exhaustion, inability to focus, easily frustrated, uneasiness, physical issues, and 
problems sleeping (APA, 2013, 2022). The anxiety has a major impact on the 
individual’s daily academic, social, personal life, or work (APA, 2013, 2022). A mental 
health diagnosis from a sociocultural perspective has pervasive concerns about several 
issues, including apprehension about minority status (Hunter & Schmidt, 2010). A mental 
health diagnosis with the initials GAD in the research literature (Coles et al., 2014; 
generalized anxiety as severe anxiety with intense worry and strain in the body.

*In-Group Colorism*

It is a form of bias that includes negative engagement from fellow African Americans 
regarding other African Americans’ skin hue in one’s racial group (Oh et al., 2021).

*Internalized Racism*

It is a form of bias that individuals adopt from the majority White perspectives that are 
negative regarding the Black community that one is a part of in terms of race/culture 
(Sosoo et al., 2020).
**Out-Group Colorism**

A bias that includes negative engagement from the majority group of White Americans regarding communities of color (Sosoo et al., 2020).

**Panic Attacks**

Neal-Barnett (2003) identifies panic attacks as the frequently recognized type of anxiety that consists of brief tension with somatic symptoms including elevated heart, perspiration, and problems taking breaths. Panic attacks require less than four symptoms and may predictable due to apprehension regarding a situation or unpredictable with no prompt (APA, 2013, 2022).

**Panic Disorder**

A mental health diagnosis that includes continual panic attacks with elevated apprehension and a minimum of four panic attack symptoms (APA, 2013, 2022). Symptoms are physical in nature including racing heart, labored breathing, stomach pain, weakness, feeling cold or hot, inability to stay still, and gasping for breath (APA, 2013, 2022). Panic disorder includes emotional symptoms of disconnection, out of sorts, and concerns about being alive. (APA, 2013, 2022). Panic disorder includes continual apprehension regarding panic attacks and impacts one month after panic attacks and severe adjustment issues (APA, 2013, 2022). A mental health diagnosis with the initials (PD) (Weisberg et al. 2014).

**Perceptions**

Behavioral health professionals’ perspective regarding the suitability of a behavioral health diagnosis, understanding of the client’s presenting issues, and how come to
treatment decisions with consideration of the client’s social milieu, race, and socioeconomic status (Joy & Bartholomew, 2021).

**Positionality**

This concept includes a behavioral health professional’s clinical practice and duration, history, education, job role, therapeutic interventions, diagnostic skills, and supervision (Joy & Bartholomew, 2021).

**Racism**

A prejudice that stems from White Americans having a leading role in society where they engage in the mistreatment of communities of color due to their skin color/race (Oh et al., 2021).

**Social Anxiety Disorder**

Mental health diagnosis includes heightened anxiety and fear regarding possible judgment in social circumstances, including communication or assessment of presentation (APA 2013, 2022; Chapman et al., 2013, 2015a; Neal-Barnett, 2003). Individuals with SAD can experience physical symptoms or circumvent events that can lead to stress socially or with presentations (Chapman et al., 2015a). SAD includes apprehension regarding social experiences where do not engage in the social encounter (APA, 2013). The apprehension does not match the threat of the social experience with a duration of six months or more with a major impact on their daily academic, social, personal life, or work (APA, 2013, 2022). From a sociocultural perspective, SAD includes concerns about shame due to race (Hunter & Schmidt, 2010). Examples include an African American adult experiencing intense stress conducting a speech to a majority White group (Hunter & Schmidt, 2010). Social phobia and SAD are terms used

**Sociocultural Factors**

*Sociocultural factors* include "acculturation, ethnic identity, socioeconomic status," and educational history (Chapman et al., 2015a, p. 140). Sociocultural factors include experiences dealing with racism, social support systems, and "stereotype threat" (Chapman et al., 2012, p. 69). These factors include bias regarding mental diagnoses, focusing primarily on physical health, and commitment to faith practices (Hopkins & Shook, 2017). Additional components are “gender and sexual orientation” (Fink et al., 1996, p. 208). Finally, *sociocultural factors* include apprehension due to being in a community of color and not in the majority group and incorrect assumption that bodily symptoms of anxiety due to a health or medical concern (Hunter & Schmidt, 2010).

**Socioeconomic Status (SES)**

SES includes the highest level of an individual’s highest level of education, salary, and access to health insurance (Gibbs et al., 2013).

**Specific Phobia**

It is a mental health diagnosis including apprehension regarding a particular item or experience that involves increased worry and circumventing using the item or engaging in the experience (APA, 2013, 2022). Specific phobia occurs in the apprehension of animals, encounters, wound from needles for giving blood, and physical setting (APA, 2013, 2022). Neal-Barnett (2003) identified specific phobia as a sense of apprehension regarding animals, items, or areas of life that involve no form of assessment. The apprehension does not match the threat of the object or experience with a duration of six
months or more with a major impact on their daily academic, social, personal life, or work (APA, 2013, 2022).

**The Salience of Physical Illness**

Importance given to pervasive physical health conditions, including heart-related issues and diabetes (Hunter & Schmidt, 2010). There is an assumption that bodily symptoms of anxiety are due to a physical health condition, not anxiety (Hunter & Schmidt, 2010). The importance given to pervasive health ailments including heart-related issues and “diabetes” (Hunter & Schmidt, 2010, p. 213).

**The Stigma of Mental Illness**

The stigma includes concerns regarding emotions, perceptions, and thought processes regarding possibly having a mental health diagnosis. Further issues include concerns regarding the mental health diagnosis’s impact (Hunter & Schmidt, 2010). The potential impacts of stigma include not participating in anxiety studies, not attending therapy, and not disclosing experiences of anxiety (Hunter & Schmidt, 2010).

**Treatment**

It is a form of services that includes meeting with a behavioral health professional regarding anxiety, feelings or substance use (Johnson & Coles, 2013).
Chapter Two

Literature Review

There is limited insight into specific anxiety disorder symptoms that present in African American client populations (Beidel et al., 1994; Hopkins & Shook, 2017; Hunter & Schmidt, 2010; Neal & Turner, 1991; Sibrava et al., 2013; Williams et al., 2013). Prior studies often feature on African Americans with anxiety in low-income, “middle class,” or high-income brackets without including African Americans across social classes in the same study to identify similarities or differences in symptoms (Carter et al., 2003; Chapman et al., 2012; Hernandez et al., 2022; Hunt et al., 2013; Johnson et al., 2009; Joy & Bartholomew, 2021; Neal-Barnett & Crowther, 2000, p. 129). Exploring SES for African American college students dealing with anxiety is essential (Manning et al., 2017). It would be helpful to know the variation in generalized anxiety disorder for African Americans across SES (Kirakosian, 2018). This research study aims to identify the type of anxiety disorders that present more for African American adults to aid behavioral health professionals’ conceptualization of anxiety disorders (Chapman et al., 2012; Neal & Turner, 1991). The review of the current research includes the literature search strategy and an exploration of the occurrence of anxiety disorders in African American adults across gender and for college students, as well as anxiety symptoms. There will be an exploration of contributing factors of anxiety disorders amongst African American adults, including discrimination, in-group bias, cultural factors, environmental factors, family influences, and the notion of strength. This literature review includes protective factors of anxiety disorders amongst African American adults and the impact of anxiety disorders. This study includes African Americans’ anxiety disorder experiences with behavioral health professionals regarding effectiveness and obstacles to treatment. Lastly, the literature review
summarizes health professionals’ perceptions of treating African Americans with anxiety disorders.

I searched for literature through the exploration of the University of New Orleans and the Xavier University of Louisiana electronic databases exploring *EBSCO HOST, Science Direct, and PRO-QUEST* utilizing search phrases such as *African American and anxiety disorders, African American and anxiety, African American and anxiety assessments, Black and anxiety, behavioral health professional’s perception of anxiety, psychiatrist’s perception of anxiety, Black women and anxiety, Black men and anxiety, pharmacotherapy for anxiety, psychiatric medications for anxiety, perceptions of anxiety disorders, anxiety disparity, anxiety treatment, recognizing anxiety disorders, recognizing anxiety disorders and African American*. In addition, there were google searches, mainly *Pub Med Search, Semantic Scholar, and Research Gate*, on *African American and anxiety disorders, African American and anxiety, African American and anxiety assessments, and behavioral health professionals’ perception of anxiety disorders*. Finally, I searched specific anxiety assessments and inventories through *EBSCO HOST, Pub Med Search, and Research Gate* through the University of New Orleans electronic database.

**Occurrence of Anxiety Disorders in African Americans**

The occurrence of anxiety disorders amongst African Americans is inconclusive due to varying sample sizes and lower research participation (Gordon et al., 2015; Neal & Turner, 1991; Williams et al., 2013). Researchers found increases in anxiety disorders amongst African American young adults considering that generalized anxiety disorder (GAD) increases in late adolescence to twenties for African Americans, social anxiety disorder (SAD) increases before age 20, and panic disorder and mid-to-late adolescence (Himle et al., 2009). There was an
elevated level of a generalized anxiety disorder (GAD) for African American adults across gender in their mid-thirties with a more impoverished background (Mondi et al., 2022). There were increases in anxiety disorders for African American adults living in public housing (Simning et al., 2011). African American adults had higher state anxiety than Caucasian Americans, where they did not vary in cognitive or physical symptoms of anxiety (Williams et al., 2012). Biracial adults (one biological parent who is African American) and one biological parent who is White American) had similar rates of anxiety, whether men or women (Smith, 2014). Black and Biracial (Black and Latino) young adults not in sexual majority groups like bisexual and pansexual had more heightened anxiety, and Black or Biracial Black and Latino and gay (Parra et al., 2023).

Research studies include similarities in anxiety disorder frequency among African American and Caucasian adults (Brown et al., 1999; Manseau & Case, 2014). African Americans and Caucasians with social anxiety disorders both have issues fulfilling unfavorable stereotypes about their social connection that has a strong relationship with apprehension regarding negative judgment from others, with Caucasian Americans having more issues regarding negative judgment from others (Johnson & Anderson, 2014). African Americans and Caucasian Americans with panic disorder had comparable symptoms in a study of primarily women with lesser economic resources (Friedman et al., 1994). There were similar rates of anxiety across different racial groups for college students (Kim et al., 2022; Seehuus et al., 2021). There were similar rates of anxiety disorders across different racial groups for college students prior to the COVID-19 pandemic and during the pandemic (Kim et al., 2022). African Americans and White Americans in a non-client population had similar rates of anxiety (Hopkins, 2018). However, African Americans experienced higher prejudice, societal shame, cultural distinctiveness, and
religiousness (Hopkins, 2018). African Americans in study two had similar rates of anxiety (Hopkins, 2018). Anxiety disorders are a prevailing concern for African American and Caucasian-American populations in the United States (Himle et al., 2009). There is no distinction in mental health issues, including anxiety for Black, Caucasian, or American Indian senior citizens, where it is hard to measure variation in anxiety across race and gender (Jiménez et al., 2022).

Extensive studies highlighted that anxiety disorders present less often for African Americans (Breslau et al., 2006; Gibbs et al., 2013; Himle et al., 2009; Hofmann & Hinton, 2014; Kantor & Kantor, 2020; Mays et al., 2018; Russell et al., 2022). 83.66% of African Americans have no mental health disorder, or anxiety disorder (Taylor et al., 2021). African Americans were less likely to have anxiety disorders during the initial stages of the COVID-19 pandemic in March 2020, which does not reflect the entirety of the pandemic (Kantor & Kantor, 2020). There were decreased rates of generalized anxiety disorder, panic disorder, and social anxiety for African Americans compared to Caucasian Americans (Gibbs et al., 2013; Hofmann & Hinton, 2014). Anxiety decreases as people get older across racial groups (Jiménez et al., 2022). The Defense Medical Epidemiological Database results from 1999 to 2018 were that Black active-duty military individuals in the army, air force, navy, and marine corps, were less likely to have an anxiety disorder diagnosis for panic disorder, generalized anxiety disorder, or agoraphobia (Russell et al., 2022). The only category where Black active-duty military individuals were not less likely to have an anxiety disorder was agoraphobia without a history of panic disorder (Russell et al., 2022).

**Anxiety Disorders in African American Women**
African American women are likely to have anxiety disorders (Jones et al., 2020; Neal-Barnett & Crowther, 2000). African American women across studies presented with specific phobia and social phobia (Chapman et al., 2012; Petrie et al., 2013). African American women were more likely to have generalized anxiety and panic disorders (Himle et al., 2009). 71% of African American women from the middle class and upper SES presented with panic disorder and former anxiety disorder, primarily *simple phobia* (Neal-Barnett & Crowther, 2000). Trends indicate higher rates of anxiety disorders for African American women experiencing chronic intimate partner violence (Lacey et al., 2015, 2021). African American women who were pregnant or less than 18 months after giving birth had a greater likelihood of perinatal anxiety disorders (Hernandez et al., 2022). Specifically, African American women who had anxiety before pregnancy were over three times more likely to have anxiety during pregnancy (Hernandez et al., 2022). Through reviewing current literature, some anxiety disorder research on African American women includes outdated samples and former anxiety diagnoses of *obsessive-compulsive disorder* and *post-traumatic stress disorder* (APA, 2013, 1994; Brown et al., 1999; Jackson et al., 2004; Jones et al., 2020; Lacey et al., 2015, 2021; Simning et al., 2011). There is a larger question of what is causing African American women to experience more anxiety with gender as the only indicator thus far due to women typically receiving an anxiety diagnosis (Banks et al., 2006; Vanderminden & Esala, 2019; Williams et al., 2021).

**Anxiety Disorders in African American Men**

An analysis of more African American men’s voices in anxiety disorders research is warranted (Chapman et al., 2012; Gordon et al., 2015; Markell et al., 2014; Petrie et al., 2013). African American men were among the least likely Black male groups to present with anxiety disorders or long running anxiety disorders (Mays et al., 2018). Conversely, Black sexual
minority men (BSMM) have increased anxiety compared to heterosexual African American men and women (Graham et al., 2011).

**Anxiety Disorders in African American College Students**

There are varying perspectives on the occurrence of anxiety disorders for African American college students. Over 60% of African American men and women, as well as White college men, experienced anxiety their freshman year, with African American women maintaining high anxiety levels up to their senior year (Williams et al., 2021). There were similar rates of anxiety for African Americans and White American college students, with higher “positive affectivity” for African Americans (Williams et al., 2018, p. 923). *Psychological inflexibility* for African American, Asian American, and White college students impacts the role of hiding anxiety and bodily symptoms (Mendoza et al., 2018).

Furthermore, Black college students, where 69% were African American and who were often told by peers that they acted White, were more likely to experience anxiety, depression, and stress (Durkee & Williams, 2015). Caucasian American college students at a large university identified greater anxiety than African American college students (Chapman et al., 2009). Alternatively, African American college students had less trait anxiety than White college students (Lindsey, 2014). Distinct identities and a greater need for approval were not significant contributing factors to trait anxiety for African American college students (Lindsey, 2014). A particular challenge is that some research studies of African American college students were at PWIs and did not include HBCUS or more diverse universities (Durkee & Williams, 2015; Perkins et al., 2022).

Different studies include various perspectives on the frequency of social anxiety for African American college students (Buckner & Dean, 2017; Manning et al., 2017). There was no
variation in social anxiety across gender or age for African American and White college students (Buckner & Dean, 2017). In other studies, African American college students who are more responsive to anxiety and have difficulty adapting to discomfort have more anxiety provocations and social anxiety (Manning et al., 2017).

**Anxiety Symptoms in African American Adults**

African American perspectives on anxiety will impact how they verbalize and address their symptoms (Carter et al., 1996). African Americans did not disclose anxiety symptoms frequently during the COVID-19 pandemic from March 2020 to November 2020 (Owens & Saw, 2021). The presentation of anxiety disorders for African Americans includes describing more physical symptoms throughout most of the literature (Gordon et al., 2015; Heurtin-Roberts et al., 1997; Hunter & Schmidt, 2010; Neal-Barnett et al., 2011a; Vanderminden & Esala, 2019). However, in other research studies, somatic symptoms regarding anxiety were similar for African Americans and European Americans (Hopkins, 2018). Potentially, African Americans have similar symptoms and different symptomatology with cultural variations for panic disorder with agoraphobia (Carter et al., 1996). Researchers are unsure of the differences in the presentation of specific phobias for African Americans and Caucasian Americans; however, there is a distinction in the presentation of specific phobias among both groups (Chapman et al., 2008). Therefore, it is essential to explore unique anxiety features for African Americans (Sibrava et al., 2013). In addition, it is imperative to explore the variation across African Americans in measuring anxiety disorders in this group (Chapman et al., 2015b).

African American college students and African American adults in the community identified more fears linked to animals, social anxiety, when exploring specific phobias (Chapman et al., 2008, 2011). Specific animal fears for African American college students and
adults include the fears of “strange dogs, rats, and mice” (Chapman et al., 2008, p. 767, 2011, p. 543). African American college students had more fears of weather elements, altitude, and heightened fear regarding water regarding specific phobias (Chapman et al., 2008). There is a need for more research regarding water-based fears for African Americans (Chapman et al., 2008). Finally, African Americans were concerned with not accomplishing their goals to prevent harsh judgment (Chapman et al., 2008, 2011).

**Contributing Factors to Anxiety Disorders in African Americans**

There has been limited research on what contributes to anxiety for African Americans (Chang, 2018). No single factor leads to anxiety for African American college students (Salami & Walker, 2014). Neal-Barnett (2003) described that “family, genes, hormones, trauma, discrimination, and stress” are factors that contribute to anxiety for Black women (p. 27). In addition, African Americans who cannot accept doubt is a risk for anxiety (Liao et al., 2016).

**Discrimination**

African Americans experience higher levels of discrimination that link to anxiety symptoms in this population (Banks et al., 2006; Mouzon et al., 2017; Soto et al., 2011; Williams et al., 2018). African Americans are more prone to have experiences with discrimination in the United States of America (Hofmann & Hinton, 2014). Discrimination connects to heightened reporting of anxiety disorders for African Americans with discrimination encounters whether daily, current, or across the past (Banks et al., 2006; Chapman et al., 2012; Lacey et al., 2015, 2021; Mouzon et al., 2017; Soto et al., 2011). Heightened discrimination encounters were related to increased anxiety for African Americans via the *Beck Anxiety Inventory* (BAI; Beck et al., 1998; *STAI Trait Anxiety Inventory* (STAI; Spielberger et al., 1970) (Hopkins, 2018). Specifically, discrimination was a significant factor in generalized anxiety disorder (GAD)
presenting across years for African Americans, even for a longer duration than for Black Caribbeans, particularly White Americans (Soto et al., 2011). Blacks employed in the student affairs division in the higher education field cope with *racial battle fatigue* in a narrative study identified experiencing anxiety without a specific exploration of who were African American employees or not (Quaye et al., 2020).

Clients of color present with anxiety due to experiencing “discrimination, racism or microaggressions” (Chapman et al., 2013, p. 170). Specifically, microaggressions attached to viewing African Americans as unsuccessful and an unwanted community with damaging slander significantly link to anxiety (Williams et al., 2018). Adverse stereotyping can contribute to social anxiety disorder in African Americans (Chapman et al., 2012; Johnson, 2006). A minimum of one encounter of mistreatment or biased behaviors of police connected to the increased likelihood of African American experiencing an anxiety disorder in the last year (Oh et al., 2017). In studies one and two, African Americans had more physical anxiety symptoms, and discrimination encounters had heightened anxiety (Hopkins, 2018).

African American seniors experience more anxiety due to discrimination (Carden et al., 2022; Mouzon et al., 2017). Specifically, African American seniors had ongoing encounters with discrimination identifying in some cases feeling inferior on an annual basis, lack of courtesy in food establishments, and monitoring while shopping with links to increased anxiety disorders in this population (Mouzon et al., 2017). Ethnic identity does not help African American seniors regarding daily discrimination and anxiety (Carden et al., 2022).

Racial microaggressions are linked to anxiety for African American college and graduate students (Liao et al., 2016). African American college students who were highly involved in political activism and experienced racial/ethnic microaggressions had increased anxiety (Hope et
al., 2018). 30% to 75% of African American college students experienced anxiety even in counseling with no perceived racial and ethnic discrimination (PRDD) (Chao et al., 2012). Anxiety heightened for African American college students with increased rates of PRDD (Chao et al., 2012).

African American women who experienced gendered racial microaggressions more often had a heightened anxiety response where there was a connection between discrimination and anxiety (Wright & Lewis, 2020). Neal-Barnett (2003) discussed that the mental outcome of undergoing situations with prejudice and discrimination for Black women is anxiety. African American women of a lower socioeconomic status (SES) experience significant encounters of discrimination that significantly increase their probability of having an anxiety disorder (Banks et al., 2006; Lacey et al., 2015). African Americans with lesser economic resources at healthcare facilities in Atlanta, Georgia, mostly women who experienced racism, were likelier to have chronic anxiety symptoms (Mekawi et al., 2021). Daily encounters with discrimination, prior behavioral health support, significant life circumstances, and depression symptoms were related to anxiety for African American women (Banks et al., 2006).

Of black college students, where 63% were African American, it was more likely that Black women who had low levels of respect in society were more prone to have anxiety due to increases in discrimination on and outside of online platforms (Perkins et al., 2022). In addition, African American women with panic disorder with agoraphobia with higher SES had increased stress at their job due to race which worsened their overall anxiety and panic symptoms (Carter et al., 2003). Therefore, it is essential to look at how acculturation and racism impact the development of panic disorders in African American women and their willingness to receive treatment (Carter et al., 2003).
The single contributing factor regarding racism is thoughts, and physical anxiety symptoms are *institutional race-related stress, not cultural race-related stress* and *individual race-related stress* (Lee et al., 2015). However, causation is complex regarding whether institutional race-related stress affects elevated anxiety or heightens *institutional race-related stress* (Lee et al., 2015). It would be essential to know if the anxiety symptoms occurred after the discrimination encounters for African Americans (Banks et al., 2006). It is imperative to understand the connection between discrimination and the concept of fear in anxiety disorders for African Americans (Hunter & Schmidt, 2010). African American men’s specific experiences with discrimination and anxiety are not in the research (Carter et al., 2003; Wright & Lewis, 2020).

Research studies show no direct link between heightened anxiety or anxiety disorders and discrimination against African Americans (Graham et al., 2015; Hopkins, 2018; Kline et al., 2021). There is research where African Americans’ encounters with racism in the last year had no strong association with anxiety provocation or general anxiety (Graham et al., 2013). African Americans and Europeans in study one and study two have similar rates of anxiety, and African Americans had more discrimination encounters (Hopkins, 2018). Conversely, there was no connection between racial discrimination and generalized anxiety disorder and social anxiety disorder for African American college students per the students’ response, and there was no formal clinical assessment (Kline et al., 2021). Anxiety symptoms and anxiety were less for African American college students who experienced racist encounters in the last year and lived by their values (Graham et al., 2015). Discrimination does not lead to anxiety for African American men (Banks, 2006). African women, mostly college women in the Midwest who did
not emphasize stigma, had lower anxiety levels (Watson & Hunter, 2015). It may be beneficial to decrease stigma for African American women and decrease anxiety (Watson & Hunter, 2015).

**In-Group Bias**

*Self and group-focused internalized racism* were indicative of heightened anxiety for African American adults (James, 2021; Sosoo et al., 2020). African American college students with internalized racism connected to having social anxiety (Kline et al., 2021). Especially, African American college students who had average to heightened internalized racism, including fixed perceptions of a racial group and desiring specific hair textures, were more prone to have heightened anxiety (Sosoo et al., 2020). Colorism in terms of *in-group colorism and out-group colorism* has a major relationship with anxiety disorders for African Americans (Oh et al., 2021). Lighter-hued African Americans were more likely to have an anxiety disorder, although an outdated sample included PTSD as an anxiety disorder that is no longer in the DSM-5 and DSM-5-TR (APA, 2013, 2022; Bijou & Colen, 2022). Adverse perceptions of one’s sexuality with “internalized homonegativity, discrimination, harassment” had a significant connection with anxiety for Black sexual minority men (BSMM) (Graham et al., 2011, pp. 1, 6). BSMM experienced enduring discrimination and harassment in everyday society, shopping, and legal systems (Graham et al., 2011). Conversely, increased self-stigma there was no connection between heightened rates of anxiety in African Americans in study one, and there was a connection between increased self-stigma and heightened anxiety in study two related to the *Beck Anxiety Inventory* (Hopkins, 2018). Increased public stigmas have no connection with heightened rates of anxiety for African Americans (Hopkins, 2018).

**Cultural Factors**
It is essential to understand the role of culture in understanding anxiety disorders for African American adults (Carter & Sbrocco, 2018; Chapman et al., 2011; Gordon & Teachman, 2008; Graham et al., 2013). Socio-cultural factors including but not limited to ethnicity, adjusting to the majority culture, income bracket, and status provide perspective on behavioral health professionals’ assessment and diagnosis for African Americans considering the root causes of anxiety (Carter & Sbrocco, 2018; Chapman et al., 2012, 2013, 2015a; Hopkins & Shook, 2017; Lacey et al., 2015; Sibrava et al., 2013; Soto et al., 2011; Vanderminden & Esala, 2019). The underlying contributing factors to a specific phobia for African American college students and adults are social-and animal-based fears with links to family members sharing fears (Chapman et al., 2008, 2011). In addition, apprehension of a specific phobia for African Americans includes increased responsibility to achieve (Chapman et al., 2008, 2011). In a case study of an African American woman and physician with a social anxiety disorder, race played a role in the client's fear of her work environment with concerns of social judgment (Fink et al., 1996). Therefore, it is imperative to explore acculturation specifically in African Americans with social phobia (Petrie et al., 2013). Conversely, African American medical students from the “Medical Student Cognitive Habits and Growth Evaluation” (Phelan et al., 2014) in their first year with less racial identification had lesser anxiety than their peers with more racial identification (Hardeman et al., 2016, p. 251).

**Family Influences**

It is prevalent for African American mothers of eight-to 14-year-olds to have an anxiety disorder, including agoraphobia, generalized anxiety disorder, panic disorder, social phobia, obsessive-compulsive disorder (OCD), and post-traumatic disorder (PTSD) (Boyd & Tervo-Clemmens, 2013). The issue with the relevancy of the research on anxiety disorders and parental
impact is that OCD and PTSD are no longer in the *DSM-5* or *DSM-TR* (APA, 2013, 2022, Boyd & Tervo-Clemmens, 2013). The children of African American parents, predominantly mothers with anxiety disorders, namely specific phobia and social phobia, which had lesser income earnings, had four times the probability of having specific and social phobia if their parent had an anxiety disorder (Chapman et al., 2012). African Americans, mostly women with panic disorder and agoraphobia of lesser economic resources, had more parental issues, including more division and grief growing up, parental addiction, and lesser anxiety, depression, separation anxiety, or fear regarding school and their family (Friedman et al., 1994). Research is absent about African American fathers’ role in their children having anxiety disorders, biological or sociologically (Chapman et al., 2012).

There are varied perspectives on the role of family across different studies as a protection or risk factor for anxiety for African American young adults (Assari et al., 2018; Augustine et al., 2022; Chapman & Woodruff-Borden, 2009; Levine et al., 2015; Mounts et al., 2006). Family cohesion during late adolescence through *self-regulation* encouraging awareness and monitoring is a protective factor against anxiety issues in young adulthood (Augustine et al., 2022). Thus, a healthy parenting style may influence internal monitoring for adolescents to have fewer anxiety issues as young adults (Augustine et al., 2022). The experience of having tight familial bonds helps African Americans avoid social anxiety with stressful communication within their family (Levine et al., 2015). A protective factor for African American college students at a midwestern university not experiencing heightened anxiety was if their parents were open to their college acclimation and the importance of their interpersonal relationships (Mounts et al., 2006). African American or Black college students with parents that are “protective, strict, and demanding” do not influence their level of anxiety, with a possible explanation that a sign of support rather than
concern for the young adult (Carter et al., 2001, p. 566). For African American young adults in a longitudinal research study, parents’ marital status in adolescence regarding intact marriages between parents does not serve as a buffer against anxiety like for White youth (Assari et al., 2018).

Furthermore, family functioning was more related to anxiety for White American college students than African American college students in connection to The McMaster Family Assessment Device (FAD; Epstein et al., 1983) (Chapman & Woodruff-Borden, 2009). Stressful communication with family connects to social anxiety disorder (SAD) for African Americans (Levine et al., 2015). The experience of having stressful communication often with family for African Americans connects to experiencing SAD for the year and across the lifespan (Levine et al., 2015).

Older adults in African American families may communicate messages about specific fears to younger adults (Chapman et al., 2008). Probable explanations for more animal fears for African Americans include messaging from the home community regarding fear of animals in African American communities (Chapman et al., 2011). However, it is not sure what leads to fear of animals for African Americans (Chapman et al., 2008).

**Environmental Factors**

There is not ample research on the variation in anxiety symptoms for African Americans (Carter et al., 1996; Himle et al., 2009). African Americans that felt that not seen as being successful, not favored due to racial group, and experienced negatives like “environmental insults” were more likely to experience anxiety (Williams et al., 2018, p. 925). African American mothers with a history of stressful circumstances and abuse had heightened trait anxiety (Mitchell & Ronzio, 2011). Significant life circumstances, chronic health issue, or ill-treatment
were related to anxiety for African American men (Banks et al., 2006). Specifically, embarrassment, harmful bodily situations, a relationship ending, taking on different responsibilities, or being forced into illegal activity connects to heightened anxiety for pansexual, bisexual, and non-majority sexual groups for Black and biracial Black and Latino people (Parra et al., 2022).

Trauma was a major factor in increased anxiety for African American regarding employment status and earnings (Dennis, 2021). African American women, not men, who did not have gainful employment were more likely to experience anxiety (Dennis, 2021). African Americans whose highest level of education was high school experienced heightened anxiety compared to those who earned a college degree (Dennis, 2021). The variation in anxiety symptoms has some drawbacks considering that only African American adults from Detroit were in the research study and not representative of other African Americans in the U.S. (Dennis, 2021). African American women with fewer earnings with perinatal mood and anxiety disorders had *adverse childhood experiences*, including prior abuse, whether emotional, physical, or sexual, during their youth (Hernandez et al., 2022). In addition, African American women with perinatal anxiety disorders with fewer earnings had self-confidence issues (Hernandez et al., 2022). HBCU students whose parents lost their employment during the COVID-19 pandemic or whose family home had more people residing during the pandemic were more prone to experience anxiety (Wang & Goodman, 2022). Interestingly, socioeconomic status and education level did not contribute to anxiety and worry levels for African American adults aged 50 and older (Conti et al., 2017).

**Notion of Strength in African American Women**
Anxiety presents for African American women with the *Strong Black Woman (SBW)* race-gender schema with their perseverance beliefs to fulfill home and work tasks despite heightened anxiety (Neal-Barnett & Crowther, 2000; Neal-Barnett et al., 2011a; Watson & Hunter, 2015). Neal-Barnett (2003, p. 22) addressed that “the Strong Black woman” is likely to experience anxiety. African American women recognized that the notion of strength was a potential cause of anxiety and panic symptoms due to beliefs others place on them, hassles, navigating life with little help, and self-doubt (Neal-Barnett et al., 2011a). African American women in sister circles assumed panic attacks did not present in African American women (Neal-Barnett et al., 2011a).

There was a strong connection between the SBW schema and anxiety for African American women in a study of mostly African American women at a PWI in the Midwest (Liao et al., 2020). Perfectionism contributes to higher anxiety for African American college students at a Midwestern university, where a majority of the study participants were women (Chang, 2017). African American/Black women in college and graduate school at a PWI in the Midwest who were on three specific blogs that catered more to Black topics experienced more anxiety (Stanton et al., 2017). African American women in college who tended to align with the *Strong Black Woman Archetype* (SBW), there was no connection to anxiety which the *Depression and Anxiety Scale (DASS-21; Lovibond & Lovibond, 1995)* does not assess the physical anxiety symptoms with a focus more on provocation (Donovan & West, 2015).

**Social Factors**

African Americans with flexibility challenges and a lack of comfort are more likely to experience anxiety provocations and social anxiety (Manning et al., 2017). African American college students who struggled with social engagement, were timider, did not recognize the
importance of interpersonal relationships, felt uncomfortable communicating with strangers, and were prone to have heightened anxiety (Mounts et al., 2006). Loneliness contributes to higher anxiety for African American college students at a Midwestern university, where a majority of the study participants were women (Chang, 2017). Loneliness has a major connection to anxiety for African American women (Chang, 2018). There is a connection between anxiety sensitivity and social anxiety for African American college students (Manning et al., 2017). Specifically, (post-event processing PEP) includes how much focus that African American college students use to reflect after their social activities, which has a major connection to social anxiety (Buckner & Dean, 2017). Stigma, pessimistic outlook, and stereotypes regarding African American college students can lead to social anxiety disorder (Johnson, 2006). Impostor syndrome is connected to social anxiety for Black college students attending PWIs with increased John Henryism may feel pushed to succeed and not think that their determination is sufficient (Bernard et al., 2020).

**Protective Factors for Anxiety and Anxiety Disorders in African American Adults**

There is not one general protective factor for anxiety and anxiety disorders for African American college students. Social networks protect African American college students (Liao et al., 2016; Mounts et al., 2006). Optimism and “adaptive coping” helped to decrease anxiety regarding COVID for African American college and graduate students at an HBCU (Singleton et al., 2022, p. 12). Self-compassion was the protective factor for the SBW schema, depression, anxiety, and loneliness for mostly African American women at a PWI in the Midwest (Liao et al., 2020). Black college students with an official diagnosis of asthma or who reported symptoms and who managed their asthma better before the COVID-19 pandemic had less anxiety amid the pandemic (Ramos et al., 2023).
Anxiety reduction connects to more global wellness for Black adults in the United States (Kalkbrenner, 2023). Increased self-esteem was related to less anxiety for pregnant African American women who gave birth less than 18 months prior (Hernandez et al., 2022). Social networks, mental flexibility, stronger ethnic identification, and lower introduction to violence in the neighborhood helped Black or African American mothers experience less trait anxiety (Mitchell & Ronzio, 2011). Ethnic identification that is solid may serve as a protective factor for Black/African Americans in general and college students when it comes to anxiety (Williams et al., 2012). Familial bonds that are nurturing and encouraging connect to decreased anxiety for mostly African American and a few Afro-Carribans and Africans in the Mid-Atlantic states in the United States (Pollock et al., 2015). For African American seniors, belonging to the church was a protective factor from the effects of discrimination and was a connection to generalized anxiety disorder (Nguyen, 2018).

Impact of Anxiety Disorders on African American Adults

There is credence for behavioral health professionals to diagnose African Americans properly with anxiety disorders considering that African Americans experience a more severe progression of anxiety disorder symptoms that include lesser abilities to carry out daily tasks and decreased *psychosocial functioning* (Himle et al., 2009; Moitra et al., 2014; Sibrava et al., 2013). African American adults have more enduring impacts of anxiety disorders than Caucasian adults (Gibbs et al., 2013). The average course of social anxiety disorder for African Americans was 28.02 years, generalized anxiety was 17.3 years, and *panic disorder with agoraphobia* (PDA) was 13.2 years, with no prior studies on the duration (Sibrava et al., 2013). Specifically, African American women have more heightened experiences with panic disorder (Jones et al., 2020; Neal-Barnett & Crowther, 2000). African American mothers with social phobia heightened their
depression symptoms (Boyd & Tervo-Clemmens, 2013). More anxiety symptoms in African American adults connect to more perspectives that their health will worsen, considering that African Americans with difficulty controlling their emotions without adequate coping skills report more negative health outcomes (Carter & Walker, 2014). African Americans with generalized anxiety disorder are more prone to have suicidal ideation (Assari et al., 2013).

African Americans with a lower socioeconomic status had more debilitating anxiety and experienced greater difficulties (Moitra et al., 2014). In addition, African Americans, mostly women with lesser economic resources with panic disorder and agoraphobia, experienced heightened stress (Friedman et al., 1994). Further issues for African Americans with social anxiety disorder and panic disorder were not having gainful employment, lower earnings, and disability (Sibrava et al., 2013). African Americans with panic disorder and agoraphobia, primarily women with lesser economic resources, had a higher probability of going to the emergency room (Friedman et al., 1994).

African Americans with anxiety disorders present with more physical health issues (Johnson & Lawrence, 2013; Neal-Barnett & Crowther, 2000; Oh et al., 2022). Black adults who experienced a heart condition had increased anxiety sensitivity more than Caucasian Americans (Alcántara et al., 2017). Black adults with heart conditions who experienced heightened anxiety sensitivity had a connection with over a minute decrease in overall sleep which other factors impacted their sleep (Alcántara et al., 2017). African American young adults in good physical shape who experience anxiety prior to a stress test are more prone to have an increased blood pressure reaction, where essential to look at *state anxiety* which is an immediate reaction to a stressful encounter (Pointer et al., 2012). However, no focus was on other variables, including mental and communal aspects (Pointer et al., 2012). Anxiety regarding COVID is central to
alcohol and drug intake for African American college and graduate students attending an HBCU (Singleton et al., 2022).

Specifically, African American men present with severe health issues in addition to their anxiety diagnosis or anxiety (Banks et al., 2006; Johnson & Lawrence, 2013). Oppression and significant health issues have major links to anxiety for African American men (Banks et al., 2006). Victimization and ill-treatment were more associated with anxiety for African American men (Banks et al., 2006). Racial discrimination leads to anxiety which connects to severe health issues for African American women (Carter et al., 2016).

Researchers have found that across studies, African Americans with panic disorder had heightened isolated sleep paralysis (Friedman et al., 1994; Neal-Barnett & Crowther, 2000; Ramsawh et al., 2008). Specifically, studies with primarily African American women showed a higher probability of isolated sleep paralysis (ISP) with panic disorder (Friedman et al., 1994; Neal-Barnett & Crowther, 2000). African Americans, Afro-Carribean, and Black Africans with ISP react more to anxiety, with 66% fearing physical symptoms within the body (Ramsawh et al., 2008). There is hope that more African Americans could correctly identify panic disorder and panic attack symptoms due to African Americans’ familiarity with isolated sleep paralysis (Coles et al., 2014).

Coping with Anxiety for African American Adults

Faith and Spirituality

African Americans utilize their spiritual beliefs, religion, familial support, and friendships as coping skills for anxiety (Neal-Barnett & Crowther, 2000; Neal-Barnett et al., 2011a). In alignment with the “Theoretical Framework for the Impact of Anxiety,” African Americans with significant racial identification seek support for anxiety from the emergency
room, faith-based groups, and church or family assistance (Carter et al., 1996, p. 456). Neal-Barnett (2003) addressed that there are Black women who utilize their faith to cope with anxiety. Religion may help African Americans with anxiety (Hodge et al., 2022; Neal-Barnett & Crowther, 2000). Active involvement in religion related to less anxiety for African American college women, and challenges with religion related to more anxiety for African American college men (Cokley et al., 2013). Active engagement in religion and a positive outlook were associated with helping decrease thought-affiliated symptoms of anxiety for African American college and graduate students and help with *individual* and *cultural race-related stress* (Lee et al., 2015).

Specifically, prayer was a source of coping for emotional well-being for many African Americans with agoraphobia and social phobia and tension for African Americans with agoraphobia and generalized anxiety disorder (Taylor et al., 2021). Prayer was related to less probability of agoraphobia and social phobia for African American adults (Hodge et al., 2022). African Americans with GAD were more prone to prioritize prayer as a coping skill for stress (Taylor et al., 2021). Specifically, weekly church attendance connects to less probability of a panic disorder or agoraphobia across the year or duration of lifespan for African American adults (Hodge et al., 2022). African Americans who went to a church service at different times during the month or a handful of times during the year and not at all have a high likelihood of social phobia (Hodge et al., 2022). In addition, hearing spiritual messages on the radio and focusing on God for coping is related to less probability of panic disorder in a year or across one’s life span for African American adults (Hodge et al., 2022).

On the other hand, reading information on religion connects with a higher likelihood of experiencing panic disorder and agoraphobia across a year for African American adults and
generalized anxiety disorder throughout their life span (Hodge et al., 2022). However, African Americans with panic disorder did not identify prayer as their significant coping skill due to their engagement with their faith and not diagnostic reasons (Taylor et al., 2021). African Americans who did not attend church service had less probability of panic disorder throughout their life span (Hodge et al., 2022). African Americans with greater spiritual coping skills had increased anxiety in connection with the Beck Anxiety Inventory (BAI; Beck et al., 1998) in study one and not study two, where spiritual coping skills had no connection to anxiety (Hopkins, 2018). African American college students who utilized ritual-centered coping had frequently heightened anxiety for this population in addition to relationship indicators of race-related stress as opposed to when the rituals were used less often (Greer, 2011). A potential explanation is that adherence to certain customs and traditions might have an underlying meaning of being independent in coping patterns (Greer, 2011). Faith-based practices did not protect SBW schema and anxiety for primarily African American women at a PWI in the Midwest (Liao et al., 2020). Active involvement with religion and challenges with religion related to more anxiety for African American men (Cokley et al., 2013). African Americans with greater levels on the “Negative Religious Coping Scale” experienced heightened anxiety via the Beck Anxiety Inventory (BAI; Beck et al., 1998) (Hopkins, 2018, pp. 59-60).

**Immediate Support Circle**

Messaging and conditioning in the African American community are to disclose information to the immediate support circle (Williams et al., 2013). African Americans would encourage their friends to receive mental health support for anxiety from “primary care physicians” (Schubert et al., 2014, p. 715).
African American women have found “sister circles” with “peer support” of other African American women to be beneficial (Neal-Barnett et al., 2011a, p. 6, 2011b, p. 7). In addition, African American women with panic disorder with mild agoraphobia of higher SES background have a space to process the increased stress at their job due to race which worsens their overall anxiety and panic symptoms (Carter et al., 2003). Furthermore, groups and family counseling may be helpful for African American women who experience heightened anxiety symptoms due to gendered racial microaggressions (Wright & Lewis, 2020). Conversely, supportive networks did not protect SBW schema and anxiety for primarily African American women at a PWI in the Midwest (Liao et al., 2020).

African American college men were more likely to engage in sports for leisure on campus rather than meet with a behavioral health professional in the campus counseling center, even when experiencing increased anxiety (Williams et al., 2021). Moreover, by their senior year in college, African American men were likely to play recreational sports often to cope with anxiety (Williams et al., 2021).

**African Americans’ Receptivity to Anxiety Disorder Treatment**

African Americans, whether women or both women and men, did display some receptivity for meeting with behavioral health professionals (Brown et al., 1999; Mays et al., 2018; McCall et al., 2020; Williams et al., 2021). African Americans were just as likely as Caucasian adults to receive treatment for anxiety disorders (Brown et al., 1999). African Americans and Caucasian Americans had similar perspectives regarding treatment for anxiety disorders, with no wide variation in favorable perspectives of anxiety medication except for African Americans not taking medication for anxiety often (Hunt et al., 2013). African Americans with more acculturation may be more aware of their anxiety symptoms and more
receptive to treatment resources (Carter et al., 1996). African Americans were just as likely as Caucasian Americans to encourage their friends to get treatment for anxiety (Schubert et al., 2014). Black college students were more likely to attend therapeutic services if their anxiety symptoms were chronic and there was lesser cultural mistrust (Dean et al., 2018). In addition, Black college students were more prone to attend therapeutic services if there was an “intolerance of uncertainty” and more anxiety symptoms. (Dean et al., 2018, p. 698).

African Americans with hypothetical case scenarios were more prone to suggest generalized anxiety disorder treatment than Caucasian Americans for their friends (Schubert et al., 2014). African Americans with hypothetical case scenarios were prone to suggest their friend meet with a psychologist or psychiatrist for social anxiety disorder (Schubert et al., 2014). Thus, the friend’s receptivity to their friend’s suggestion for treatment is contingent upon ethnic background (Schubert et al., 2014). In theoretical cases, African Americans did not have as negative a perception of social anxiety (Abdullah & Brown, 2020).

African American women were receptive to receiving behavioral health services for anxiety (McCall et al., 2020). 70.6% of African American women were open to telehealth via video for anxiety treatment (McCall et al., 2019). Specifically, women aged 50 and younger were receptive to telehealth via video, whereas women over 50 were less receptive to telehealth via video (McCall et al., 2019). Approximately 51% of African American women think that talking to their behavioral health professional via text would be beneficial (McCall et al., 2020). African American women in college were more likely to seek counseling services for anxiety at their university counseling center (Williams et al., 2021). African American men met with behavioral health or healthcare professionals for panic disorder with no specific factors about a tendency to receive treatment for this anxiety diagnosis (Mays et al., 2018). A critique of the current research
is not including African American men and their perspectives on anxiety disorder treatment to fully understand the utility of telehealth for this population (McCall et al., 2019, 2020).

**Assessments of Anxiety Disorders in African American Adults**

There are screenings for African Americans for “social anxiety, specific phobia, and worry” (Carter & Sbrocco, 2018, p. 187). It is essential to know if a frequently utilized assessment of worry is normed in varied communities of color (DeLapp et al., 2016). Furthermore, it is essential to know if the *Penn State Worry Questionnaire-Abbreviated (PSWQ-A)* can measure severe worry for African Americans with GAD (DeLapp et al., 2016). It is essential to have a *Brief Panic Disorder Screen* that can include symptoms specific to African Americans or panic disorder assessments that include African American culture (Johnson et al., 2007). Some assessments, like the *Structured Clinical Interview for DSM-IV Disorders (SCID-I; First, Spitzer, Gibbons, & Williams, 1994)*, were based on the DSM-IV for African American women with panic symptomatology (APA, 1994; Carter et al., 2003). The *Structured Clinical Interview for DSM-IV Axis I-Disorders (SCID-IV; First et al., 1996)* was an assessment based on the DSM-IV as well for African American adults in the *Harvard/Brown Anxiety Research Project-Phase II (HARP-II)* from (APA, 1994; Weisberg et al., 2012, as cited in Sibrava et al., 2013). The DSM-5-TR would be more relevant for anxiety disorder diagnosis in current research studies (APA, 2022). It is essential to measure anxiety for African Americans (Assari et al., 2013).

**Anxiety Assessments**

The *World Health Organization Composite International Diagnostic Interview (WHO-CIDI; Kessler & Utsun, 2004)* measures anxiety disorders from the *National Survey on American Life* across various research studies on anxiety and African Americans from now outdated
research with the (Jackson et al., 2004, as cited in Himle et al., 2009; Johnson & Lawrence et al., 2013; Jones et al., 2020; Lacey et al., 2015, 2021; Mays et al., 2018; Oh et al., 2021, 2022; Soto et al., 2011; Taylor et al., 2021). The WMH-CIDI from the Collaborative Psychiatric Epidemiology Studies (Heeringa et al., 2004) of African Americans, Caucasian Americans, and Latino Americans show comparable social anxiety symptoms for African Americans and Latino Americans where there was an inability to decipher variation in social fears of different races (Asnaani et al., 2015). However, none of these research studies included reliability or accuracy statistics for African Americans or the general population for the WHO-CIDI (Kessler & Utsun, 2004) or WMH-CIDI (Heeringa et al., 2004, as cited in Himle et al., 2009; Johnson-Lawrence et al., 2013; Jones et al., 2020; Lacey et al., 2015, 2021; Mouzon et al., 2017; Oh et al., 2021, 2022; Soto et al., 2011; Taylor et al., 2021). Only one study included a focus on anxiety disorders amongst lesbian, gay, and bisexual African Americans from the WHO-CIDI (Kessler et al., 2005, as cited in Meyer et al., 2008). An issue is that the anxiety diagnoses came from the DSM-IV (APA, 1994, as cited in Himle et al., 2009; Meyer et al., 2008; Mouzon et al., 2017). In addition, some of the studies focused either exclusively on African American men or African American women but not diversity of gender across the studies (Johnson-Lawrence et al., 2013; Jones et al., 2020; Lacey et al., 2015, 2021; Mays et al., 2018).

The Anxiety Disorders Interview Schedule (ADIS-IV; Brown, Di Nardo, & Barlow) is a commonly utilized measure for anxiety (Chapman et al., 2012). ADIS-IV is a reliable measure for anxiety disorders among African American women (Chapman et al., 2012; Petrie et al., 2013). In addition, ADIS-IV is a reliable measure of anxiety disorders for African American parents, primarily women and children (Chapman et al., 2012). The ADIS-IV had a reliability of more than .79 for panic disorder and agoraphobia; however, an issue was that no race of the
research participants was included in the study in Pennsylvania (Porter et al., 2017). However, an issue with the ADIS-IV is that this measure screens for anxiety based on the *Diagnostic and Statistical Manual for Mental Health Disorders* (DSM-IV; APA, 1994), whereas this diagnostic category is currently outdated compared to the current DSM-5-TR (APA, 2022; Chapman et al., 2012; Porter et al., 2017). Additionally, research on the efficacy of ADIS-IV is not evident for most African American men (Chapman et al., 2012; Petrie et al., 2013).

The *Anxiety Sensitivity Index* (ASI; Reiss, Peterson, Gursky, & McNally, 1986) is a frequent screening for anxiety sensitivity for different races and was comparable across races for mostly women at a university in Houston that included African American, Caucasian American, Latino, and Asian American college students (Talvosky & Norton, 2015a). The ASI is a reliable and valid measure for African Americans (Hunter et al., 2012). The ASI had strong reliability of .94 for Black and mostly Caucasian adults with heart conditions (Alcántara et al., 2017). However, there is variance regarding physical issues with two items on the measure, namely “cardiovascular” and “unsteadiness,” which vary in connection to anxiety to decipher between worries regarding health from worries regarding anxiety (Hunter et al., 2012, p. 515). On the other hand, the *ASI-3* (Taylor et al., 2007) has strong reliability for African American populations, including a score of .89 for college students and a score of .95 for adults (Manning et al., 2017; Reitzel et al., 2017). The *ASI Revised (ASI-R)* had strong reliability, with the *36-Item ASI-R* as a more reliable measure than the *21-item ASI-R*, were similar among African Americans and Caucasian American college students, mostly women (Arnau et al., 2009).

However, assessments like the *Anxiety Sensitivity Index* (ASI; Reiss, Peterson, Gursky, & McNally, 1986) validated in Caucasian American populations and not amongst African Americans (Hunter et al., 2012). Furthermore, the ASI was utilized for a small percentage of the
study participants that were African American women, with little data on the effectiveness for African American men (Hunter et al., 2012). The ASI-3 was reliable for populations of primarily white women in college white no-anxiety diagnoses (Reilly et al., 2012; Wheaton et al., 2012). Therefore, there is a strong need to use current anxiety inventories like the ASI-3 (Alcántara et al., 2017).

The Beck Anxiety Inventory (BAI; Beck & Steer, 1993; Beck et al., 1988) is a frequently utilized measure for diagnosis and anxiety studies (Bardhosí et al., 2016; Contreras et al., 2004). The BAI has strong reliability, is an accurate measure of anxiety, and differentiates between different anxiety disorders from varied mental health conditions (Beck et al., 1988). There was a strong connection between the BAI and Hamilton Anxiety Rating Scale and other screenings (Beck et al., 1988). The BAI is a frequent and reliable anxiety inventory for studies of senior citizens (Therrien & Hunsley, 2013). In addition, the BAI is a reliable measure for senior citizens with GAD and those that did not have a diagnosis (Wetherell & Gatz, 2005). The BAI across different versions was a reliable measure of anxiety symptomatology for African American college students in the southeast, south, and Midwest (Chang, 2017; Chapman et al., 2009 DeLapp et al., 2016; Williams et al., 2018). The BAI is a reliable measure in general for college students and African American and Caucasian-American college students (Chapman & Woodruff-Borden, 2009; DeLapp et al., 2016; Williams et al., 2018). The BAI (Beck & Steer, 1990) is also a reliable measure for African American graduate students (Lee et al., 2015). The BAI (Beck et al., 1988) was a reliable inventory for college students across races in Houston (Robinson et al., 2010). The BAI (Beck et al., 1988) was highly reliable for Black adults (Reitzel et al., 2017). In addition, the BAI (Beck & Steer, 1990) is an adequate assessment of panic disorder at an anxiety clinic for adults across ethnicities, primarily Caucasian and women, with
2.3% of African American study participants from 1994 to 2004 (Leyfer et al., 2006). The BAI (Beck, 1990) had a reliability of .91 for college students in Virginia and adults who were primarily Caucasian (Williams et al., 2012). The BAI may be beneficial for African Americans with revisions to measure anxiety more adequately (Chapman et al., 2009).

There is a need for more research regarding communities of color with the BAI when outcomes may vary with diagnosis in studies depending on if participants of different racial backgrounds (Bardhosi et al., 2016). The “four and six factors” BAI was a better match for African Americans than Caucasian Americans; however, it was not a significant match (Chapman et al., 2009, p. 391). African Americans did not endorse as much anxiety as Caucasian Americans on the BAI (Chapman & Woodruff-Borden, 2009). The BAI could better measure physical features than cognitive anxiety in African American and Caucasian Americans (Chapman et al., 2009). There is a need to know more about the specific components of the BAI for African Americans (Chapman et al., 2009). It will be essential to explore the distinctions in how the BAI performs for women compared to men regarding more anxiety assessed for women with this measure (Bardhosi et al., 2016). There were no specifics regarding demographics with the BAI (Beck et al., 1988). The BAI for senior citizens is on the basis of the older DSM-IV (APA, 1994, as cited in Wetherell & Gatz, 2005). The BAI (Beck et al., 1988) was not the best inventory of anxiety in senior citizens with GAD, although a reliable measure, where it compared ok with the Hamilton Anxiety Scale (HAMA; Hamilton, 1959) and Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Brokovic, 1990) (Wetherell & Gatz, 2005). The physical questions on BAI related to the entire assessment of HAMA and not the cognitive items for the clinical and non-clinical populations connected to the PSWQ (Wetherell & Gatz, 2005). The cognitive questions connected to the PSWQ more than the physical questions.
(Wetherell & Gatz, 2005). The BAI could not assess the chronicity of GAD with cognitive or physical symptoms (Wetherell & Gatz, 2005). It was hard to decipher the difference between BAI and inventories of depression with no mention of race or gender (Wetherell & Gatz, 2005). People with higher scores on the BAI do not have an anxiety diagnosis, and a greater score on the BAI connects to a panic disorder diagnosis (Leyfer et al., 2006). However, the BAI is not an effective assessment of overall anxiety (Leyfer et al., 2006).

The BSI is a frequent anxiety assessment tool in studies of senior citizens (Therrien & Hunsley, 2013). The Brief Symptom Inventory (53-BSI; Derogatis & Melisaratos, 1983) was a reliable measure of anxiety symptoms for Black and African American adults in the study (James, 2021). The 53-BSI has solid internal reliability of .83 anxiety for Black and African American women in college and graduate school at a PWI and HBCU in the southeast and .85 for Black college students at universities in the Southern region of Louisiana (Dean et al., 2018; Jerald et al., 2017). In addition, the Brief Symptom Inventory 18 (BSI-18; Derogatis, 2001) was a reliable instrument across racial groups, including African American, Asian American, and Caucasian American college students in the southeast of .78 to .87 (Mendoza et al., 2018). The BSI-18 (Derogatis, 2000) was a solid and reliable measure for Black and Caucasian mothers and not Latino mothers from the Healthy Passages study sample in the south and west coast from (Windle et al., 2004, as cited in Wiesner et al., 2010). Black mothers had less support for three of the questions on the BSI, and averages were larger for Black women than Caucasian women for physical symptoms and anxiety (Weisner et al., 2010). Black and biracial Black and Latino young adults in the Healthy Young Men’s Cohort Study from (Kipke et al., 2019) had a reliability of 0.83 for anxiety on the BSI-18 for those in the sexual minority study (as cited in Parra et al., 2022). There was a strong reliability of .84 on the BSI (Derogatis, 1993) for African Americans.
at healthcare facilities in Atlanta (Mekawi et al., 2021). There are not many studies on the components of the BSI for African Americans (Chao et al., 2019). The BSI (Derogatis, 1993) had a strong internal consistency of .87 for predominantly Caucasian women participants; however, it did not give specific internal consistency for different racial groups (Dour et al., 2014).

The Depression, Anxiety, and Stress Scale (DASS-21; Lovibond & Lovibond, 2015) had strong reliability for anxiety for African American college students at varied universities, including universities in the south with intense social anxiety, metropolitan college, and other colleges in the United States in different research studies (Buckner & Dean, 2017; Graham et al., 2013; Seehuus et al., 2021). The DASS-21 was also a reliable instrument for graduate students at a metropolitan college (Graham et al., 2013). The DASS-21 was a reliable measure of anxiety at .82 for Black college women at a metropolitan university (Donovan & West, 2015). In addition, the DASS-21 was a reliable inventory for Black/African American and Afro-Caribbean adult women (Liao et al., 2020; Wright & Lewis, 2020).

However, the accuracy of the DASS-21 had no validation for Black/African Americans (Graham et al., 2013). The DASS-21 does not assess symptoms for the prior week and not for a duration of time where racist encounters may take place over a longer timespan (Graham et al., 2013, 2015). In addition, the DASS-21 was measured primarily amongst women and not Black men to grasp the measure's utility (Graham et al., 2015). There was strong reliability for the DASS-21 for primarily White and Asian adults in college and treatment program with no information on African American experience (Ovanessian et al., 2019).

The Inventory of Depression and Anxiety Symptoms (IDAS; Watson et al., 2007) was a reliable screening tool for African American college students at .82 to .88 at a university in the
Midwest (Manning et al., 2017). The IDAS (Watson et al., 2007; Watson et al., 2008) had solid reliability for one study group that mainly was Caucasian American and another group that was equally African American and Caucasian American and had more diagnoses (Stasik-O’Brien et al., 2019). The IDAS had internal consistency and was accurate for measuring anxiety and assessing GAD and panic disorder and was a solid measure for diagnosis for the Black and White participants (Stasik-O’Brien et al., 2019). The IDAS identified social phobia from the DSM-5 and distinguished different symptoms (Stasik-O’Brien et al., 2019). There were no major differences across races with the IDAS-II (Watson et al., 2012) that represented all states in the U.S.; only the sample was largely Caucasian American (Nelson et al., 2018). The IDAS-II (Watson et al., 2012) can measure social phobia, specific phobia, and agoraphobia (Nelson et al., 2018). The IDAS-II allows behavioral health professionals to focus on particular symptoms (Nelson et al., 2018).

However, the IDAS was tested on predominantly Caucasian American college students (Smith, 2014). The IDAS-II was a solid to robust screening that was all-encompassing for anxiety for senior citizens, primarily Caucasian, in research with internal consistency and utilization across age groups (Weitzner et al., 2020). Therefore, there is a need for further research on the efficacy of the IDAS for biracial American college students with one African American biological parent (Smith, 2014). The IDAS was not a solid measure for specific phobias (Stasik-O’Brien et al., 2019).

The Mood and Anxiety Symptom Questionnaire (Mini-MASQ; Cutrona et al., 2000) has solid internal reliability and accuracy of .76 for African American women in Georgia and Florida from the Family and Community Health Study; but only looked at anxiety for a week timespan (Carter et al., 2016). The (MASQ; Watson et al., 1995) had solid reliability for anxiety
provocation of .81 for African American women in the Midwest who were mainly in college (Watson & Hunter, 1995). MASQ (Watson & Clark, 1991) used amongst a racially diverse group of African American, Latino, Caucasian American, and Asian American college students at University of Houston, where the reliability of the measure for “anxious arousal” (AA) was .92 and .90 for “general distress” (GD) (Talvosky & Norton, 2015b, p. 434). The MASQ is a reliable and valid measure for African American Latino, Caucasian-American, and Asian American college students (Talvosky & Norton, 2015b). MASQ-GD connected to PANAS-NA, and BAI and MASQ-AA connected to PANAS-NA and PANAS-PA across races with no focus on gender in the research (Talvosky & Norton, 2015b). Unfortunately, there is no data on the effectiveness of the Mini-MASQ or MASQ for African American men (Carter et al., 2016; Watson & Hunter, 2015).

The Geriatric Anxiety Inventory is a frequent anxiety assessment in studies of senior citizens (Therrien & Hunsley, 2013). The Geriatric Anxiety Inventory (GAI; Pachman et al., 2007) had solid reliability and accuracy for senior citizens with no information on race (Johnco et al., 2015; Therrien & Hunsley, 2013). The reliability of the GAI was solid for those without an anxiety diagnosis at .73 and .85 for those with an anxiety diagnosis. The GAI was more proficient than the Geriatric Anxiety Inventory-Short Form (GAI-SF; Byrne & Pachana, 2011) of people with an anxiety diagnosis (Johnco et al., 2015). The GAI was reliable in measuring the chronicity of anxiety; it compares well to other anxiety measures for senior citizens and notices progress with therapeutic services for mostly Caucasian American women (Ball et al., 2015).

The GAI connects men and women with GAD with the Hospital Anxiety and Depression Scale (HAD-SA) and not as much with HAMA with the use of the DSM-IV-TR (APA, 2000 as cited in Ball et al., 2015).
The Geriatric Anxiety Inventory-Short Form (GAI-SF; Byrne & Pachana, 2011) had an average consistency of .71 for African American senior citizens with lesser earnings and was a more reliable and accurate instrument for Caucasian Americans (Shrestha et al., 2020). African American adults with GAD and anxiety disorder not otherwise specified age of 50 and up and who had no major reduction in anxiety from the GAI-SF from prior to treatment to after CBT treatment than their Caucasian or Latino counterparts with a study of mostly women (Conti et al., 2017). The GAI-SF had solid reliability and accuracy for senior citizens with no information on race and only knew that primarily women were in the study (Johnco et al., 2015). The reliability for those without an anxiety diagnosis of .71 and .58 was sufficient for those with an anxiety diagnosis on the GAI-SF (Johnco et al., 2015). The GAI-SF inventory may be helpful in health clinics or research locations (Johnco et al., 2015). Reliability was sufficient for those with and without an anxiety diagnosis and may be helpful in health clinics or research locations, predominantly women in the study (Johnco et al., 2015). An issue was needing more men and senior citizens to understand the full utility of GAI-SF (Shrestha et al., 2020).

The Hamilton Anxiety Rating Scale (HAM-A; Hamilton, 1959) is an often-used anxiety assessment for diagnosing patients and in research. The HAM-A is a widely utilized anxiety measure created before consistent categories of anxiety diagnosis and is helpful for research (Shear et al., 2001). The HAM-A is frequently utilized in research on GAD and the level of chronicity of other anxiety diagnoses (Shear et al., 2001). The HAM-A had strong reliability of .80 to .93 for African and Caucasian Americans, with even more robust reliability for African Americans with generalized anxiety disorder, with no major distinction amongst both populations and featured in only one study for African Americans (Markell et al., 2014). SIGH-A is the Structured Interview Guide for the Hamilton Anxiety Inventory (SIGH-A; Williams,
1996) was a reliable measure for African American adults from 2018-2020, although the focus of the study was not on anxiety more on alcohol use and PTSD (Marks et al., 2022). The SIGH-A would be a more reliable guide for mental health professionals (Shear et al., 2001). The HARS was a reliable measure for panic disorder in Pennsylvania with no inclusion of race (Porter et al., 2017). The HARS-II was an effective anxiety inventory and did better than the HARS with a focus on physical symptoms and focus on the panic disorder (Porter et al., 2017). The Hamilton Anxiety Rating Scale Interview Guide (HARS-IG) was used for individuals in the hospital, mostly women with no inclusion of race, with a range of mental health diagnoses including anxiety disorders, most with some form of anxiety, 20% anxiety disorder mostly major depression (Bruss et al., 1994). The HARS-IG is beneficial in measuring anxiety and is more reliable than HARS (Bruss et al., 1994).

There are variations of the HAM-A measure where it is difficult to decipher specifics of the measure utilized mainly for Caucasian Americans (Marks et al., 2022). The HAM-A and HARS focus on the basis of the DSM-IV, with no information regarding race or demographics (Porter et al., 2017; Shear et al., 2001). A problem of screening senior citizens with HAM-A is the focus on physical symptoms related to serious medical illness and medication use (Ball et al., 2015). There was no endorsement for the HARS-R-II or HARS because of the lesser association between HARS and HARS-R-II, panic disorder, and issues with the inventories (Porter et al., 2017).

The PANAS-X is a frequently used screening for anxiety for African Americans (Carter & Sbrocco, 2018; Petrie et al., 2013). The PANAS-X is particularly helpful for screening social phobia (Petrie et al., 2013). The PANAS-X is utilized more for research and is essential to explore for diagnosing patients. The PANAS-X had strong reliability for the positive and
negative affect of .89 and .92 for African American women (Petrie et al., 2013). Therefore, it is vital to study the PANAS-X for African American men (Petrie et al., 2013).

*The Positive and Negative Affect Schedule* (*PANAS*; Watson, Clark & Tellegen, 1988) had strong reliability for African American and Caucasian Adults for the positive and negative measures (Brenes et al., 2008). The PANAS also had solid reliability for African American and Caucasian college students (Lancaster et al., 2015; Williams et al., 2018). The negative affect measure of the PANAS-NA was solid for African American college students in the Midwest and a PWI (Lancaster et al., 2015; Manning et al., 2017). The PANAS's positive and negative affect measures had strong reliability of .91 and .89 for African American and Caucasian college students at a southern and midwestern universities (Williams et al., 2018). The PANAS for the negative affect schedule had a strong reliability score for African American adults in Texas (Reitzel et al., 2017). The PANAS measure and short forms have internal consistency and accuracy for utilization with African American adults in San Diego, California although, no measure for anxiety in the study (Merz et al., 2013). Positive affect may be more beneficial for diagnosing anxiety in African American women and negative affect for social phobia (Petrie et al., 2013). The internal consistency of the positive and negative measures was solid for bisexual young adults, mostly Caucasian and only a small percentage from communities of color or biracial (Flanders, 2015).

The Symptom Checklist-90-Revised (*SCL90-R*; Derogatis, 1996) had a reliability of .79 for the first group and .60 for the second group of Black college students at a PWI where a focus on “anxiety” and “phobic anxiety” (Sosoo et al., 2020, p. 574). The SCL-90-R was utilized for Black men and women, primarily women in college in Atlanta, Georgia, for the *Spit for Science* (*S4S*) study (Dick et al., 2014), where the internal consistency was 0.85 for the anxiety
responses (Williams et al., 2021). The SCL-90-R was a frequent anxiety assessment in studies of senior citizens (Therrien & Hunsley, 2013).

**Generalized Anxiety Disorder and Symptom Assessments**

The *Generalized Anxiety Disorder 7-Item* (GAD-7; Spitzer, 2006) is a frequently utilized and accurate assessment of general anxiety for different communities and clinical locations, including hospital, community, and medical settings (Johnson et al., 2019). GAD-7 relates to depression, coping with stress, worry, and functioning and measure similarly across gender (Kirakosian, 2018). The GAD-7 was a stronger measure than the PWSQ-10 (Yao et al., 2016). The GAD-7 was a solid measure of reliability and accuracy in a substantial study of 857 African American college students, mostly women (Kirakosian, 2018). The GAD-7 had strong reliability of .93 for African American and Latino college students (Ramos et al., 2023). The GAD-7 had strong reliability for African American and Caucasian senior citizens with lower earnings to determine if GAD is present and was a useful measure for marginalized communities across socioeconomic status (Shrestha et al., 2020). The GAD-7 accurately and consistently measures general anxiety for research participants receiving psychological treatment (Johnson et al., 2019). It will be vital to know the “test-retest reliability” of GAD-7 for African Americans (Kirakosian, 2018, p. 27). African American college students varied widely from other racial groups on the GAD-7 score (Parkerson et al., 2015). African American college students scored at lesser rates of GAD, even when they experienced more GAD symptoms than other racial groups with parallel symptoms (Parkerson et al., 2015). The *Generalized Anxiety Disorder Questionnaire-IV* (GAD-Q-IV; Newman, 2002) was a solid measure of GAD where able to screen for GAD with no major variation for different racial populations, including African American college students, mostly
women in Houston and treatment program with mostly Caucasian American women (Robinson et al., 2010).

An issue is that there were no specifics on how effective the GAD-7 was for communities of color (Johnson et al., 2019). It was impossible to measure variation for anxiety and no distinction in mental health issues across race and gender for Black, Caucasian, or American Indians due to the study population size (Jiménez et al., 2022). GAD-7 would not classify if there is an official disorder; however, exploration may result in an anxiety diagnosis (Wang & Goodman, 2022). The GAD-Q-IV was not able to show distinction with the PSWQ as much for college students across races and mostly Caucasian women in a treatment program (Robinson et al., 2010). Furthermore, the GAD-7 criteria were from the DSM-IV, and a few questions may not match the exact criteria of the more recent DSM-5-TR (APA, 2000, 2022; Spitzer et al., 2006). The GAD-7 was a reliable inventory for stress and anxiety for senior citizens, primarily Caucasian (Weitzner et al., 2020). It is essential to know how GAD-7 performs for other adult populations and senior citizens across states (Kirakosian, 2018).

The Penn State Worry Questionnaire (PSWQ; Meyer et al., 1990) had strong reliability of .80 to .93 for African Americans in screening for generalized anxiety disorder (Markell et al., 2014). The PSWQ has strong reliability of .91 for African American college students and all students in the study in the Northeast (Hambrick et al., 2010). There were challenges in assessing anxiety with the PSWQ for African American and Asian college students to qualify for variation in anxiety (Hambrick et al., 2010). It is harder to measure minute variation when there is lesser chronic worry (Hambrick et al., 2010). The PSWQ is used to a certain extent across locations (Hambrick et al., 2010).
The internal consistency of the PSW-Q was .92, and accuracy was solid for the sample of predominantly White clients in a partial hospitalization program in New England with only 1% Black/African American (Kertz et al., 2014). The PSW-Q was one of the best of the three measures for showing improvement prior to and after treatment (Kertz et al., 2014). The PSWQ was a frequent and consistent anxiety inventory in studies of senior citizens with no mention of race or demographics (Therrien & Hunsley, 2013). The PSWQ is a reliable inventory for senior citizens, mostly Caucasian (Weitzner et al., 2020). There was high reliability of the PSWQ with no mention of race for senior citizens (Wetherell & Gatz, 2005). The PSW-Q in a predominantly Caucasian American sample of primarily women with adults with anxiety disorder and with college students with no diagnosis at varied locations focused on the older DSM-IV-TR (Wheaton et al., 2012). There was strong reliability for the PSWQ for primarily White and Asian adults in college and treatment program with no information on African American experience (Ovanessian et al., 2019).

The *Penn State Worry Questionnaire-Abbreviated* (PSWQ-A; Hopko et al., 2003) assessed whether there was generalized anxiety disorder across race and earnings, and this tool was a better instrument to assess the possibility of GAD (Shrestha et al., 2020). The PSWQ-A has solid reliability with African American and Caucasian Adults in the sample of different ages (Brenes et al., 2008). PSWQ-A is a reliable and accurate screening for African American and Caucasian American college students, mostly women, for severe worry and a strong association with the PSWQ (DeLapp et al., 2016). Also, the PSWQ-A has solid reliability for low-income African American seniors and was a helpful measure for marginalized communities with less financial resources (Shrestha et al. 2020). There was solid reliability for African Americans and Caucasian Americans with the PSWQ-A (Shrestha et al., 2020). There was a correlation between
the PSWQ-A and the GAD-7 (Shrestha et al., 2020). African American adults with GAD and *anxiety disorder not otherwise specified* age of 50 and up and with no major reduction in worry from the PSWQ-A prior to treatment to after CBT treatment than their Caucasian or Latino counterparts (Conti et al., 2017).

The reliability of the PSW-QA was high for those with an anxiety diagnosis and with a clinical diagnosis that was mostly women with no mention of race (Johnco et al., 2015). The internal consistency of the PSWQ-A and PSWQ-3 was strong for the sample of predominantly White clients in a partial hospitalization program in New England; it was an adequate measure comparable to the PSW-Q (Kertz et al., 2014). Reliability was solid, and accuracy and solid performance with clients for the PSWQ-A and PSWQ-3 with GAD symptoms reduced from prior to and after treatment and easy for health professionals to utilize and for research purposes (Kertz et al., 2014). The PSWQ-10 was a very accurate and assess well with other inventories with progression over duration of clinical services, compared with the GAD-7, and is a solid inventory or worry and GAD with a largely Caucasian population at an anxiety treatment center (Yao et al., 2016).

The *Generalized Anxiety Disorder Questionnaire-IV* (*GAD-Q-IV*; Newman et al., 2002) was a solid measure of GAD for different racial populations, including African American, Latino, Caucasian American, and Asian American college students in Houston, primarily women and treatment program participants mostly women and Caucasian American (Robinson et al., 2010). The GAD-Q-IV performed well for different races for students and those in treatment with no major variation and could screen for GAD (Robinson et al., 2010). There was variation with the gender with symptoms for students, and there was less association with “intolerance of uncertainty” for groups including African Americans (Robinson et al., 2010, p. 259). The GAD-
Q-IV could not show a distinction with PSWQ as much (Robinson et al., 2010). An issue with the GADQ-IV was that there was no specific information regarding reliability for African American/Black college students or any demographic in this study (Kim et al., 2022).

**Assessments for Panic Disorder**

The *Panic Disorder Severity Scale* (PDSS; Shear, Barlow, Brown, et al., 1997) is universally effective (Furukawa et al., 2009). The PDSS accurately measures panic disorder for clinical populations (Keough et al., 2012; Shear et al., 1997). The PDSS is a frequently used assessment of panic disorder (Keough et al., 2012). The PDSS is a consistent measure of panic disorder (Shear et al., 1997). An issue is that most of the study participants were 96.8% Caucasian, with no mention of African Americans or communities of color at one clinic (Keough et al., 2012). There was no specific information on race regarding the effectiveness of the PDSS (Furukawa et al., 2009; Shear et al., 1997). Further issues are the focus on panic disorder from an older version of the DSM when the current DSM is DSM-5-TR (APA, 2022; Keough et al., 2012; Shear et al., 1997).

The *Brief Panic Disorder Screen* (BPDS; Apfeldorf et al., 1994) is more likely to determine the panic disorder diagnosis for Caucasian Americans than African Americans and is a better measure for Caucasian Americans in the sample (Johnson et al., 2007). African Americans had higher scores for cardiovascular even with no panic disorder diagnosis on the BPDS (Johnson et al., 2007). There was very little reliability of 0.386 in the BPDS for African Americans with panic disorder (Johnson et al., 2007).

**Assessments for Social Anxiety Disorder**

*The Social Anxiety Scale* (SIAS) (SIAS; Mattick & Clarke, 1998) is a frequently utilized social anxiety assessment for clients and general communities (Carter et al., 2014). The SIAS
was used in some capacity across locations (Hambrick et al., 2010). The SIAS is a practical assessment (Hambrick et al., 2010). There is the utility of the SIAS in the assessment of social anxiety for African Americans (Carter et al., 2014). The SIAS has strong reliability of 0.92 for African American adults, whereas no prior study with reliability is solid for all African Americans (Chapman et al., 2015b). The SIAS is a solid screening for social anxiety diagnosis that was particularly strong for African Americans (Chapman et al., 2015b). The SIAS has strong reliability for Black/African American college students at two HBCUs and two PWI’s in the southeast, for a university in the south, for a university in the northeast, and a university in the Midwest across studies with primarily women (Bernard et al., 2020; Buckner & Dean, 2017; Hambrick et al., 2010; Lancaster et al., 2015).

The SIAS does not fully measure interaction anxiety for African Americans (Carter et al., 2014; Hambrick et al., 2010). There is varied criteria selection on the SIAS for African Americans rather than Caucasian Americans (Hambrick et al., 2010). An issue is that most of the student participants with SIAS were women, thus unable to infer effectiveness for African American men (Carter et al., 2014). There is a need to have better measures of interaction and performance anxiety for African Americans who experience judgment from the larger public (Carter et al., 2014). The SIAS is reliable for college students, primarily women and Caucasian Americans with no diagnosis and adults with OCD, PSTD, and hypochondriasis not in the current DSM under anxiety diagnoses (APA, 2022; Wheaton et al., 2012).

The Social Phobia Scale (SPS; Mattick & Clarke, 1998) is useful in assessing social anxiety for African Americans (Carter et al., 2014). The SPS has strong reliability of 0.94 for African American adults, whereas no prior study with reliability is solid for all African Americans (Chapman et al., 2015b). Therefore, there needs to be a thorough exploration of the
SPS for African Americans (Carter et al., 2014). The SPS does not fully measure anxiety for African Americans (Carter et al., 2014). Criteria on the SPS, namely blushing, is more challenging to measure due to the variation in skin tone (Carter et al., 2014).

The short form SIAS and SPS was a solid measure for individuals without a social phobia diagnosis, mostly Caucasian American college students and men at a Midwestern university, and are similar to the general SIAS and SPS measure (Fergus et al., 2012). The short form SIAS and SPS had strong reliability of .88 for the SIAS and .83 for the SPS and accuracy for individuals, primarily men and Caucasian Americans in an anxiety disorder program, and a strong association of .90 with the complete measure (Fergus et al., 2012). The SIAS and SPS had a solid association with the Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987). The SIAS and SPS short forms (Peters et al., 2012) with predominantly Caucasian American, primarily women and college students, and no African Americans in the research; there was partial confidence in the “two-factor model” of these measures and no confidence in (Fergus et al., 2012 measure, as cited in Gomez, 2016, p. 87)

The Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987) is a frequently utilized assessment for social anxiety that is consistent and accurate with greater than 400 individuals in clinical populations (Heimberg et al., 1999). However, there needs to be a mention of demographics regarding the utility of the LSAS to know if a helpful measure for African Americans (Heimberg et al., 1999). There is a need to know more about the specifics of the LSAS measure (Heimberg & Holaway, 2007). The LSAS is mostly an accurate measure with solid reliability in a study of 50% Caucasians with no specifics of other ethnicities and more men where it is impossible to determine variation across race for the LAS (Heimberg & Holaway,
Therefore, knowing race’s influence on LSAS outcomes is imperative (Heimberg & Holaway, 2007).

The Social Phobia Inventory (SPIN) was a consistent and accurate assessment of social phobia (Connor et al., 2000). The SPIN was a reliable inventory of social anxiety disorders for mostly Caucasian men (Aderka et al., 2013). The SPIN was a reliable inventory for primarily women and Caucasian Americans at a PWI in Ohio (Reilly et al., 2012). The Mini-SPIN-R was a reliable and accurate inventory of the chronicity of social anxiety and a better measure of picking up social anxiety for those diagnosed (Aderka et al., 2013). In contrast, the mini-Spin (Connor, 2001) would be sufficient for empirical studies (Aderka et al., 2013). There is no certainty of how the Mini-SPIN-R performs for clients during receiving therapeutic services based on the DSM-IV (Aderka et al., 2013). A noted issue of the study is that there was no research on the effectiveness of SPIN for communities of color and specifically African Americans with social phobia (Connor et al., 2000). The SPIN’s instrument included a focus on the past DSM-IV (Aderka et al., 2013).

Assessments for Specific Phobia

The Fear Survey Schedule-2nd edition (FSS-II; Greer, 1965) was a reliable measure for research in Ontario, Canada, with a focus on the DSM-IV with clinical population and college students with largely White and Asian participants, mostly women and included obsessive-compulsive diagnosis no longer in the DSM (Ovanesian et al., 2019). The FSS-II is one of the initial measures of specific phobia to look at specific components of the inventory for African Americans and Caucasian adults, primarily women in the Midwest, where there is wide variation in fears in the two groups (Chapman et al., 2008). African Americans in college and general settings reported more fears of “animals” specifically (“insects, strange dogs, rats, and mice”)
across studies (Chapman et al., 2008, p. 767 and 2011, p. 544). African Americans reported more fears of their “natural environment” and “social anxiety and identified more fears than Caucasian Americans “(Chapman et al., 2008, p. 767). There is no specific understanding of how African Americans develop fears of animals (Chapman et al., 2008). The FSS-II did not match the results from the study in the area of fear of the “natural environment” (Chapman et al., 2011, p. 544).

An issue with the research is that African American adults disclose their fears without collateral inventories of specific phobias or monitoring symptoms (Chapman et al., 2011). There is a need for more assessments of specific phobias with the FSS-II for African American men (Chapman et al., 2011). Overall, there is a need for more significance of the specific phobia measure (Chapman et al., 2011).

The *Specific Phobia Questionnaire (SPQ; Fairbrother & Antony, 2012)* is a reliable and valuable measure to differentiate between people with a specific phobia and those with an exact phobia (Ovanessian et al., 2019). The SPQ is helpful for research and aligns with the more recent DSM-5 (APA, 2013; Ovanessian et al., 2019). Unfortunately, the SPQ study population was predominantly White and Asian college students and adults in Ontario, which does not shed light on the African American experience with specific phobia (Ovanessian et al., 2019).

Assessments for State-Trait Anxiety

*State Trait Anxiety Inventory (STAI; Speilberger et al., 1983)* had a solid reliability for African American college students at a university in the south (Lindsey, 2014). The STAI a fair reliability for African American college students at a university in the Midwest (Chapman & Woodruff-Borden, 2009). There is a solid reliability of .88 for the STAI for African American adults including students and employees in North Carolina (Pointer et al., 2012). The STAI-S has a strong reliability of .96 for Black sexual minority men at a university in the South (Graham et
al., 2011). The STAI has a strong reliability of .90 for African American mothers (Mitchell & Ronzio, 2011). There was no information on reliability of the State Trait Anxiety Inventory (STAI-S; Speilberger, Gorusch, & Lushene, 1979) for African American women with panic symptomatology (Carter et al., 2003). STAI is a frequent anxiety assessment in studies of senior citizens STAI with no mention of race (Therrien & Hunsley, 2013)

Effectiveness of Treatment for African Americans with Anxiety Disorders

One treatment that was particularly effective for African Americans with anxiety was cognitive behavioral therapy (CBT) and particularly for African American women (Carter et al., 2003; Jonassaint et al., 2017; Markell et al., 2014). African Americans with anxiety did well with an online version of cognitive behavioral therapy (Jonassaint et al., 2017). African American women experiencing anxiety disorders have positive treatment outcomes that involve behavioral health professionals’ providing cognitive-behavioral therapy in clinical practice (Carter et al., 2003; Markell et al., 2014). In addition, African Americans, primarily women in the study who were mothers and many without jobs, did well with parenting skills, CBT, medication, and group counseling for panic disorder (Friedman et al., 1994).

There are varied anxiety disorder treatments that are beneficial for African American adults. Sister Circles or peer support groups help African American women from low to high-income brackets to discuss anxiety, panic symptoms, and stigma (Johnson et al., 2009; Neal-Barnett et al., 2011a, p. 6, 2011b, p. 7). African American women with panic disorder and agoraphobia completed in-vivo-exposure to overcome fears in public spaces (Carter et al., 2003). Social effectiveness therapy was an effective treatment protocol in a case study of an African American woman and physician with social phobia and avoidant personality disorder (Fink et al., 1996). Telehealth will be an effective modality for therapy for African American women coping
with anxiety (McCall et al., 2019). *Cognitive-emotional debriefing* helped reduce anxiety symptoms for African American college students (Greer, 2011). Mindfulness appears to help decrease *anxious arousal* for African American undergraduates and graduate students and can be effective for behavioral health professionals to utilize with their clientele (Graham et al., 2013). Furthermore, African Americans and Caucasian Americans with panic disorder and agoraphobia had comparable and somewhat effective therapeutic benefits, where therapy was most effective when the family was part of the therapeutic services (Friedman et al., 1994). A review of the literature is challenging in not knowing what anxiety disorder treatments work well for African American men due to them missing from the research on treatment or therapeutic interventions (Carter et al., 2003; Johnson et al., 2009; Markell et al., 2014; Neal-Barnett et al., 2011a, 2011b; Fink et al., 1996).

There were different perspectives on the acclimation of text messaging for anxiety disorder treatment (McCall et al., 2020). Less than 50% of African American women would recommend using text messaging with their behavioral health professionals to assist with coping with their anxiety (McCall et al., 2020). African American’s women issues with using text messaging with their behavioral health professional were protecting their communication via text, not a professional mode of therapy, detached, and the possibility of misinterpretation (McCall et al., 2020). 48.5% of African American women approved text messaging for anxiety disorder treatment with their behavioral health professionals (McCall et al., 2020). On the other hand, 51% of African American women thought it would be beneficial to use text messaging with their behavioral health professional to cope with anxiety, with 86% of these women being ok with this communication mode (McCall et al., 2020). There is no information on African American men’s thoughts on using text messaging for anxiety (McCall et al., 2020).
There would be no certainty that anxiety improved for African Americans due to the cultural awareness of the behavioral health professional (Carter et al., 2003; 2012). Furthermore, it was not certain if African American women with anxiety did well in treatment due to therapeutic interventions, dialogue between group participants and therapist, or if discussing race benefited the clients (Carter et al., 2003).

**Treatment Issues for African Americans with Anxiety Disorders**

African Americans with anxiety disorders had a lower probability of using medication management or meet with a behavioral health professional (Brenes et al., 2008; Chapman et al., 2012; Neal-Barnett et al., 2011a). Interestingly, African Americans were least likely to use medication despite having favorable views of medication management for anxiety (Hunt et al., 2013). Greater than 90% of people across racial and ethnic groups, gender, and age do not seek help from behavioral health or health professionals for anxiety disorders due to a lack of awareness, financial expenses, and intensity of symptoms (Johnson & Coles, 2013). The lack of receptivity for anxiety diagnosis for African Americans includes physical health rationale for anxiety symptoms, not admitting that they have symptoms, and difficulty acquiring treatment (Carter et al., 1996; Hunter & Schmidt, 2010; Neal-Barnett & Crowther, 2000; Neal-Barnett et al., 2011a). Specifically, African American men were not as prone to meet with a behavioral health or healthcare professional for generalized anxiety disorder (Mays et al., 2018). African American men in college were less likely to receive counseling from their university counseling center even when they experienced heightened anxiety symptoms (Williams et al., 2021). Furthermore, African American clients do not get medication management with probable explanations for issues with their activity level and taxing anxiety symptoms (Moitra et al., 2014). Per the "Theoretical Framework for the Impact of Ethnicity," negative cognitions

Obstacles to treatment for anxiety disorders include stigma and cultural mistrust for some African Americans, impacting their ability to seek therapy or medication management due to analyzing health professionals’ intentions (Johnson et al., 2009; Moitra et al., 2014). Black college students at universities in the Southern region of Louisiana were less likely to attend therapeutic services if their anxiety symptoms were chronic when there was more cultural mistrust (Dean et al., 2018). Even for African American career-driven women, stigma prevents them from receiving behavioral health services for anxiety (Neal-Barnett et al., 2011a). In alignment with the "Theoretical Framework for the Impact of Ethnicity," African Americans with anxiety who have significant racial identification may not have confidence in the intentions of White providers to go to them for professional help (Carter et al., 1996, pp. 456-457).

14.3% of African American/Black pregnant women in Appalachia (Pennsylvanian or West Virginia) had heightened dental anxiety largely due to encounters with racism in dental offices (Sokoto et al., 2022). Thus, prompting African American women to be least likely to seek dental care when most have dental insurance and only a small percentage of college education (Sokoto et al., 2022). 44% of the African/Black women in the study had dental anxiety (Sokoto et al., 2022). Dental anxiety can relate to the specific phobia in the DSM-5 and DSM-5-TR (APA, 2013, 2022; Sokoto et al., 2022).

Overlooking Anxiety Symptoms in the African American Community
African Americans particularly “middle-class African American women” were dismissive of their anxiety symptoms (Neal-Barnett & Crowther, 2000, p. 134). Fewer than 50% of African American women with panic disorder attended counseling, with most going to treatment for their marriage or divorce concerns and not their actual anxiety disorder, possibly with links to the conditioning of women (Neal-Barnett & Crowther, 2000). Additionally, 68% of African American and Caribbean Black women met with a healthcare professional or behavioral health professional for anxiety disorders over time, but only 25% in the last year (Jones et al., 2020.) African American middle-class women identify themselves as strong, which may be indicative of their dismissiveness of anxiety symptoms and the Strong Black Woman Race-Gender Schema (SBW), which heightened anxiety for African American women across age and earnings (Neal-Barnett & Crowther, 2000; Neal-Barnett et al., 2011a; Watson & Hunter, 2015).

There are issues with several anxiety disorder assessments regarding the usefulness of behavioral health professionals to measure anxiety precisely for African Americans (Johnson et al., 2007; West et al., 2013). DASS-21 and FFMQ have not been normed on African American populations (West et al., 2013). The brief panic disorder screen is more accurate for Caucasian Americans than for African Americans (Johnson et al., 2007). The Social Phobia Scale (SPS: Mattick & Clarke, 1998) and the Social Interaction Scale (SIAAS: Mattick & Clarke, 1998) are mixed in terms of effectiveness with African American adults where there are some issues with reliability and measuring specific aspects of “interaction anxiety” with social anxiety regarding results (Carter et al., 2014, p. 641). Furthermore, it is hard to measure blushing as a feature of social anxiety disorder for African Americans with darker compared to lighter skin tones (Carter et al., 2014). SPS does not fully measure “performance anxiety” and SIAS does not fully measure “interaction anxiety” for African Americans (Carter et al., 2014, p. 641).
Several studies show that African Americans do not complete anxiety disorder treatment (Jonassaint et al., 2017; Obasaju, 2009). African Americans were more prone to not finishing the online version of cognitive behavioral therapy that could help with their anxiety symptoms (Jonassaint et al., 2017). In a quantitative dissertation on African Americans with social phobia, currently known as social anxiety disorder, they had a higher likelihood at 3.62 times the probability of leaving individual counseling early and 9.29 times the probability of leaving cognitive behavioral (CBT) group counseling early regarding treatment drop out (Obasaju, 2009). African Americans with social anxiety disorders were more likely to leave CBT group counseling early than individual counseling with no plausible rationale (Obasaju, 2009). It did not matter whether other group participants or the behavioral health professional leading the group were African American or not in terms of group counseling retention (Obasaju, 2009). Interestingly, not related to treatment dropout, but adults with GAD and anxiety disorder not otherwise specified who was younger from the age of 50 and up and who were African American had no major progress with worry or African Americans are likely to have less reduction in GAD symptoms with CBT interventions than their counterparts (Conti et al., 2017).

**Health Professionals Perception of Treating African Americans with Anxiety Disorders**

Some studies give context to how medical and behavioral health professionals’ background impact clients with anxiety disorders in clinical practice without referencing the client's race, ethnicity, and gender (Lawrence et al., 2015; Stout & Maldonado, 2017). Some behavioral health professionals had the same perspective about anxiety disorders across race or socioeconomic status, where their perspective of systemic issues did not impact their diagnostic assessment (Joy & Bartholomew, 2021). Some behavioral health professionals treat clients with anxiety disorders contingent upon their symptomatology and understanding of their environment
(Joy & Bartholomew, 2021). However, most diagnosed the clients in the scenarios with GAD even when the symptoms due to environment (Joy & Bartholomew, 2021). In one study, most behavioral health professionals who provided their perceptions of anxiety disorders were white (Joy & Bartholomew, 2021). In hypothetical client cases, Black and Asian primary care doctors indicated they would counsel clients with anxiety and give referrals to psychiatrists more than Caucasian primary care doctors (Lawrence et al., 2015). Primary care doctors who completed their medical courses in foreign countries had a higher probability of counseling their clients with anxiety (Lawrence et al., 2015). Black primary care doctors were willing to treat their clients with anxiety with medication management (Lawrence et al., 2015). An issue is that the research literature on behavioral health professionals’ perception of anxiety disorders focuses on conjectural cases, not actual client cases (Joy & Bartholomew, 2021: Lawrence et al., 2015). Stout and Maldonado’s (2017) study of behavioral health professionals’ perception of clients in poverty with anxiety highlighted the behavioral health professionals’ skills working with anxiety disorders as one factor in successful treatment experience.

African Americans across research studies are less likely to receive an anxiety diagnosis in general or, in most cases, when meeting with psychiatrists or primary care doctors (Stockdale, 2008; Vanderminden & Esala, 2019). Some healthcare professionals, including psychiatrists and primary care doctors, do not diagnose African Americans with anxiety disorders due to reliance on physical health disease as a rationalization for African American anxiety symptoms (Hunter & Schmidt, 2010; Stockdale et al., 2008; Vanderminden & Esala, 2019). Despite African Americans presenting with physical symptoms of anxiety, there is a tendency for behavioral health and medical professionals to overlook physical symptoms in anxiety diagnosis (Hunter et al., 2012; Hunter & Schmidt, 2010; Vanderminden & Esala, 2019). Screening for anxiety
disorders is challenging for African American adults because some anxiety measures are not precise tools for determining if African Americans have anxiety disorders (Carter et al., 2012; Johnson et al., 2007; Parkerson et al., 2015). Behavioral health professionals need to be mindful of how certain measures, namely GAD-7, may not be the most exact measure for African Americans and focus on other mechanisms to gauge anxiety experiences for this population (Parkerson, 2015). As a result, health professionals diagnose African Americans with anxiety with erroneous mental health diagnoses (Vanderminden & Esala, 2019). An explanation for anxiety diagnosis discrepancies for African Americans is the physician or diagnostic bias resulting in not fully exploring symptoms (Last & Perrin, 1993; Vanderminden & Esala, 2019).

Additionally, African American clients did not receive therapeutic approaches, whether counseling or medication management for generalized anxiety disorder, panic disorder and social phobia, from medical providers across specialties and psychiatry (Manseau & Case, 2014). Conversely, African American, White, and Latino clients did receive medication management for anxiety disorders; however, African American clients received counseling at 50% of the rate of White clients (Samander & Harman, 2020). Healthcare professionals often did not provide African American clients with medication management for anxiety (Lagomasino et al., 2011; Moitra et al., 2014). Furthermore, medical doctors who provided medical care for mostly White clientele often did not provide African American clients with medication management in general medical or psychiatry offices (Lagomasino et al., 2011). Alternately, in some cases, African Americans received comparable rates of antidepressants as Whites with psychiatrists and were less likely to receive the medication across most years with the primary care doctors (Stockdale et al., 2008).
Pugach & Goodman (2015, p. 419) highlighted the importance of behavioral health professionals’ awareness to process their socioeconomic stressors and the impact of “discrimination” and their financial position on the client’s self-perception and worldview with women in poverty (50% African American) with anxiety and other mental health disorders. Behavioral health professionals must be mindful of cultural variation in presenting a social anxiety disorder (SAD) in diverse populations to ask clients questions regarding their experiences with discrimination in connection to their interpersonal interactions (Chapman et al., 2012). Healthcare professionals must assess Black or African American mothers across SES for abuse and stressful experiences to identify if they have more of a proclivity for anxiety (Mitchell & Ronzio, 2011).

Thus, behavioral health professionals need to look at sociocultural factors when assessing African Americans with anxiety disorder, including racial identity, assimilation, social class, educational background, familial background, and experiencing bias in terms of contribution to the anxiety disorder (Carter & Sbrocco, 2018; Chapman et al., 2012, 2013, 2015a; Hopkins & Shook, 2017; Lacey et al., 2015; Sibrava et al., 2013; Soto et al., 2011; Vanderminden & Esala, 2019). Furthermore, it is imperative to explore sociocultural variables in connection to Black college students with anxiety attending therapeutic services (Dean et al., 2018). Healthcare professionals, including medical doctors in general, and psychiatrists would need to consider their positionality and decisions regarding modality and therapeutic approaches with the client and inform their clients of varied mechanisms to work with mental health issues, including anxiety (Lawrence et al., 2015).

Behavioral health professionals need to listen to and acknowledge their client’s reports or encounters with racism and focus on the connection to their presenting concerns for clients to be
transparent in therapy (Kelly, 2006). Healthcare professionals need to focus on the impact of colorism on African Americans in programming and healthcare, considering that *in-group colorism* and *out-group colorism* has a major relationship with mental health disorders and anxiety disorders for this population (Oh et al., 2021). Researchers must explore what leads behavioral health professionals to have distinct approaches due to the client’s race and socioeconomic status (Joy & Bartholomew, 2021). It is imperative that healthcare professionals screen, diagnose, and provide effective interventions for anxiety for African American women (Hernandez et al., 2022)

**Summary**

The dearth of literature on behavioral health professionals’ understanding of anxiety disorder presentation in African Americans and the lack of consensus regarding the occurrence of anxiety disorders for this population supports exploring how behavioral health professionals assess and diagnose anxiety disorders among African Americans (Neal & Turner, 1991; Williams et al., 2013). Behavioral health professionals must be aware of their positionality and the different aspects of a social anxiety disorder (Chapman et al., 2013). This research study included exploration of the positionality of behavioral health professionals across various anxiety disorders. Behavioral health professionals can explore the relationship between racial microaggressions and anxiety for African American undergraduate and graduate students (Liao et al., 2016). There are known screenings for “social anxiety, specific phobia, and worry” for African Americans (Carter & Sbrocco, 2018, p. 187). However, this research study will identified current assessments of anxiety and anxiety disorders that are relevant and in sync with the current mental health diagnostic categories of the *DSM-V-TR* for African American adults (APA, 2022).
This research study helped behavioral health professionals grow in their perception of anxiety disorder occurrence for African American adults (Chapman et al., 2012; Neal & Turner, 1991). It is imperative to know the variation in anxiety for African Americans to aid behavioral health professionals in therapeutic resources and counseling designed for this population (Hopkins & Skook, 2017). Thus, the research aims were to know the impact and treatment outcomes for African Americans with anxiety disorders (Himle et al., 2009). This study helps to focus on the importance of awareness of sociocultural factors in client’s anxiety presentation and behavioral health professionals’ practical skills to properly conceptualize anxiety disorders amongst African Americans (Carter & Sbrocco, 2018; Chapman et al., 2012, 2013, 2015a; Hopkins & Shook, 2017; Lacey et al., 2015; Sibrava et al., 2013; Soto et al., 2011; Vanderminden & Esala, 2019).
Chapter 3

Methodology

Hermeneutic phenomenology (Gadamer, 1975/2013; Heidegger, 1962/2013) was the methodological approach for my research questions with exploration of the behavioral health professionals’ experiences working with African American adult clients with anxiety disorders and their positionality. In this chapter, I focused on the rationale of hermeneutic phenomenology, research design, sample, instruments, and data collection process. Additional focus included the research questions, data analysis, the trustworthiness of the study, and a summary. There was inclusion of the role of the researcher and experience with the research topic.

Research Questions

This study included exploration of the following research questions (1) How do behavioral health professionals perceive the presentation of anxiety disorders among African American adult clients across socioeconomic status and gender? The second central question: (2) How does behavioral health professionals’ positionality influence their perception of the presentation of anxiety disorders amongst African American adult clients?

Rationale

A qualitative methodological approach helped the researcher explore variations in anxiety disorder symptomatology for African Americans through dialogue with behavioral health professionals beyond existing quantitative data (Heurtin-Roberts et al., 1997; Vanderminden & Esala, 2019). The focus in hermeneutics is not adherence to “experimental” techniques (Gadamer, 1975/2013; van Manen, 2016, p. 6). The hermeneutic phenomenological approach provided context to how behavioral health professionals perceive anxiety disorder presentation in African Americans to treat this population despite limited research (Brown et al., 1999; Carter et
African American men are mostly missing from most studies on anxiety disorders (Chapman et al., 2011, 2012, 2015b; Durkee & Williams, 2015; Gordon et al., 2015; Markell et al., 2014; Perkins et al., 2022; Petrie et al., 2013. Given these limitations, the study’s focus was on the importance of awareness of sociocultural factors in a client's anxiety presentation and behavioral health professionals’ practical skills to properly understand anxiety disorders and symptoms among African Americans (Carter & Sbrocco, 2018; Chapman et al., 2012, 2013, 2015a; Hopkins & Shook, 2017; Lacey et al., 2015; Sibrava et al., 2013; Soto et al., 2011; Vanderminden & Esala, 2019). There was a focus on the meaning of participants’ perceptions of how they counsel, diagnose, and treat African American clients with anxiety. A phenomenological approach helped to explore what leads to behavioral health professionals’ choices regarding treating African American clients with anxiety disorders (Damsgaard, 2021).

Research Design

Hermeneutic Phenomenology

p. 84). The phenomenological lens included perceiving a way of life (Heidegger, 1962/2013). There is a focus on regard for society, care for others, and our presence in hermeneutic phenomenology (Gadamer, 1975/2013; Heidegger, 1962/2013). The entirety of a person’s interaction with society must be considered in hermeneutics (Gadamer, 1975/2013). Experience connected to a life trajectory in hermeneutics (Gadamer, 1975/2013). “All understanding is interpretation” in hermeneutics (Gadamer, 2013, p. 407). Inquiry, application, and exploration of language were critical to hermeneutic phenomenology (Gadamer, 1975/2013). Therefore, it was necessary to look at the entirety of a factor or occurrence in hermeneutics (Gadamer, 1975/2013). The researcher in this hermeneutic phenomenological study processed the entire occurrence of behavioral health professional’s perception of counseling, providing medication management, or assessing African American clients with anxiety disorders (Gadamer, 1975/2013; Heidegger, 1962/2013; Loftus & Higgs, 2010). Specific to my research topic was how (Heidegger, 1962/2013) highlighted that anxiety is part of existence in society and an ordinary part of life without a specific experience that triggers anxiety. Particular thoughts, feelings, and perspectives constituted anxiety (Heidegger, 1962/2013). Hermeneutic phenomenology did not include inherently within the methodology considerations regarding race, socioeconomic status, gender, or positionality in reference to my research questions related to my research analysis.

Hermeneutic phenomenology included focus on finding the “meaning” of the participant’s “experience” (Bynum & Varpio, 2018, p. 252; Dangal & Joshi, 2020; Dibley et al., 2020, pp. 46, 56; van Manen, 2016, pp. 11, 24). First, the researcher and participant decipher the “meaning” of the phenomenon (Dangal & Joshi, 2020; Lauterbach, 2018; van Manen, 2016, pp. 11, 24). “Descriptions” in hermeneutic phenomenology provided background for the “meaning” of the participant's life encounters (Dangal & Joshi, 2020, p. 31; van Manen, 2016, pp. 25, 31;
Wharne, 2019, p. 5). Meaning in hermeneutic phenomenology existed between the researcher and participant’s continual discourse in recognizing the phenomenon (Laverty, 2003; Vandermause & Fleming, 2011; van Manen, 2016, pp. 11, 24). It was imperative to understand “double consciousness” when exploring the positionality and racial identity of the behavioral health professionals in this study (W.E.B. Du Bois, 1903, 1994, as cited in Medina, 2012).

Hermeneutic phenomenology connected to my proposed research study with purposive sampling to decipher the meaning of several behavioral health professionals’ experiences with the same phenomenon of working with African American clients with anxiety disorders in a therapeutic capacity (Dibley et al., 2020) The theoretical framework in hermeneutic phenomenology helped with sampling and research questions and aids in understanding data collection and the aim of the research discoveries (Lopez & Willis, 2004). Hermeneutic phenomenology connected my research questions with an exploration of behavioral health professionals’ experiences working with African American adult clients presenting with anxiety disorders across socioeconomic status and gender and their positionality (Alsaigh & Coyne, 2021; Vandermause & Fleming, 2011; van Manen, 2016). The hermeneutic phenomenological lens had at center the already identified notions behavioral professionals have working with African American clients with anxiety disorders and constant processing of how to grasp anxiety disorders in this population outside of prior perceptions of the clients (Damsgaard, 2021; Gadamer, 1975/2013; Heidegger, 1962/2013; Loftus & Higgs, 2010). As researcher, I used the hermeneutic phenomenological perspective to focus on the varied perspectives of the participants through a “dialogical” approach through the behavioral health professionals’ experiences and the spaces in which they work (Loftus & Higgs, 2010, p. 383). Additionally, there was space for
varied and diverse perspectives of behavioral health professionals, which was not an all-encompassing approach.

There were some limitations of hermeneutic phenomenology in connection to my research questions. In hermeneutic phenomenology, some limitations included “hermeneutical injustice,” where dialogue from some people are not part of consideration or comprehension (Medina, 2012, pp. 202-203). Fricker (2013, p. 52) defined “hermeneutical injustice” as a person unable to conceptualize their life circumstances or discuss these encounters in interpersonal dynamics. “Hermeneutical marginalization” extends to people dealing with those external to them having difficulty in their perception of how they dialogue those life circumstances (Medina, 2012, p. 207). Furthermore, African Americans exist with “double consciousness” within the larger society and their communities from (W.E.B. Du Bois, 1903, 1994, as cited in Medina, 2012). According to Medina (2012, p. 213), a further "hermeneutical" issue was "white ignorance," where those who are White with more access to resources and who are unaware and who do not engage in reflection of the connotation of being White in society, their level of access, or the impact of their background. It is concerning when individuals who identify as White do not process the realities of “race or racism” add harm with aiding in discrimination across different groups (Robinson, 1999, p. 74). “White ignorance” is not a shared experience for everyone who is White in a society where they have diverse backgrounds (Mills, 2007, pp. 22-23). “White ignorance” is relative to ethnically diverse individuals who hold onto certain notions aligned with the majority group that are not favorable for their ethnic group (Mills, 2007, p. 22). On the other hand, Fricker (2013) defined “white ignorance” as not a "hermeneutical injustice" but as more of a predisposition about learning where those who engage in these practices are at fault and not those who are recipients (Fricker, 2013, p. 53; Mills, 2013, p. 41). It was essential
for me as the researcher to engage in “hermeneutical justice” by understanding how my background as doctoral candidate in counselor education, my clinical and wellness role at an HBCU, and my beliefs connect and differ from the participants with my openness to participants’ dialogue and sharing of their perceptions with care (Medina, 2012, p. 216).

**Sociogenic Phenomenology**

Sociogenic phenomenology provided a robust exploration of the meaning of the research participant’s experience by exploring their race, social life, and systemic barriers (LaViscount & Jeffers, 2021). Frantz Fanon (1967/2008) highlighted *sociogeny* as important, not just *phylogeny* and *ontogeny*. From a sociogenic perspective, Black men have vacillated between feeling a sense of prominence and lowliness, considering Black youth will be seen as peculiar once they interact with White society (Fanon, 1967/2008). Black men’s engagements with the world are for the larger White society (Fanon, 1967/2008). Fanon (1967/2008) focused on the "lived experience of the Black man" whereas “transcendental phenomenology” includes the researcher removing their awareness of life occurrences whereas “interpretation” and prior life encounters are relevant with the hermeneutic phenomenological approach (Damsgaard, 2021, p. 5; Gadamer, 2013, p. 407; Grbich, 2013, pp. 97, 99). The notion of “bracketing out” one’s awareness of anxiety disorder presentation and positionality was not a realistic concept under the hermeneutic approach (Dibley et al., 2020, p. 41). Sociogenic phenomenology included alternate means of data collection through discourse, consideration of race and the past, and not merely a review of interviews (La Viscount & Jeffers, 2021). The research question in sociogenic phenomenology developed through research participants and includes their experiences (LaViscount & Jeffers, 2021). My perceptions as an African American and behavioral health professional was
imperative for the research to interview behavioral health professionals treating African Americans with anxiety disorders (LaViscount & Jeffers, 2021).

My research centered on behavioral health professionals’ perceptions of anxiety disorders amongst African American clients where it was integral for me to include the notion of how African Americans have been deemed as the “irrational other” where they are regulated to the lowest place in society and seen as devoid of their existence (Wynter, 2003, p. 266). Further terminology exclusively labeled African Americans as the “dysselected by evolution until proven otherwise” that furthers this plaguing narrative of the presupposed less than status of this cultural group (Wynter, 2003, p. 267). African Americans were historically seen as immoral from a spiritual lens in connection to “sin.” (Wynter, 2003, p. 304). African Americans’ expected condition due to “otherness” included facing discrimination in the “southern” region of America (Wynter, 2003, p. 323). Thus, African Americans experience challenges to demystify these myths of their identity in larger society (Wynter, 2003).

Sample

Sampling Size and Criteria

The recruitment plan was utilizing purposive sampling (Dibley et al., 2020; Patton, 1990) with three to 12 licensed behavioral health professionals with at least a master’s degree in the behavioral health field (counseling, social work, clinical or health psychology, psychiatric nursing or psychiatry) with experience with the phenomenon of working with African American clients with anxiety disorders. All participants had an active license in their mental health field (Williams, 2010). I had a total of nine licensed behavioral health professionals in the study. Study participation requirements included having an active license in behavioral health fields including counseling, social work, clinical or health psychology, psychiatric nursing, or
psychiatry. Additional study requirements were that each participant currently worked as a licensed behavioral health professional at a Historically Black College/University (HBCU) in the southeast. The participants in this study had to provide counseling, evaluation, or prescribe medication for African American clients with anxiety disorders. All participants must be 18 years or older.

**Demographic Criteria for Participants**

I explored the demographic background of the nine licensed behavioral health professionals in this research study with the inclusion of their (1) age range (2) racial background (3) gender (4) educational background (5) license in behavioral health field (6) behavioral health certifications (7) length of time working as a behavioral health professional and (8) behavioral health diagnoses work with the most [50% or more of time], and (9) length of time providing assessment, counseling or medication management for African Americans with anxiety disorders. More demographic background information included (10) current job title, (11) current job setting (12) job duties (13) age range of clientele (14) and population work with regarding sampling racial background. I asked each participant during the interview to identify their own pseudonym to protect participant confidentiality in the study (American Counseling Association [ACA] Code of Ethics, 2014, Section G. 4. D; Dibley et al, 2020). One participant was not certain of the pseudonym name to select and allowed the researcher to identify a pseudonym name for them. I was able to ascertain the participant’s background from the behavioral health professional’s responses on the demographic questionnaire.

**Summary of Demographics**

All nine of the participants worked at HBCU’s in the southeast across varied states in the southeast where three participants were from the same state where no state names will be part of
this research to protect participant confidentiality (American Counseling Association [ACA] Code of Ethics, 2014, Section G. 4. D; Dibley et al., 2020). Seven of the participants worked at public HBCU’s and two participants worked at private HBCU’s in the southeast where no inclusion of the university names was a part of this research study to protect participant confidentiality (American Counseling Association [ACA] Code of Ethics, 2014, Section G. 4. d).

Six of the nine participants were licensed professional counselors, and three participants were licensed clinical social workers. Participants’ experience of providing counseling and assessment for anxiety disorders included: three participants with 10 to 15 years of experience, two participants with 15 to 20 years of experience, one participant with over 20 years of experience, one participant with 17 years (school and clinical) and five years in clinical regarding experience, one participant with five to nine years of experience, one participant with one to four years of experience. The participant’s educational backgrounds included two participants with a doctoral degree, two participants were doctoral candidates (all but dissertation), five participants had earned master’s degrees and were current doctoral students, and one participant earned a master’s degree. Eight of the nine participants were women and one man. Eight of the nine participants identified as African American or Black and one participant identified as biracial. Participants age group was from age 26 to 65 and above. Four participants were in the age group 36 to 46, three participants 47 to 57, 1 participant 65 and above, and one participant 26 to 35. The participant’s job titles included that four of the participants were directors of their university counseling centers, one was a disabilities counselor, and four identified their therapy titles as either, LPC, LCSW and two as psychotherapists. All nine of the participants identified that anxiety diagnoses were one of the behavioral health diagnoses that they worked with the most in their clinical practice in connection to having a purposeful sample (Patton, 1990).
There is a table that includes demographic information regarding participants in Table 1 below.

**Participants**

**Table 1**

*Participant Demographic Information*

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age Range</th>
<th>Racial Background</th>
<th>Gender</th>
<th>Licensure</th>
<th>Job Title at HBCU</th>
<th>Years of Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. Z</td>
<td>36 to 46</td>
<td>African American</td>
<td>Male</td>
<td>LPC-S</td>
<td>Director of Student Counseling &amp; Wellness</td>
<td>15 to 20 years</td>
</tr>
<tr>
<td>Ms. A</td>
<td>36 to 46</td>
<td>Black</td>
<td>Female</td>
<td>LPC</td>
<td>Director</td>
<td>10 to 15 years</td>
</tr>
<tr>
<td>Cara</td>
<td>36 to 46</td>
<td>Black/African American</td>
<td>Woman</td>
<td>LPC</td>
<td>Director, Counseling Center/Services; Therapist/Counselor</td>
<td>17 years</td>
</tr>
<tr>
<td>Jade</td>
<td>26 to 35</td>
<td>Black/African American</td>
<td>Cisgender Female</td>
<td>LPC</td>
<td>LPC</td>
<td>5 to 9 years</td>
</tr>
<tr>
<td>Lady Bug</td>
<td>47 to 57</td>
<td>African American/Black</td>
<td>Female</td>
<td>LPC</td>
<td>Disabilities Counselor</td>
<td>1 to 4 years</td>
</tr>
<tr>
<td>Shasha</td>
<td>36 to 46</td>
<td>Biracial</td>
<td>Female</td>
<td>LCSW</td>
<td>LCSW</td>
<td>10 to 15 years</td>
</tr>
<tr>
<td>Jasmine</td>
<td>47 to 57</td>
<td>African American</td>
<td>Female</td>
<td>LCSW</td>
<td>Director of Student Counseling Services</td>
<td>Over 20 years</td>
</tr>
<tr>
<td>Ashley Nicole</td>
<td>47 to 57</td>
<td>African American/Black</td>
<td>Female</td>
<td>LCSW</td>
<td>Psychotherapist</td>
<td>10 to 15 years</td>
</tr>
<tr>
<td>Dr. Zora</td>
<td>65 and above</td>
<td>African American</td>
<td>Female</td>
<td>LPC</td>
<td>Psychotherapist</td>
<td>15 to 20 years</td>
</tr>
</tbody>
</table>
Note. Adapted from *Types of Mental Health Professionals* by National Alliance of Mental Illness, 2020). LPC-S = Licensed Professional Counselor-Supervisor; LPC = Licensed Professional Counselor; LCSW = Licensed Clinical Social Worker

**Mr. Z**

Mr. Z is an African American man in the 36-to-46 age group who is a (LPC-S) with a master’s degree. He has 15-to-20 years of experience working as a licensed behavioral health professional. He has behavioral health certification in LAC supervision, telehealth, and drug addictions. Mr. Z identified that he mostly works with behavioral health diagnoses including *anxiety disorders, bipolar and related disorders, neurodevelopmental disorders, substance-related and other disorders, and trauma-and-stressor related disorders* (APA, 2022). He worked for 15 to 20 years providing counseling and assessment for African Americans with anxiety disorders. Mr. Z is currently the director of counseling & student wellness at an HBCU, works in an employee assistance program (EAP), and in private practice. His job duties include assessment, case management, counseling, consultation, diagnosis, outreach, presentations and referral. Mr. Z worked with all age groups including children, adolescents, young adults (18-25), adults, and senior or geriatric population. He has worked across diverse racial backgrounds with clients including American Indian or Alaska Native, Black or African American, Hispanic or Latino, White or Caucasian American, and biracial or multiracial (African American and White).

**Ms. A**

Ms. A is a Black/African American woman in the 36-to-46 age group who is a LPC with a master’s degree and currently pursuing doctoral coursework. She has 10 to 15 years of experience working as a licensed behavioral health professional. Ms. A is a board-certified telemental health provider. Ms. A identified that she mostly works with behavioral health
diagnoses including anxiety disorders, and trauma-and-stressor related disorders (APA, 2022). She has been working for 10 to 15 years providing counseling and assessment for African Americans with anxiety disorders. Ms. A is currently the director of a college counseling center at an HBCU. Her job duties include assessment, counseling, consultation, and presentations. Ms. A has worked with young adults aged 18-25 and worked with African American or Black clients.

Cara

Cara is an African American woman in the 36-to-46 age group who is a (LPC) with a master’s degree and a Ph.D. candidate/all but dissertation (ABD). She has a total of 17 years of experience as a licensed behavioral health professional with 17 years of experience in school and clinical with 5 years of clinical experience. Cara has behavioral health certifications as a national certified counselor (NCC), national certified school counselor, (NCSC), approved clinical supervisor (ACS), board certified-telemental health provider (BC-TMH), global career development facilitator (GDCF), and mental health first aid instructor. She identified that she mostly works with behavioral health diagnoses including anxiety disorders, depressive disorders, and neurodevelopmental disorders (APA, 2022). Cara has been working for 17 years (school and clinical)/ five years in clinical only providing counseling and assessment for African Americans with anxiety disorders. She is the director of counseling center/services at an HBCU, a therapist and counselor, and works in private practice and with sports and performance consultation. Cara’s job duties include assessment, counseling, consultation, outreach, presentations and other job duties. She worked with young adults (18-25), and adults. Cara has worked across diverse racial backgrounds with clients including Black or African American, Hispanic or Latino, Middle Eastern or North African, White, or Caucasian American, biracial or multiracial and Asian/Asian American/AAPI.
Jade

Jade is a Black/African American cisgender female in the 26-to-35 age group who is a (LPC) with a master’s degree and pursuing doctoral coursework. She has five to nine years of experience as a licensed behavioral health professional. Jade has behavioral health certification where EMDR trained. She identified that she mostly works with behavioral health diagnoses including anxiety disorders, bipolar and related disorders, depressive disorders, and trauma-and-stressor related disorders (APA, 2022). Jade has been working for five to nine years providing assessment and counseling for African Americans with anxiety disorders. She is a LPC at an HBCU and works in private practice. Jade’s job duties include counseling, outreach, presentations and referral. She works with young adults (18-25), and adults. Jade has worked with clients including Black or African American.

Lady Bug

Lady Bug is an African American/Black woman in the 47-to-57 age group who is a (LPC) with a master’s degree and pursuing doctoral coursework. She has one to four years of experience as a licensed behavioral health professional. Lady Bug has behavioral health certification as a national certified counselor. She identified that she mostly works with behavioral health diagnoses including anxiety disorders, depressive disorders, depressive disorders, and trauma-and-stressor related disorders. (APA, 2022). Lady Bug has been working for one to four years providing assessment and counseling for African Americans with anxiety disorders. She is a disabilities counselor at an HBCU, and checks notes for a behavioral health company. Lady Bug’s job duties include assessment, consultation, outreach, and presentations. She works with young adults (18-25) mostly, and adults. Lady Bug has worked with clients including Black or African American, biracial and multiracial.
Shasha

Shasha is a biracial woman in the 36-to-46 age group who is a (LCSW) with a master’s degree, Ph.D. candidate all but dissertation (ABD). She has 10 to 15 years of experience as a licensed behavioral health professional. Shasha identified that she mostly works with behavioral health diagnoses including anxiety disorders and trauma exposure itself (APA, 2022). Shasha has been working for 20 years providing assessment and counseling for African Americans with anxiety disorders. She is a licensed clinical social worker at an HBCU. Shasha’s job duties include assessment, case management, counseling consultation, diagnosis, outreach, presentations, referral, and psychoeducation. She works with young adults (18-25). Shasha works with clients including Black or African American, Hispanic or Latino, Middle Eastern or North African, White or Caucasian, biracial and multiracial, and not certain of all the demographics of clients.

Jasmine

Jasmine is an African American/Black woman in the 47-to-57 age group who is a (LCSW) with a doctoral degree. She has over 20 years of experience as a licensed behavioral health professional. Jasmine identified that she mostly works with behavioral health diagnoses including anxiety disorders and depressive disorders (APA, 2022). Jasmine has been working for over 20 years providing assessment and counseling for African Americans with anxiety disorders. She is the director of student counseling services at an HBCU. Jasmine’s job duties include assessment, case management, counseling, consultation, outreach, presentations, and referral. She works with young adults (18-25). Jasmine works with clients including Black or African American, White or Caucasian.
Ashley Nicole

Ashley Nicole is an African American/Black woman in the 47-to-57 age group who is a (LCSW) pursuing doctoral coursework. She has 10 to 15 years of experience where fully licensed for 10 years and began the process 13 years ago. Ashley Nicole is in the process of registering as a licensed clinical addiction specialist. Ashley Nicole identified that she mostly works with behavioral health diagnoses including anxiety disorders, bipolar and related disorders, depressive disorders, somatic symptom and related disorders, substance-related and other disorders, trauma-and stressor related disorders (APA, 2022). She discussed that have experience working with obsessive compulsive disorders; however, do not work 50% of her time in this area (APA, 2022). Ashley Nicole discussed that have experience working with clients with grief and loss. She has been working for 10 to 15 years providing assessment and counseling for African Americans with anxiety disorders. She is a psychotherapist at an HBCU and has a private practice. Ashley Nicole’s job duties include assessment, case management, counseling, consultation, diagnosis, outreach, and presentations. She provides referrals not that often but every now and then if individuals need additional services for intensive in-home or other forms of treatment. Ashley Nicole works with children, adolescents, young adults (18-25), adults, senior and geriatric population. She specified that work with clients aged 8 to 77. Ashley Nicole works with clients including Black or African American, White or Caucasian, biracial and or multiracial, and not as much Middle Eastern or North African clients.

Dr. Zora

Dr. Zora is an African American woman in the 65 and above group who is a licensed professional counselor with a doctoral degree. She has certifications that include that a national certified counselor, certified professional counselor supervisor, board certified telemental health,
and certified sex therapy informed professional health provider. She has 15 to 20 years of experience where licensed as a behavioral health professional. Dr. Zora identified that she mostly works with behavioral health diagnoses including anxiety disorders, bipolar and related disorders, depressive disorders, personality disorders, and trauma-and stressor related disorders (APA, 2022). Dr. Zora has been working for 15 to 20 years providing assessment and counseling for African Americans with anxiety disorders. She is a psychotherapist at an HBCU and has a private practice. Dr. Zora’s job duties include counseling, consultation, and presentations. Dr. Zora works with children, adolescents, young adults (18-25), adults, senior and geriatric population. She specified that work with clients aged 8 to 77. Dr. Zora with clients including Black or African American, Hispanic or Latino, Middle Eastern or North African, White or Caucasian, biracial and or multiracial, European, and Asian.

Data Collection Procedures

I created an interview guide in Appendix A with 14 questions (Rubin & Rubin, 2011; Stout & Maldonado, 2017). The interview guide had no norming on a prior sample or population. Interview questions included an “open-ended” format (Dibley et al., 2020, p. 97; Spence, 2017, p. 838; Stout & Maldonado, 2017, p. 23). I conducted a semi-structured interview with the behavioral health professionals for the hermeneutic phenomenological study (Kierski, 2014; Lauterbach, 2018; Wharne, 2019). In addition, I used follow-up questions contingent on participants’ responses and probes (Lichtman, 2013). It was important to use questions that were not directing a certain response with the research participants (Aguas, 2022).

Participant Recruitment

I submitted all the necessary forms to the Institutional Review Board (IRB) at the University of New Orleans (UNO) including the IRB application, demographic questionnaire,
interview guide, and recruitment letter. I received approval from IRB at UNO that I could commence the research study as of 6/21/2023 located in Appendix A. I later submitted the recruitment letter and recruitment email to IRB as well as updated documents. I recruited from June 2023 to January 2024 securing the first interview in July of 2023. I updated the interview months on the recruitment letter and email sent to prospective participants from August to September of 2023, October 2023, November 2023, December 2023 or January 2024. I was last able to successfully recruit participants in October of 2023. The demographic questionnaire is in Appendix B, recruitment letter is in Appendix D, and the recruitment email is in Appendix E.

**Recruitment Plan**

The recruitment plan was to utilize purposive sampling (Dibley et al., 2020; Patton, 1990) with three to 12 licensed behavioral health professionals with at least a master’s degree in the behavioral health field who were presumed to have experience working with African American clients with anxiety disorders due to working at a HBCU counseling center. My recruitment plans included calling, sending emails, and posting on listservs for participants who are behavioral health professionals at university counseling centers at Historically Black Colleges and Universities (HBCUs) (Joy & Bartholomew, 2021). I had social media listed as a recruitment method on my IRB application; however, I did not use this method to garner research participants (Dibley et al., 2020). I sent out a dissertation research recruitment letter to the American College Counseling Association (ACCA) listserv and to a counseling division email for the Southeast and a HBCU behavioral health initiative (Dibley et al., 2020). A licensed mental health professional posted my dissertation flyer in their Facebook groups as of 7/7/2023 in which no participants acquired via social media. I utilized the National Center for Education Statistics, U.S. Department of Education (2021) list of “Historically Black College and
Universities” to identify universities where I could then search the webpages of each of the HBCU’s counseling centers. I searched specifically for HBCU counseling center webpages in the southeastern region of the United States. I looked for email addresses for directors and counseling center staff of the HBCU counseling centers. I searched for licensure credentials next to the mental health professional’s names at HBCU’s for purposeful sampling. I mostly emailed directors of HBCU counseling centers in the southeast the recruitment letter under the assumption that they may have to approve of the study or the dissemination of the study recruitment letter in Appendix B and email in Appendix C to their counseling center staff. I emailed the general counseling center emails my recruitment letter if no identifiable staff member emails were on the university’s websites. I called HBCU counseling centers where there were no general emails or emails for mental health professionals on the counseling center website. I called HBCU counseling centers main contact number to assist with better recruitment potential. I utilized a phone script in Appendix D to speak specifically with staff members about my dissertation, where the staff member would direct me to a director or other staff members or ask if I could email my recruitment letter. I sent out follow-up emails within at least two-weeks after the original recruitment email and sometimes sent out three to four emails to recruit for an identified staff member of the HBCU counseling center. I noticed that when I sent three to four emails to the staff member that it was unsuccessful attempt in securing the participant. I was able to successfully recruit three participants who responded affirmatively of interest in the study via email. I successfully recruited five participants through phone call, recruitment email/letter, and follow up email from the prospective participant. Participant recruitment for one participant was via the initial phone call. It was unexpected; however, snowball sampling was helpful in securing one participant where a participant suggested a prospective participant for the study and other
HBCU counseling centers that I could reach out too (Dibley et al., 2020; Moser & Korstjens, 2018).

I provided all participants with informed consent before study implementation to explore the helpfulness, the potential harm of the study, and the purpose of the research (ACA, 2014; Section G.2.a.; Vanderpot et al., 2018; van Manen, 2016). The consent form had emergency contacts including 911 for behavioral health or physical emergencies, 24-hour crisis hotlines including: SAMHSA confidential treatment referral line, Metropolitan Crisis Response Team, Jefferson Parish Mobile Crisis Team, and the national Suicide and Crisis Lifeline. The consent form included that participants who reported suicidal thoughts, plan or ideation would receive immediate crisis services and referral and will not be included in study. I provided all participants with a password protected informed consent form in Appendix E and demographic questionnaire in Appendix F. Each participant was to complete a demographic questionnaire before the start of the interview, including their clinical practice in the behavioral health professional role (Hughes et al., 2016; Joy & Bartholomew, 2021; Stout & Maldonado, 2017; Summers & Lassiter, 2022). Six of the nine participants completed the demographic questionnaire prior to start of the interview with the researcher. One participant asked for the interview questions prior to the interview. I sent four participants updated consent forms that files would be stored in a locked file cabinet. The updated consent form included that there would be peer debriefing in the study with review of interview transcripts and findings (Janesick, 2007). All participants signed the updated consent form. I sent out calendar invites for the Zoom-HIPPA interview two days prior to the interview.

Data collection in this hermeneutic phenomenological study consisted of semi-structured video and audiotaped interviews that lasted from 36 minutes to two hours and five minutes with
an “open-ended” format to gather the participant’s experience with providing clinical services in the form of assessment, counseling, diagnosis, and or medication management for African American clients with anxiety disorders (Dibley et al., 2020, p. 97; Kierski, 2014; Lauterbach, 2018; Spence, 2017, p. 838; Stout & Maldonado, 2017, p. 23; van Manen, 2016; Wharne, 2019). My original plan was to conduct interviews via HIPPA Zoom for interviews with research participants outside of the Greater New Orleans area who are located in the Southeastern region of the United States and via hand-held audio recorder for participants in the Greater New Orleans area (Stout & Maldonado, 2017). I was to use a hand-held audio recorder to record in-person interviews with research participants in the Greater New Orleans area (Stout & Maldonado, 2017). I conducted all the interviews via HIPPA Zoom for all participants in the Southeastern region of the United States using the interview script in Appendix G. Interview times ranged from 36 minutes to two hours and five minutes in duration. Interviews were saved on a “password protected” laptop to protect the confidentiality of the participants and did not include any potentially harmful information to protect study participants (ACA, 2014, Section G.4.d.; Stout & Maldonado, 2017, p. 25). Interview questions four and nine on the interview guide helped to solidify and verify that participants in the study had experience working with African American clients with anxiety disorders. These interview questions include a focus on the behavioral health professionals experience and preparation for working with African American clients with anxiety disorders. Data collection included confirming participant’s replies “where trustworthiness” “is verified by the community” in which I reflected on the participant’s responses during the interview and asked clarification questions (LaViscount & Jeffers, 2021, p. 60). Awareness derives from questions, and questions help with more flexibility, providing
perception and clarity (Gadamer, 1975/2013). I sent a thank you email after the completion of the study in Appendix H.

**Role of the Researcher**

A strength of hermeneutic phenomenology was that I had an awareness of my research topic where my perception of my experiences counseling African American clients with anxiety disorders was instrumental (Dibley et al., 2020; Gadamer, 1975/2013; Heidegger, 1962/2013; van Manen, 2016). It was imperative as researcher that I know the purpose of my “positionality” in connection to the to all behavioral health professionals in the study, regarding that we all practice clinically as behavioral health professionals at HBCU’s in the southeast (Boveda & Annamma, 2023, pp. 306-307; Jacobson & Mustafa, 2019). The “Social Identity Map” was a useful resource to ascertain how myself and the behavioral health professionals in the study align and have variation (Jacobson & Mutsfa, 2019, p. 7). The behavioral health professionals and I are African American where one participant was biracial where African American was also a part of the participant’s racial background (Boveda & Annamma, 2023, p. 306; Jacobson & Mustafa, 2019). I work at a private HBCU like two of the behavioral health professionals in the research study (Jacobson & Mustafa, 2019). There was some variation in clinical experiences including that a few of the behavioral health professionals in my research study had more years of experience providing counseling or assessment for African Americans with anxiety disorders than I have (Jacobson & Mustafa, 2019). Three of the participants were LCSW’s in which I am an LPC-S and where a majority of the behavioral health professionals were in the counseling profession similar to the researcher (Jacobson & Mustafa, 2019; National Alliance of Mental Illness, 2020). Eight of the nine behavioral health professionals in the study were women alike me except for one who was a man. (Jacobson & Mustafa, 2017). More than half of the behavioral
health professionals were in a different age group than the researcher (Jacobsen & Mustafa, 2019). It was imperative for interpretation in hermeneutic phenomenological research for the researcher to acknowledge assumptions and experience of the phenomenon under study (Gadamer, 1975/2013; Heidegger, 1962/2013). Reflexivity is essential in hermeneutic phenomenology to see the researcher’s connection with the research (Wharne, 2019). “Researcher subjectivity” includes the individual experiences of the researcher with the research topic (Dibley et al., 2020, p. 73; Lauterbach, 2018, p. 285). The researcher refrained from detaching from the previous experience of the topic ahead of time, which helps clarify or creates confusion (Gadamer, 1975/2013).

My role as a researcher was significant to this study and analysis, considering that I am an African American woman and a licensed professional counselor, board approved supervisor, licensed addiction counselor, and nationally certified counselor (Dahlstrom, 2010; Dibley et al., 2020; Gadamer, 1975/2013; Heidegger, 1962/2013; Lauterbach, 2018, Lopez & Willis, 1994; van Manen, 2016; Wharne, 2019). Black feminist thought and inclusion of my “positionality” is a pathway for acknowledging myself as African American woman that I have clinical awareness of anxiety disorders for over 15 years with over 13 year specifically counseling African American clients as well as reading a range of research literature with a specific focus on African Americans (Boveda & Anamma, 2023, p. 307; Collins, 2022, Few et al., 2003). Diverse individuals and communities of color can express and provide meaning regarding who they are to work towards more equitable spaces (Collins, 2022; Few et al., 2003). It was imperative when discussing “positionality “to also include the significance of “race” (Boveda & Anamma, 2023, p. 310). I facilitated an anxiety support group at my job for the spring 2019 semester. I have conducted several presentations for mainly African American college students and some
graduate students on general mental health including anxiety, anxiety disorders, and on coping with anxiety and stress. I have served as a doctoral university supervisor for master’s mental health counseling interns and a few school counseling interns that have worked with clients with anxiety symptoms or anxiety diagnoses. I currently serve on the Black student mental health advisory board for the Institute for Capacity Building (ICB) with the United Negro College Fund (UNCF). I explored how my educational background in having a master’s degree in professional counseling, my doctoral program in counselor education, and my “positionality” influence my research and bias awareness (Johnson & Christensen, 2014; Sinclair, 2020, p. 450).

It was essential to engage in reflection when researching underrepresented and disenfranchised groups to grasp “ways of knowing” where I as researcher focused on the Black feminist lens in consideration of the behavioral health professionals expressing the meaning of their experiences diagnosing African Americans with anxiety disorders and their perception of anxiety disorders amongst this population (Boveda & Annamma, 2023, p. 311; Collins, 2022; Dillard, 2000, p. 663). Furthermore, Boveda and Annamma’s (2023) perspective gives credence to my selection of Hunter and Schmidt’s (2010) A Sociocultural Model of Anxiety in African Americans as part of my theoretical approach regarding the behavioral health professional’s perception of the presentation of anxiety disorders amongst African Americans. It was integral as researcher that I explore the experiences of “multiply marginalized people” which connects to research question one in this study where I explored the behavioral health professional’s perception of anxiety disorders across socioeconomic status and gender (Boveda & Annamma, 2023, p. 311). “SES” was one essential aspect to explore in research (Milner, 2007, p. 390). I asked questions regarding anxiety disorder presentation for African American women, men, and those with diverse gender identities or LGBTQ + population. I considered the “positionality” of
the participants in my research regarding their background and their perception of anxiety disorders which included age, ethnicity, gender, language, socioeconomic status, and sexual orientation (Boveda & Annamma, 2023, p. 311).

I tried as a researcher in this study to utilize the interviews in a manner to gather the wealth of clinical work that the behavioral health professionals had provided whether counseling or diagnosis, to grasp the meaning of anxiety disorders for them, their life story, steps of preparation and creative resources that are associated with their grasp of anxiety disorders (Collins, 2022). There was no consensus on behavioral health professionals’ perception of anxiety disorders among African American clients because the goal of hermeneutic phenomenology is not to have a singular perception from the behavioral health professionals (Dibley et al., 2020). I considered that because I interviewed African American women, they will offer unlimited access to racial and gender similarities (Few et al., 2003). I recognized my power in the space in the researcher role (Few et al., 2003).

“Data saturation” was not a concept in hermeneutic phenomenology due to lack of feasibility as each participant is likely not to have an all-encompassing understanding regarding anxiety disorders amongst African American clients or likely not disclose all details of their clinical practice (Dibley et al., 2020, p. 61) “Data saturation” in terms of finding a parallel perception of how behavioral health professionals perceive anxiety amongst African American clients or a parallel influence of their positionality is not the research objective (van Manen, 2014, p. 353). The research plan consisted of the researcher continuing the research exploration and stop once there are no more divergent perceptions via “data analysis” (van Manen, 2014, p. 353). Overall, the purpose of the research was not giving an exact response to focus on the sum total of perspectives (Dibley et al., 2020). A feminist theoretical lens considers that there is not a
singular way to grasp meaning and for exploration (Dillard, 2000). The outcome of the study was to look at “themes” identified that are a solid response to adequately address the “research question” (Dibley et al., 2020, pp. 61-62).

Data Analysis

It was integral to focus on the interview “transcriptions” for exploring the perceptions of behavioral health professionals working with African American adult clients with anxiety disorders (Hycner, 1985, p. 280; Priest, 2002; Wharne, 2019). Data collection forms for the hermeneutic approach included dialogue to concord with research participants and the researcher (Gadamer, 1975/2013). Dialogue is how humans convey their connection and perception of people, their own life, and the larger societal context (Heidegger, 1962/2013). It is hard to predict the exact nature of a dialogue (Gadamer, 1975/2013). I looked for the communication of life circumstances throughout the interview transcripts that describe the phenomenon (Aguas, 2022; Moustakas, 1994; van Manen, 2016). Hermeneutics includes analysis of recorded words in research (Gadamer, 1975; 2013/Heidegger, 1962/2013). I focused on the meaning of the behavioral health professionals’ experience (perception) of anxiety disorders regarding their African American clients and have them meditate on their clinical experience with clients with counseling, evaluation, or treatment, whether counseling or medication management (Hycner, 1985; Wharne, 2019). None of the research participants prescribed medication management due to medication management not being a part of their clinical practice, licensure or credentials. The analysis in hermeneutic phenomenology is when meaning connects to grasping a concept that may not be direct or follow a specific pattern (Heidegger, 1962/2013). Thematizing is the awareness of human existence, conceptualization, and completion in hermeneutic phenomenology (Heidegger, 1962/2013).
I focused on the overall meaning of the participant’s experiences by reviewing the interview transcripts via the hermeneutic phenomenological approach (Suddick et al., 2020). I use varied *hermeneutic circles* to look for discourse within the circles (Suddick et al., 2020). The hermeneutic circle involves how humans grasp information by exploring different angles, from the “whole to its parts” (Gadamer, 1975/2013, p. 196). The hermeneutic circle looks at how behavioral health professionals and my interpretation of anxiety disorders perception among African American clients (Gadamer, 1975/2013). As the researcher, I described the phenomenon (Heidegger, 1962/2013).

My transcription processed consisted of transcribing while watching the HIPPA Zoom video twice to include verbatim [verbal language] and nonverbal communication via facial expressions, hand gestures, minimal encouragers, nodding, physical body language of the participant and the interviewer (Dibley et al. 2020). I utilized the Zoom audio to listen as my third check of the verbatim transcripts in a Word document to process the data where I made any needed corrections (Stout & Maldonado, 2017). I focused on the exactness of the verbal discourse via the Zoom audio between the participant and interviewer as the communication between participant and researcher is essential (Dibley et al., 2020; van Manen, 2016).

Interpretation is central to the awareness and importance of the phenomenon in hermeneutic phenomenology (Dangal & Joshi, 2020; Dahlstrom, 2010; Heidegger, 1962/2013). In addition, interpretation includes a multifaceted process of grasping the realm in which we live in hermeneutic phenomenology (Heidegger, 1962/2013). The researcher with interpretation must view behavioral health professionals’ perception of providing clinical services to clients with anxiety disorders (Damsgaard, 2021; Loftus & Higgs, 2010). The interpretation is individual and conceptual in hermeneutics (Heidegger, 1962/2013; van Manen, 2016). The researcher had to
conceptualize what was taking place from the participant’s perspective, where the difference in perception is ok (Gadamer, 1975, 2013). Level one analysis in hermeneutic phenomenology involved adding observations regarding the participant’s statements (Wharne, 2019). Level two analysis focused on different statements linked to themes, and level three analysis included an integration of the different transcripts to focus on the myriad of pivotal experiences for participants without focusing on a generalized perspective (Vanderpot, 2018; Wharne, 2019). The *hermeneutic circle* is instrumental in hermeneutic phenomenology (Laverty, 2003). The *hermeneutic circle* was helpful to utilize to review the participants’ interview transcripts to focus on different terms, statements, and the overall transcript (Vanderpot, 2018). It was essential to explore the entirety of the phenomena and not just a singular aspect to interpret the "meaning" of the phenomenon (Heidegger, 1962/2013, p. 426).

**Analytic Memo**

I utilized the *analytic memo* throughout the process of transcribing interviews and reading interviews varied times (Saldaña, 2021). The analytic memos were helpful in the researcher exploring the participant’s perspective of anxiety disorders and their positionality regarding their experiences and positionality (Saldaña, 2021). I wrote and explored similarities and differences as well as connections with the interviewee’s responses with my literature review and the theoretical frameworks in the research study during and after transcribing each interview. I identified and wrote similarities and differences as I read each interview transcript for a total of three times as hermeneutic phenomenology includes identifying themes in the study via the “selective approach” to identify substantial statements about the meaning of the participants experience (Saldaña, 2021; van Manen, 2016, pp. 92-95). I typed connections and differences in comparison to my participants experiences in the *analytic memo* and if different statements had a
connection to my perspectives of counseling or social issues (Saldaña, 2021). I typed a summary of each interview after the first reading (Saldaña, 2021). I explored and wrote connections with the interviewee’s response with my literature review and the theoretical frameworks in the research study after the first, second, and third reading of all of the interview transcripts. I identified and wrote similarities and differences across interview participants as well as surprises after the first, second, and third reading of the interview transcripts. I wrote one descriptive statement after the second reading of each interview transcript to help me reflect on the interviewee’s response per question and focused on words that commonly appeared in the interview (van Manen, 2016). I categorized the data with written and physical descriptions to understand the meaning of the participant’s experiences (Dangal & Joshi, 2020; Moustakas, 1994). I wrote an overall reflection summary after the third reading of each interview transcript (Saldaña, 2021). I included in the memo if there was a particular question that I wish I would have asked during the interview (Saldaña, 2021).

Creative Resources

A focus on creative resources was part of the recruitment letter identifying that I would ask participants to submit flyers or brochures for groups, programs, presentations, and services they provide to see if they are in areas of anxiety, anxiety disorders, or working with African American clients (Ardévol, 2012; Rose, 2016). I asked participants via interview question 13 if they utilized creative resources including website information, flyers, brochures, presentations, journal articles, and books to gather information regarding their experience with these creative platforms from a hermeneutic perspective (Gadamer, 1975/2013). I asked initial participants if they would be willing to bring the creative materials to a follow-up interview. I informed most participants that I would likely not need a second interview if I have data saturation due to
processing with my methodologist not to exhaust the participants. I recognized that “data saturation” is not a concept in hermeneutic phenomenology through further research (Dibley et al., 2020). I asked if participants would be willing to share the creative materials for data analysis only. All participants agreed that ok with sharing materials that in most cases were mostly presentations or handouts. Most participants had not created materials specific for anxiety. One participant emailed creative materials via flyers. My plan was to focus on the context of the pictures of the flyers, brochures, and presentation to focus on the depiction of anxiety disorders place of the frame of reference of focus on behavioral health professionals’ perception of anxiety disorders amongst African American clients to see if parallels across the material (Dibley et al., 2020; Gadamer, 1975/2013). Thus, since receiving flyers from one participant I included my perception of those creative materials and the participant’s responses to question 13 as part of my data analysis.

**Reflexive Journal**

Data collection included me using and maintaining a *reflexive journal* during the duration of my research study to process my preconceived notions, knowledge, and experiences with my research focus, journal articles, books, and data collection on anxiety disorders in African American adults (Hycner, 1985; Ladd & De Decker, 2022; Laverty, 2003; Spence, 2017). I created a reflexive journal for post interview. I included my perspectives including the connections to my experiences from my positionality and background as variation from the participants as well as my thoughts, emotions, and experiences post interview, after transcribing and reading the interview transcripts in what I define as a *reflexive journal/ analytic memo* (Dibley et al., 2020; Hycner, 1985; Ladd & De Decker, 2022; Laverty, 2003; Milner, 2007;
Saldaña, 2021; Spence, 2017; van Manen, 2016). I utilized the feminist framework in exploring my perspective and experience of the interviewing each participant (Dillard, 2000).

Coding

I transcribed my interviews precisely and reviewed every statement for coding thoroughly, and coding was on objects of concern and meanings to maintain a record of emerging themes (Larkin & Thompson, 2012). I coded the data and utilized a qualitative data analysis computer program called Nvivo 14 Transcription (Lumivero, 2023). I reviewed the interview transcripts “line by line approach” “sentence by sentence” to identify themes to understand the ways behavioral health professionals perceive the presentation of anxiety disorders and how their positionality influences their perceptions (van Manen, 2014, 2016, pp. 92-95). I coded the interview transcripts to the two “research questions” in this study under “structural codes/structural coding” (1) behavioral health professional’s perception of anxiety disorders and (2) behavioral health professionals positionality influence where the coding process consisted of gathering substantive information (Adu, 2023a,b; Saldaña, 2021, pp. 130-131, 133, 368). I placed other supplemental information from interview transcripts in a code titled “additional findings” (Adu, 2023b).

The overall coding process sought to be “inductive” as I devised codes in Nvivo while analyzing the interview transcripts (Lumivero, 2023; Saldaña, 2021, pp. 40). I utilized “process codes/coding” to look at the experiences of behavioral health professionals working with African American clients with anxiety disorders through the process of counseling, diagnosis, assessment, and treatment approaches (Saldaña, 2021, pp. 8-9, 95, 97, 143, 365). I utilized “in vivo codes/coding” to grasp the specific verbal dialogue and statements of the behavioral health professionals in describing their experience (Saldaña, 2021, pp.7, 10, 95, 97, 100, 137, 139-140,
I implemented “emotion coding” to focus on feelings regarding interview question five when it came to feelings regarding the meaning of behavioral health professionals diagnosing African American clients with anxiety disorders (Saldaña, 2021, pp. 159, 363). There was use of “values coding” to identify participants’ specific worldview and perspectives regarding presentation of anxiety disorders across socioeconomic status and gender for research question one and their “positionality” in research question two (Saldaña, 2021, pp. 168, 173, 369). I used “versus coding” to consider two different positions of the behavioral health professional’s viewpoints (Saldaña, 2021, pp. 174-175, 177, 368-370). I coded using “theming the data phenomenologically” with the terms “is” and “means” to code the participant’s perception (Saldaña, 2021, pp. 268, 369). I utilized “eclectic coding” where used varied coding techniques across all the interview transcripts (Saldaña, 2021, pp. 222-223, 227, 363). I coded one interview transcript at time (Saldaña, 2021, pp. 7, 10). Coding includes the researcher’s perception of the collection of the research (Saldaña, 2021). Coding was a continual process that including un-coding and “re-coded” statements from the interview transcripts (Saldaña, 2021, pp. 22, 299).

There is not a specific quantity of “codes, categories or themes” for the research study (Saldaña, 2021, p. 33). I utilized different “categories” and “subcategories” (Saldaña, 2021, p.17). Themes became evident from the “coding” process and “categories” (Saldaña, 2021, p. 19). I maintained a “codebook” exported into word and excel throughout the data analysis process (Lumivero, 2013; Saldaña, 2021, p. 41). The final analysis included identifying the codes utilized the most, putting codes together that match and aligning “codes into themes” (Saldaña, 2021, p. 280). It was helpful to identify themes to better understand the importance of the behavioral health professional’s perception and positionality regarding anxiety disorder presentation for African American clients (Saldaña, 2021). I focused on the textual (“what”) and
"structural" (“how”) descriptions to understand the meaning of participants’ experiences (Dangal & Joshi, 2020, p. 38; Moustakas, 1994). From the sociogenic phenomenological approach, I focused on race, systemic influences, and past life accounts regarding behavioral health professional experience counseling, diagnosing, or providing therapeutic interventions for African American clients with anxiety disorders (LaViscount & Jeffers, 2021).

**Trustworthiness of the Study**

The researcher followed the American Counseling Association (ACA) Code of Ethics on research and publication, to remain objective, to follow state and federal guidelines when conducting research, and the role of the researcher to safeguard the research process (Section G, 2014). I documented my experience with the phenomenon in the study before conducting the research and through the process of interviewing participants (Hycner, 1985; Lauterbach, 2018; Laverty, 2003). My utilization of a reflexive journal was integral to the study in that I considered my perspectives, emotions, if I shared congruent or dissimilar perceptions from the participants, my preconceived viewpoints, and experiences (Hycner, 1985; Ladd & De Decker, 2022; Laverty, 2003; Spence, 2017). Black feminist thought was essential to the interviews I had with my research participants, responsibility for my research, and regard for research participants to focus on the diversity of experience that behavioral health professionals in this study had with their perception of anxiety disorder presentation and their understanding of the background and connections to their perception (Collins, 2022). The 14-question demographic questionnaire added to the trustworthiness of the study particularly with question five and seven about licensure, question eight and nine regarding their experience with counseling or assessment with anxiety disorders and working with African American clients with anxiety disorders. Question
11 provided additional assurance that the participant worked at an HBCU. Question 14 in the demographic added to verification that the participant worked with African American clients.

I was deeply attuned to the data analysis process where the researcher watched each Zoom video for the interview twice and listened to the audio for accuracy of transcription for verbal and nonverbal. The watching of the Zoom video and listening to the Zoom audio helped with precision of understanding the verbal communication between researcher and participant (Lauterbach, 2018; Laverty, 2003; Stout & Maldanado, 2017; Vandermause & Fleming, 2011; van Manen, 2016). I read each interview transcript three times to understand the meaning of the participants experience (Saldaña, 2021; van Manen, 2016).

**Credibility**

**Member Checking**

I used member checking for research to share interview transcripts with each participant to check for precision of the interview transcription (Ladd & De Decker, 2022; Johnson & Christensen, 2014; van Manen, 2016). The purpose of sending the interview transcription to interviewees was to see if interviewees needed to add or correct any information in the interview. I informed participants during the interview that they can provide a response after reviewing the interview transcript if I was able to accurately capture what they discussed in the interview. One interviewee sent an email with an update regarding a mentor that the participant discussed in the interview. I originally emailed the password-protected interview transcript to the first three participants within a week of the interview. Then, I started mailing the transcripts due to the recommendation of the methodologist to safeguard transcripts to interviewees who wanted a copy of their transcripts and mailed within a few weeks after the interview. I emailed one participant a password-protected interview transcript due to the participant’s current mailing
location of preference not being in use. One participant was not interested in receiving a copy of the interview transcript. Three participants responded that ok with the interview transcript and the rest of the participants did not provide a response. I contacted one participant to ask one interview question via HIPPA zoom that I missed during the original interview.

**Peer Debriefing**

I utilized *peer debriefing* where I had one fellow doctoral student serve in this role of peer debriefer to provide balance that my preconceived notions will add to the study while allowing diverse perspectives and experiences to explore my processing of the meaning of behavioral health professional’s perception of African American clients with anxiety disorders (Spall, 1998). The peer debriefer is an African American woman and LPC-S with years of experience counseling clients with anxiety including college students, adults, and young adults. The peer debriefer brought a diversity of perspective to the study due to her not having experience working at an HBCU and not having a research focus on African Americans and anxiety disorders. Peer debriefing helped me to explore my data analysis process (Spall, 1998). The peer debriefer provided added perspective in a confidential manner where the peer debriefer was reliable and did not release any aspects of the study. The peer debriefer provided space for me to process my interview transcripts, journaling throughout the research process, potential biases, “themes” and research findings through typed feedback and meetings (Spall, 1998, pp. 287, 289) The peer debriefer was helpful for providing feedback on my perspective of the codes that I utilized in the study.

**Ethical Considerations**

I submitted all the necessary forms to the Institutional Review Board (IRB) at the University of New Orleans. I will provide participants with the informed consent form before
study implementation to explore the helpfulness, the potential harm of the study, and the purpose of the research (ACA, 2014; Section G.2.a; Vanderpot et al., 2018; van Manen, 2016). I informed all participants that they could “withdraw” from the study at any time without any consequence in my interview script as well as in the consent form (Dibley et al., 2020, pp. 76, 86). I focused on confidentiality during the interview script at the start of the interview discussing that participant’s interview responses would be kept in a secure and confidential location (ACA Code of Ethics, 2014, Section G.2.d). I discussed the purpose of the study at the beginning of the interview and in the informed consent form where the ACA Code of Ethics (2014) includes discussion at the end of gathering research. I knew none of the participants prior to the research study (Section G.2.g). I did not include the identity and names of participants and any potentially harmful/confidential information to safeguard the participants in the study (ACA Code of Ethics, 2014, Section G.4.d; Moustakas, 1994; Stout & Maldonado, 2017). There were pseudonyms for the participants, and only the informed consent will have the participant’s name, which will remain confidential (Dibley et al., 2020; Stout & Maldonado, 2017; Williams, 2010). I did not include any university names, state names, or dissertation title for any of the research participants to protect confidentiality of the participants (ACA Code of Ethics, 2014, Section G.2.d). I stored all collected information on a “password-protected” laptop and only the researcher can access the data (Dibley et al., 2020; Stout & Maldonado, 2017, p. 25). I locked without access by anyone except the researcher (Williams, 2010). I utilized a locked file cabinet for storage per inclusion in the informed consent form. I will delete all interviews after transcription and completion of the study (Stout & Maldonado, 2017).

I provided the peer debriefer with a “peer debriefing confidentiality” form to ensure no study data sharing with outside sources, including no uploading any interview transcripts,
journals, or findings to a cloud storage, and complete deletion of all materials at the conclusion of the study (Knight, 2013, p. 121; Varnado-Johnson, 2018, p. 150). The peer debriefer signed a “peer debriefing confidentiality form” to safeguard the research study where such a form has been utilized in prior research studies called the “External Auditor and Peer Debriefing Confidentiality Agreement” (Knight, 2013, p. 121; Varnado-Johnson, 2018, p. 150). The peer debriefer reviewed printed de-identified transcripts, researcher journal, and analytical memo not to have any information on cloud storage or email to safeguard the participant’s privacy, which was of the utmost importance. “The peer debriefing confidentiality form” is in Appendix I where I also provided the peer debriefer with an updated form that the peer debriefer signed (Knight, 2013, p. 121; Varnado-Johnson, 2018, p. 150).

Summary

In chapter three, I detailed a rationale for the proposed study, including recruitment plans, data collection procedures, researcher role, data analysis, trustworthiness of the study, and ethical consideration. Behavioral health professionals provided their perceptions of anxiety disorders for African American adult clients across gender and socioeconomic status and focused on their positionality. My research study included nine licensed behavioral health professionals who work with African American adult clients with anxiety disorders at HBCUs in the southeast with varied years of experience. This study will give more context to the varied perceptions that behavioral health professionals have in their work, whether diagnosing, counseling, or referring for medication management their African American clients with anxiety disorders from their unique lens. In chapter 4, I explored the specific research findings that highlight the perceptions and positionality of the participants regarding anxiety disorder presentation for African American clients.
Chapter 4

Results

Purpose of the Study

The research study’s purpose was to explore the value of the participant and researcher grasping the phenomena of behavioral health professionals working with African American clients with anxiety disorders (Gadamer, 1975/2013; Heidegger, 1962/2013). There was a focus on the meaning of behavioral health professionals’ perceptions of their experience working with African American clients with anxiety disorders, and the meaning for them individually diagnosing African American clients with one of the anxiety diagnoses in the DSM-5-TR (APA, 2022). Analysis included the overall perception of the participants regarding anxiety disorder presentation and symptom presentation across gender and socioeconomic status for African American clients. Further exploration included how prepared behavioral health professionals’ feel when working with African American clients with anxiety disorders and the steps they took for readiness in the behavioral health field. There was an integral exploration of how the behavioral health professionals’ background influenced their perception of anxiety disorder presentation for African American clients.

Introduction

Chapter four is inclusive of the perception of each of the nine behavioral health professional’s perspectives to have a comprehensive exploration of their perception of anxiety disorder presentation across socioeconomic status and gender and their positionality regarding anxiety disorder presentation in connection to African American clients (Dibley at al., 2020). Hermeneutic phenomenology (Gadamer, 2013; Heidegger, 2013) was integral as the methodological approach for my two research questions. My research questions were:
(1): How do behavioral health professionals perceive the presentation of anxiety disorders among African American adult clients across socioeconomic status and gender? The second central question: (2) How does behavioral health professionals’ positionality influence their perception of the presentation of anxiety disorders amongst African American adult clients? This chapter includes 14 major themes where four major themes were applicable to research question one and 10 major themes were relevant to second central question. There was inclusion of subthemes under each major theme. Lastly, there was a summary of insights regarding the major themes.

**Major Themes for Research Question One**

**Table 2**

*Major Themes and Subthemes for Research Question 1*

<table>
<thead>
<tr>
<th>Themes and Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Description of Anxiety Disorder Symptom Presentation in African American Adults</td>
</tr>
<tr>
<td><em>Emotional and Mental Health Presentation of Anxiety</em></td>
</tr>
<tr>
<td><em>Variation in Presentation of Anxiety</em></td>
</tr>
<tr>
<td><em>Socioeconomic Status and Presentation of Anxiety</em></td>
</tr>
<tr>
<td>“Anxiety and Anxiety Disorders What That Is And What It’s Not”</td>
</tr>
<tr>
<td><em>Physical Health Presentation of Anxiety</em></td>
</tr>
<tr>
<td><em>General Presentation of Anxiety</em></td>
</tr>
<tr>
<td><em>Social Presentation of Anxiety</em></td>
</tr>
<tr>
<td><em>Cognitive Presentation of Anxiety</em></td>
</tr>
<tr>
<td>2. “Contributing Factors to” Anxiety Disorders for African American Adults</td>
</tr>
<tr>
<td><em>African American Women’s Responsibilities and Anxiety Factors</em></td>
</tr>
<tr>
<td><em>Socioenvironmental Factors</em></td>
</tr>
<tr>
<td><em>Health/Counseling-Related Factors</em></td>
</tr>
<tr>
<td>3. “Surprises” vs. “No Suprises” Regarding Anxiety Disorder Presentation</td>
</tr>
<tr>
<td><em>Experiencing “No Surprises”</em></td>
</tr>
<tr>
<td><em>Experiencing “Surprise”</em></td>
</tr>
</tbody>
</table>
4. Pervasiveness of Anxiety for African Americans

I identified themes that helped to better understand the behavioral health professionals’ perception of anxiety disorder presentation (Saldaña, 2021).

**Theme One: Description of Anxiety Disorder Symptom Presentation in African American Adults**

All nine participants discussed the specific and diverse anxiety disorder symptom presentations for African American adults.

**Emotional and Mental Health Presentation of Anxiety**

All the participants described emotional and mental health symptoms connected to anxiety from their lens as behavioral health professionals. Participants discussed how African Americans expressed anxiety through fear as well as “trauma.” Lady Bug stated, “so you are working with anxiety, but you are working with whatever fear they have and whatever trauma they had in the past.” Mr. Z spoke about the connection between “worry” and “fear” stating, “we worry it, and we just don’t understand what’s going to happen and we fear for the future.” Mr. Z described the underlying aspects of “worry” and “fear” describing that “thought process has gone awry somewhere and you know that’s what worry is it’s not about so much about something that’s happening now it’s fear about something that’s going to happen in the future.” Mr. Z added “it’s almost a fear thing that is involved as well and some of it is sadness.” Lady Bug discussed the fear African Americans experience with seeking counseling and potentially making progress stating, “we may get to the door and turn around because of our fear of the unknown of what is not going.” “I know what is happening with me and when I get anxiety.” “Sometimes, we’re scared of being well.” Lady Bug added “like you have to like kind of change your mindsets too as well of what they you know because what happens with anxiety because we have a fear too as well.” The notion of fear connects to Hunter and Schmidt’s (2010) A Sociocultural
Model of Anxiety in African Americans. Jasmine stated that anxiety “looks like worry” “for females” and “the LGBTQ community.” Ms. A provided a distinct perspective regarding African Americans and their non-expression of anxiety “have no fear be this dominant person who walks through life with no fears whatsoever you know they are conditioned to think that and believe and live by that.” Jasmine identified how anxiety “looks like sadness” for “males” “and the LGBTQ community” “sometimes.” Jasmine’s reference includes that anxiety presentation may include the same emotional expression across two diverse African American groups.

Participants discussed how anxiety disorders are symptoms or features of other mental health diagnoses for African Americans. Lady Bug, Shasha, and Zora each connected anxiety to a mental health diagnosis of “depression.” Participants named other mental health diagnoses in the DSM-5-TR that have an affiliation with anxiety (APA, 2022). Lady Bug identified a connection between anxiety and mood issues from her clinical preparation including “in and out depression,” “doesn’t have to be MDD,” or “mood dysfunction.” Dr. Zora had a similar perspective as Lady Bug except she focused more on African American college students stating “like I mentioned so comorbid because students might have depression as well and so that depression keeps them from getting up and going to class or grooming themselves or many students are very thin because they are not eating because they have anxiety.” Shasha discussed another affiliated mental health diagnosis with anxiety including “conduct disorder like symptom.” Dr. Zora focused on another mental health condition, “my overall perception you know it is so comorbid because what I am finding is it’s attached to ADHD.” Dr. Zora described specific diagnoses that are affiliated with anxiety for African American college students including “borderline personality disorder,” “Asperger’s is a part well it’s not Asperger’s anymore because we are not using its name it’s on the autism spectrum.” Ashley Nicole
discussed some co-occurring symptoms for African Americans in the military stating “most of my work with military now is dealing with PTSD and there are some anxiety symptoms.” Cara focused on integral considerations including “if anxiety is a part of another presenting issue understanding what anxiety may commonly co-occur with or other ways in which anxiety may impact them as far as how they maybe coping with their anxiety.” Cara prompted awareness of the mental health diagnoses that may present with anxiety disorders for African Americans.

Participants utilized the term “overwhelming” to depict the intensity of the anxiety for African Americans. Lady Bug described the overall sense of unmanageability of anxiety stating, “it presents to me as something that is overwhelming for people to deal with and sometimes for people to talk about and like if it is out of control.” Ashley Nicole and Dr. Zora discussed the specific indicators of the “overwhelming” feeling. Ashley Nicole stated, “I feel like it’s the being overwhelmed to being on edge easily irritated those are the symptoms I mentioned earlier because that’s what I see a lot.” Dr. Zora added more context about this particular feeling proving an example “that many people use this description they feel as though the shoe is about to drop and so having that feeling of being on edge all the time.” “It’s difficult it’s a challenge.” Ashley Nicole provided specific information regarding the sense of “overwhelming” emotions that individuals with diverse gender identity and people “across the board” encounter “being overwhelmed” “especially working with the LGBTQ population the feeling of not being able to deal with the political climate of today.” Ashley Nicole discussed anxiety symptoms that African Americans in the military experience discussing, “and so, you know with the hypervigilance and the you know just feeling overwhelmed and things of that nature.” Ashley Nicole described how “in the military some handle things really good” and “some of them struggle because of some of the trauma that they have.” Jasmine identified different emotions African Americans with
anxiety experience including “it presents as being overtly active sometimes it presents as being sad or angry or upset.” Jasmine again highlighted the diverse emotional presentations of anxiety disorders for African Americans.

Ashley Nicole discussed “phobias” she sees with “African American clients” including “needles,” “bridges,” walking on cement,” and “social anxiety.” Ashley Nicole discussed “I have seen more of it since the COVID pandemic” regarding “phobias.” Ashley Nicole discussed how people across “racial” groups experience phobias stating, “but it it’s just been in general because of everything going on with the pandemic and things of that nature I think is more of what I have seen of that.” Ashley Nicole detailed how a client experienced “cement phobia” describing the physical presentation of symptoms, “I remember I had one lady she had a bad fall and so she had gotten to the point where she didn’t want to walk on cement.” “She didn’t want to walk on pavement,” “and she didn’t want to use a walker,” and she didn’t want to use a cane.” “But she would like use people’s cars to kind of get her different steps until she got in.” Ashley Nicole provided a distinct descriptor of specific phobia presentation for an African American woman.

Participants discussed how African American men “exhibit anger” with their emotional expression of anxiety. Ms. A described from her clinical practice that “if they, exhibit anger that doesn’t mean they are mean, cold-hearted people all the time that’s one of the primary ways that anxiety shows up in African American men.” Ms. A emphasized two more times that “exhibiting anger” is a predominant expression of anxiety for African American men. Cara expressed a similar perspective as Ms. A “I would say that sometimes what it looks like with men identifying clients is similar to how it can show up with maybe depression or depressive disorders is that there is anger, as a mask for that.” Cara addressed that the display of anxiety is via an alternate emotion for African American men.
Participants discussed the emotional presentation of anxiety in college students. Lady Bug provided a detailed descriptor of the emotional and physical aspects of anxiety for a college student who assumed a housing administrator was calling in reference to her stating, “so, she was having a whole meltdown from anxiety, and she goes from like 0 to 2000 that’s what I told her in like two seconds” Lady Bug added that the student stated, “I am about to go off.” “I am using my tools.” “She’s like walking and talking and pacing.” Dr. Zora identified a symptom that stands out with African American college students with anxiety stating, “even the younger generation with the college students their hyperaware.” Dr. Zora highlighted the intensity of how African American college students may display anxiety.

Participants spoke on how African American’s minimize their anxiety experiences and African American men have difficulty verbalizing their emotions. Cara stated, “I think sometimes it can look like an under response to stressful situations meaning not necessarily a typical response of someone who may be fidgety or someone who may have the observable signs of anxiety.” Ashley Nicole provided additional insight, “but, typically it’s hard to diagnose that sometimes because they say I don’t have anxiety I am just stressed.” In regard to African Americans, Ashley Nicole added, “we don’t use the word anxiety that’s not something that we are going to admit to a lot of times.” Ms. A focused on how African American men find it hard to communicate what is taking place internally stating, “they may tend to shut down or isolate themselves because they don’t want anyone else see them in a vulnerable state per se.” Ms. A added regarding African American men’s anxiety expression, “they are able to recognize that they are experiencing anxiety, and you know maybe a little afraid to disclose it.” “I will say that male college students are a little more hesitant than female college students to disclose that they are experiencing anxiety.” Ms. A. and Lady Bug discussed how African American men are
taught to withhold their feelings. Ms. A stated, “men feeling like they can’t really express emotions them being conditioned to not express emotions to suck it up and don’t cry.” Lady Bug added, “we create frustration in the African American community that we can’t be who we are as people we can’t with boys, we can’t talk about that frustration.” “We can’t talk as man as an African American man.” “You a boy you better suck that up and go on this is life.” Dr. Zora added her observation, “with men I am finding that it is think about the visualization it comes off as cold and I can handle it and I am not as open with emotions.” Lady Bug provided a different perception of how young girls receive prior messaging that they can verbalize their feelings stating, “and little girls what are we teaching them” that “you can talk, and you can tell.” Lady Bug discussed how messaging around anxiety expression is based on gendered messaging on how girls vs. boys should show vs. hide their anxiety. Lady Bug, Ms. A, and Dr. Zora focused on race and gender in their perceptions in accordance with prior work by (Collins, 2022) on Black feminist thought.

**Variation in Presentation of Anxiety**

Six participants discussed that there is no one anxiety symptom for African Americans. Participants identified the diversity in anxiety symptom presentation for African American men, women, individuals who are incarcerated, and for individuals with a diverse gender identity or LGBTQ+ population. Ms. A addressed that anxiety symptoms vary for the population stating, “anxiety can look different for African Americans,” and “it can viewed as anger, and you definitely have to look beyond that to see if it is you know indeed anxiety or something else.” Ashley Nicole added, “it’s you know a lot of times it I think is different it’s not different, but it is perceived differently for us.” Shasha’ perceptions were synonymous with Ms. A and Ashley Nicole with Shasha stating “it’s different for each individual you know not two individuals are
experiencing anxiety and trauma in the same way,” and “there could be so many different presentation of anxiety, and race, and sexuality is just part of the story.” Ms. A stated that “anxiety can look very different even for African American men.” Jasmine’s response was similar to Ms. A’s perspective stating, “specifically for males it looks different.” Cara brought up for African American “men that the question of their masculinity” can impact them expressing their anxiety symptoms. Ms. A and Cara provided context to prior research on the Black feminist lens by Adu-Poku (2011) which was open to considerations of race and background of Black men as well. Ms. A discussed that “the experiences of anxiety differ when it comes to African Americans when as it relates to African American women.” Jasmine held a related perception that “females it looks like it could be a mixture across the board.” Ms. A’s and Jasmine’s perceptions of variation in anxiety presentation amongst African American women was a finding that aligns with prior research on Black feminist thought by Collins (2022) that Black women may have divergent experiences.

Dr. Zora identified that there is an array of anxiety those in the criminal justice symptom experience including “analogy it’s gumbo,” “not feeling free,” “being judged,” “waiting for the other shoe to fall,” “not knowing how to emotionally regulate.” Cara added that, “within a more gender expansive identity that their perception and the way that they experience anxiety has or could have a different context all together as well.” Cara focused on how anxiety presentation can vary across gender.

Shasha added an important cultural component:

Well, I think it’s going to be crucial to consider the variety of experiences within the African American experience. So, for example we have folks from Haiti, [region of
state], Jamaica you know all of the just variety Dominican Republic there is different places and then of course all the nations of Africa. So, it is good not to generalize. Shasha’s viewpoint aligns with insights in the sociocultural framework by Hunter and Schmidt (2010) that there are differences amongst African Americans.  

Socioeconomic Status and Presentation of Anxiety

Four participants provided their perspective on how anxiety presents across different socioeconomic groups. Jade, Jasmine, and Dr. Zora did not recognize any variation in anxiety symptoms across socioeconomic status. Jade stated that “I don’t think I notice a difference.” Jasmine agreed stating, “I really don’t see a difference there I think that just as people you learn to mask it better for different socioeconomic background.” Dr. Zora had a similar perception with her client population where she went into more specifics, “I work with multimillionaires and work with those who are struggling at this time financially it presents it seems to present the same.” Dr Zora focused on that “it’s the same emotional responses and the same bodily functions of palpitations,” “perspiration,” and “fidgeting.” Dr. Zora’s perception highlighted that the physical and emotional symptoms of anxiety are similar whether lower or higher earnings in the African American community.

However, Jasmine and Cara noticed some variation in the presentation of anxiety across socioeconomic status. Jasmine discussed how anxiety presents for African Americans with lower income stating, “but if you are coming from a more impoverished background you are going to say you might not know what it is.” “You are not going to have as polished look as the student from the affluent community.” Jasmine stated, “if the student is from an affluent community, they know how to look the part as if nothing is wrong.” Cara discussed the dismissal of African American’s women’s anxiety in professional careers and how it presents for professionals in
general addressing, “like its common perception about women presenting with anxiety like oh it’s not that big of a deal they should be able to handle this they should be able to deal with this” regarding “women who maybe in high demand areas.” Cara spoke to that African American women can have unique experiences regarding financial and societal expectations from others connected to prior research by Few et al., (2003) on the Black feminist lens.

“Anxiety and Anxiety Disorders What That Is and What It’s Not”

Five participants provided insight on how it is still challenging to distinguish anxiety symptoms for African Americans. Shasha poised a point if clients are open to knowing more about the features of anxiety stating, “I don’t know if the majority of people are ready for what is happening in terms of symptom presentation at least in my community that I work with.” Cara addressed the specific difficulties pointing out, “I think there are times or considerations that communities of color of individuals of color can internalize their anxiety and so it is harder to identify it.” Cara discussed that “it’s harder to know what type of support can be available if someone doesn’t realize that their” “GI issues”, “their headaches” “are triggered by anxiety or their difference in social engagement.” Cara’s perception connects with Hunter and Schmidt’s (2010) model regarding a health-related justification when there are anxiety symptoms. Jasmine addressed the realities of identifying anxiety disorder presentation for African Americans stating, “I think that unless you peel back the layers you won’t readily recognize.” Jade added, “And knowing that anxiety symptoms you know can range even if we don’t see it on the outside doesn’t mean that someone is not experiencing anxiety.” Dr. Zora highlighted that, “there is a lot of education for African Americans as far as anxiety and anxiety disorders what that is and what it’s not.” Cara later added an area of needed focus regarding African American seniors and anxiety stating, “I think there could be better understanding of what anxiety disorders look like in
older African American populations where there traditionally has been different messaging that people have heard.” Cara addressed a gap in people’s general knowledge of anxiety symptoms where there can be growth in perception regarding African American seniors.

**Physical Health Presentation of Anxiety**

Participants described how anxiety can present physically for African American clients including one hypothetical perspective. Ms. A identified specific physical indicators including:

“I feel like when a lot of African Americans may go to the doctor, and you know try to figure out why they are having abdominal pain discomfort or why their having fibroids or cyst that are reoccurring I think a lot of medical doctors may not take anxiety or stress.

Ms. A’s perspective connects with central aspects of the conceptual model by Hunter and Schmidt’s (2010) regarding African Americans and providers focusing on physical issues for African Americans connected to a more aliment orientation than anxiety presentation.

Participants discussed the physical health issues that African Americans cope with in conjunction with anxiety. Ashley Nicole explored how anxiety can lead to physical consequences for African Americans stating, “stress and anxiety turns into health scare,” “stress turns into anxiety long-term,” and “chronic stress turns into depression it turns into all of these other health issues.” Ashley Nicole later identified other physical health issues that African American clients experience with anxiety including “lot of headaches,” “high blood pressure,” “high cholesterol” and “hives or rashes that’s a little different.” Ms. A described the physical health conditions associated with anxiety for African American women from her perspective from clinical practice and exploring the research recognizing, “lot of somatic complaints,” “a little bit of literature on we carry anxiety in our abdominal areas,” and “some reproductive issues too like fibroids.” Ms. A provided further confirmation stating, “I really can’t remember one
client who hasn’t complained about having digestive issues or some type of abdominal or gastrointestinal issues when they experience anxiety for African American women that is what I see a lot of.” Ms. A added that, “the article I did find they speak to the like the connection between anxiety and gastrointestinal like digestive issues, fibroids cyst whether they are cyst on the ovaries or cyst somewhere in the reproductive area, ulcers even.” Ms. A described the physical health symptoms associated with anxiety for African American men per her clinical experience and majority of male clients in general stating, “African American men that I have worked with who experience anxiety have complained of headaches.” The participants’ specific descriptions of health-related symptoms align with keen insights by Hunter and Schmidt (2010) regarding pervasive health ailments for African Americans.

Dr. Zora gave an example about the physical presentation of anxiety explaining:

The way I describe it to clients especially the college aged students I describe the movie the Equalizer (Fuqua, 2014) and how Denzel Washington is always looking I mean his eyes are darting everywhere just being so hyperaware and so many times it manifests in that way.

Dr. Zora’s added perspective about the intensity of anxiety presentation for African Americans.

*General Presentation of Anxiety*

Jade and Ashley Nicole focused on common anxiety symptoms across populations that are not unique to just African Americans. Jade described the “typical presentation of anxiety” includes “panic attacks, sweating, nervousness.” Jade stated, “I do think it presents itself pretty much the same as in other cultures because when I have worked with individuals of other ethnicities and backgrounds you know anxiety it seems to be anxiety.” Ashley Nicole added, “I
wouldn’t say any that are specific to them no when we’re looking at the anxiety some of the symptoms are similar across the board including “overwhelmed, difficulty sleeping,” “on edge,” “having a problem concentrating or focus.” Jade discussed that anxiety symptoms are similar for individuals in the smaller caseload of clientele she counseled with diverse gender identity or LGBTQ+ population identifying “no the few or the couple cause it’s about two clients that I work with they have the your typical anxiety symptoms.” Participants did not always find variation in anxiety symptoms regarding race, gender or sexual identity.

_Social Presentation of Anxiety_

Dr. Zora identified how anxiety can appear socially for college students stating, “they have social anxiety about going into the cafeteria so it so a lot of education a lot of psychoeducation and asking how sustainable this is.” “What can you do today?” “You know so it presents itself.” Dr. Zora stated how anxiety presents for individuals with diverse gender identity or LGBTQ+ population describing “it looks like isolation and just distrust that’s how it’s usually presents itself.” Dr. Zora’s was the only participant to identify socially withdrawn expressions of anxiety for African Americans.

_Cognitive Presentation of Anxiety_

Ms. A described the cognitive symptoms of anxiety for African American men including “brain fog, difficulty with focusing, and concentrating, wanting to withdraw.” It was interesting that only one participant highlighted cognitive presentation of anxiety when focusing on the conceptual model by Hunter and Schmidt (2010, pp. 213, 227-228) that African Americans are less likely to acknowledge “cognitive symptoms of anxiety” which was evident without much conceptualization from the behavioral health professionals in this study.
Theme Two: “Contributing Factors” to Anxiety Disorders for African American Adults

All nine of the participants identified contributing factors to anxiety disorders that were gleaned from the participants’ perspectives that may not include all potential causes for anxiety to manifest for African American adults.

African American Women, Responsibilities, and Anxiety Factors

Ms. A provided her perspective on “Black superwoman syndrome” from her clinical insight and her multifaceted daily roles:

I guess I can bring the Black superwoman syndrome into this which causes a lot of anxiety for a lot of our Black women from just my personal and professional experience. You know, working mother’s we’re doing all the things for family, for church, for everything and a lot of the time that is what causes anxiety for us. I can say that for myself.

Ms. A’s statement regarding anxiety and Black women provides a space to acknowledge African American women’s perspectives regarding anxiety including her own (Few, 2003).

Dr. Zora identified all the different roles that African American women take on within and external to the home:

100% many times African American women especially who maybe single mom and having to wear so many hats so they are wearing the hat of an employee, a mom, a daughter, a sister, the person, the financier, the person who has to carry so much of the burden.

Dr. Zora added that observed regarding African American women and roles describing “from what I have seen from 100s of people who I have counseled I see it as busyness” and “the
show must go on.” Dr. Zora considered the collective challenges African American women experience in different aspects of their life (Collins, 2022).

Lady Bug discussed that African American women in general experience significant anxiety and that it’s not enough to dismiss the significance of their anxiety:

Because I feel like as African Americans, African American women we deal with a lot of stress a lot of anxiety whether it is with family whether it’s a single mother whether it’s even being a married women with children. And then your husband is working but you still sometimes act as a single mother where to release that.

Lady Bug spoke to the shared barriers that African American women face with their multiplicity of roles connected to the conceptual model by Collins (2022) on Black feminist thought.

Lady Bug discussed her approach with African American women with the superwoman mindset and her motivation working with anxiety:

We want to be superwoman and I tell my clients all the time I say you can take that “s” off your chest it’s not necessary right and so sometimes as African American women we do not know it is ok to take that “s” off our chest because we have so much going on. So, I think that’s what you know actually draws me to it.

Lady Bug added her conceptualization of the Black woman and anxiety disorders and how she advocates for her clients not to attach to the misplaced ideals of strength (Collins, 2022).

Participants discussed that African American women faced obstacles regarding anxiety. Ashley Nicole identified the difficulties across different areas and how that can lead to anxiety identifying that they “struggle in their workplace and their personal life because being a women of color” with “external struggles, internal struggles which causes a lot of anxiety” and “always
on edge on guard.” Mr. Z identified the difficulties that Black women face from his observation of women in his life stating, “same thing my Black sisters ain’t got it no easier than the brothers.” “I got plenty of sisters and I got cousins, and I am married and it’s still the same thing.” Mr. Z referenced a quote stating, “but I believe it might just be true that they say that the “Black woman is the most disrespected person in the world” (Malcom X, 1962, as cited in Lackey, 2021). Mr. Z spoke to the inequities that African American encounter in life which was similar to insights by Collins (2022) on Black feminist thought.

Dr. Zora connected how narratives told over time impact African American women regarding anxiety in terms of messaging and social pressures:

And some of the stories that are passed down for African Americans you have to be better than everyone else you have to not let people know what’s going on that’s home talk that’s all those different sayings that happen that people fold into their everyday experiences doesn’t always apply to that moment.

Dr. Zora added “we are not that far from trusting,” “60s was a lot of distrust,” “and generations of 40 years old plus many of the things they were taught they are still living by and then they pour it on to the next generation but not in the same way but the story still exists.” Dr. Zora spoke to a concept similar to cultural mistrust that exists within prior research by Hunter and Schmidt (2010) on the Sociocultural Model of Anxiety in African Americans.

Socioenvironmental Factors

All nine participants discussed socio-environmental factors. Lady Bug described her prior observations of anxiety when visiting client’s home through her clinical experience in “mental health specialist” role:
So, a lot of the kids were like in foster care, and we did work with adolescents and 18 and younger. So, I would actually see like the anxiety or PTSD or like if they were abused or you know if parents like some parents like because they were on drugs and things like that or if they were sexually, mentally or physically abused or they had to be taken out of a home.

Lady Bug discussed further how anxiety can impact the whole family describing, “being with then….I saw the parents saw the child… and saw the grandma and granddaddy and when I saw the interaction to see ok right that is an interconnectedness too this anxiety that we are experiencing.” Lady Bug explored the familial influences with anxiety for African Americans.

Participants spoke to the significance of family including early experiences, parenting impact, and familial role. Early experiences include experiences growing up from birth to age 17 that were significant in the overall development of anxiety from the perspective of three participants. Mr. Z provided a potential scenario of anxiety disorder presentation for African American clients from “a single parent household” where “mom or your parent had to work two jobs,” and “a young child by yourself a lot” describing, “you are going to be worried.” You are going to be a little fidgety.” “We bury those feelings those emotions” and “gets worse and now here as a teenager or young adult we have panic disorder because we lived a childhood of you know neglect or whatever.” Mr. Z added the changing familial structure for African American homes where African American women are without support which can lead to anxiety including “male has been taken out of the home,” “female is now responsible for the care of the children,” and “more often than not people are coming up in single parent home.” Ashley Nicole discussed messaging growing up and how that leads to anxiety for African American men including “some of it also goes back to their childhood and things that were said to them as children and that has
caused them to have a lack of confidence and struggle with some anxiety issues as adults.”

Ashley Nicole identified what occurred prior in life as a factor in anxiety occurrence.

Lady Bug described a scenario where early experiences and parenting can impact anxiety stating:

Mom when he is yelling and screaming something is wrong so let’s talk about it let’s see what wrong with it just don’t be like he is on my nerves cause now you are trying to deal with your anxiety cause you can’t deal with his.

Lady Bug’s perspective consisted of exploration of how parents are instrumental in the progression of anxiety of their child.

Participants discussed the parental impacts of African American college students and anxiety. Jasmine stated, “I have had several this semester that say well now that I am 18, like I always knew something was off and my parents my mom my dad didn’t want to pursue it.” Lady Bug described two scenarios where there were parental influences leading to anxiety. Lady Bug provided supplemental information regarding a prior college student scenario and how parenting can contribute to the anxiety describing, “just like when I said the girl blocked her and her momma blocked her that’s not a healthy relationship.” “So, now we got to see because momma she on 10 and we are trying to get her that is not helping her right.” Lady Bug described a situation with the potential for anxiety with the “LGBT” community regarding parenting impact with a student who “was trying to find his identity” describing: “He just wanted to be identified as a girl,” “wear his makeup, “wanted to wear wigs”, “maybe get nails done,” and changed his name to a girls’ name.” Lady Bug addressed that the parent “was ok with being that way at home right, but she wasn’t ok that way on campus.” Lady Bug addressed that “we are not concerned about him we are not concerned about these anxieties we created.” Lady Bug added, “we create
frustration as parents sometimes” “with other genders and across genders.” Lady Bug’s perception was how anxiety presents for some African Americans via parental influence.

Five participants discussed the role of family in fostering anxiety where family was not a “protective factor” in contrast to Hunter and Schmidt’s (2010, p. 228) A Sociocultural Model of Anxiety in African Americans. Jasmine, Ashley Nicole and Dr. Zora focused on what it is like for African Americans with anxiety disorders not having a network of encouragement. Lady Bug described the role of family in anxiety presentation stating, “it’s I feed of this anxiety be its ten when I am around grandma and when I am around mama it is zero right.” Lady Bug included the role of home context with anxiety. Jasmine added the lack of acceptance in the familial context addressing “it’s been my experience that families have again like I said ignored it or explained it away.” Ashley Nicole specified how the “lack of support” from the social network connects to the difference in symptoms for African Americans with phobias. Ashley Nicole stated, “mostly the phobias with phobias it is just that fear that is seems to be hard for other people their family members and friends to understand like why can’t you just do it you know.” Ashley Nicole grasped how there are negative perceptions regarding phobias from African Americans external connections which may have connectedness to the “stigma of mental illness” from the conceptual framework (Hunter & Schmidt, 2010, pp. 213, 225, 228). Jasmine discussed her perspective from a friend regarding the connection with anxiety, “childhood trauma,” and “being conditioned.” Dr. Zora stated, “I find my heart going out for the college students because they don’t have that support system around them from family if they do have that family support or old friends.” Dr. Zora emphasized the challenges that college students experience when seeking validation in their inner networks.
Dr. Zora discussed specific familial issues and intra-racism that she observed “three-to-four times a week” with African American clients who are biracial:

I have found that the biracial individuals during family counseling if the whole family is there that the biracial person is talking negative about the majority group that they belong to in front of the parent that is part of that group so interesting.

Dr. Zora’s perspective looked at the variation amongst African Americans and internalized issues for biracial African Americans (Hunter & Schmidt, 2010).

Mr. Z discussed that prejudice and injustice that African Americans encounter fosters anxiety stating, “We look at African Americans in general where we look at our history of being discriminated, oppressed whatever you would say in that regard you know the anxiety issues are growing.” Mr. Z later distinctly identified that prejudice and injustice are major factors in the development of anxiety disorders for African Americans stating, “I will just say it oppression, racism, microaggression towards us.” “I think that’s one of the largest contributors to anxiety disorders amongst African Americans it’s just my personal opinion.” Mr. Z summarized “it’s the systemic inequities that is more greatly effected the African American.” Mr. Z detailed the “systemic” factors that can lead to anxiety and major inequities for African Americans and impacts for African American men addressing that “the systemic practices and policies in place which cause the African American to I guess struggle a little bit more than their counterparts.” Mr. Z listed that there are “healthcare disparities,” “educational disparities,” “housing market” issues, “financial” and “workplace” issues where there is evidence of these concerns for African Americans. Mr. Z further described a specific potential “workplace”-related racial issue explaining that “I can have the same degrees, experience,” “and knowledgebase but individual with less education experience then me but just because of the color of their skin will get the job
or a promotion it’s crazy or they are getting paid more.” Mr. Z provided a specific illustration of
the role of “systemic” factors as “contributing factors to the way a person thinks.” These
“systemic inequities” include “well the data shows that an individual if they are Black will have
a 60% harsher sentence than a White individual that commits the same crime at the same time
whatever.” Mr. Z addressed that “there is some information out there that basically says that
college educated African Americans still make less money than our Caucasian counterparts that
only have a high school degree and it’s not close at all.” Mr. Z’s perception connected with
Black feminist thought by (Collins, 2022, pp. 29, 164-164, 260, 349) regarding “race, gender,
and class” as core areas of bias that African Americans encounter from those with access where
essential to create awareness when exploring causation of anxiety disorders for this population.

Shasha discussed the connectedness with “policy” and “systems” and anxiety disorders
for African Americans stating, “I believe that there is a relation between policy and how
individual is feeling.” “A person exists within policies; we can’t exist without it at least there is
nowhere on the planet that does not have some sort of system in place.” Shasha later stated
regarding the significance of the “systemic” influences “and I am not saying just that we’re
African American necessarily but like I said before policies and systems are very important.”
Shasha’s perception reflected the progression of information and awareness (Collins, 2022).

Ashley Nicole, Dr. Zora, and Cara addressed further issues African Americans have with
how people view them regarding anxiety aligned with the conceptual framework by Hunter and
Schmidt (2010, pp. 213, 225, 228) which also extends to the “stigma of mental illness” regarding
emotionality and thinking. Dr. Zora focused on the internal conceptualization of an anxiety
diagnosis processing “and many of it may of the times it is because of who the person is telling
themselves who they are, and who they are not.” Ashley Nicole and Dr. Zora addressed further
issues African Americans have with how people view them regarding anxiety. Ashley Nicole relayed that “when we have any type or anxiety or phobia, we are not allowed to express that.” “It takes a lot I see for my African American clients to admit that they have phobias after I am able to get them through the door.” Ashley Nicole addressed that these concerns take place, “especially in our rural communities.” Ashley Nicole described a specific situation with an African American client experiencing anxiety in terms of concerns with external judgment and them gaining insight regarding their issues describing at “church” “they we speaking,” “and they talked about the facial expressions of some of the people in the congregation.” They realized that “what people say of what people think about me” “have more of a impact on them that they thought.” Dr. Zora discussed how African American police’s anxiety and how people view them, “oh 100% anxiety because of how they’re perceived and so they’re receiving negative perception as an African American police officer they are receiving that and also fearing for their life in many situations.” Cara discussed that awareness for “men identifying clients or for even for male clients in general,” “and so, the consideration is their understanding of their own perception and what others may perceive about their diagnosis if they choose to share that.” Cara’s viewpoint includes the hesitance of African American men to acknowledge that they have anxiety.

Ashley Nicole and Dr. Zora addressed the concerns regarding receiving counseling for anxiety. Ashley Nicole later focused on the minimization of anxiety regarding African Americans addressing that, “the dismissiveness is a lot of what we see in terms of people of color and just you know not being encouraged to come to the therapy because we are going to be seen as crazy or “we don’t want our family to be seen as crazy.” Dr. Zora added that “African Americans are taught that you take that to the church,” “share it with your pastor” “or you pray about it. “The opportunity for African Americans to get the clinical mental health that they need
doesn’t always exist.” Ashley Nicole further discussed how African Americans minimize their anxiety experiences stating, “I just think to be honest with a lot of my African American clients they go much longer before they try to seek help with those symptoms because they just see it as I am this way because I’m stressed.” Ashley Nicole’s discussion centers on the continued “stigma of mental illness” for African Americans that impacts acknowledgment of anxiety and receiving the necessary therapy (Hunter & Schmidt, 2010, pp. 213, 225, 228).

Ms. A discussed the specific areas of anxiety for African Americans in the “middle or upper class” encounters in employment spaces and impacts regarding self-doubt:

Those who maybe middle class or upper-class worrying about really work-related things whether it’s you know they are trying to move up in the company. Or they work for a company where there are a lot of counterparts or a lot of Caucasian or people of other ethnicities and races that work with them, and they are trying to be seen. Middle class, upper class a lot of them experience a lot of impostor syndrome that triggers anxiety.

Ms. A highlighted how there can be differentiation in what leads to anxiety regarding socioeconomic status when have more economic resources.

Ashley Nicole added further details regarding the image that African Americans in this socioeconomic group feel compelled to maintain “sometimes just I guess the anxiety of trying to keep things at a certain level because of perceptions if anything.” Ashley Nicole added her insights of how anxiety can present with greater level of economic resources.

Ms. A discussed that African Americans with lesser earnings experience anxiety connected to everyday economic challenges stating:

I would point out right now is someone who may be experiencing poverty or low income triggers some anxiety and the reasons why they are anxious. The reasons why they worry
differ than those who may be in the middle-class or upper class, those who maybe low-income they are worrying about how they are going to pay the light bills, get medicine or they going to be able to pay rent this month or they going to pay their car note this month. Ms. A provided context to the variation in what leads to anxiety regarding socioeconomic status when African Americans have lesser economic resources.

Ashley Nicole stated, “but I think we all struggle with some of the same you know anxieties about “work,” “children, “relationships” some of the same topics, but the degrees may be different if that makes sense.” Ashley Nicole looked at the universality of anxiety that still included variation in terms of the type of anxiety for African Americans.

Dr. Zora and Lady Bug discussed social causes for anxiety for African American college students. Dr. Zora addressed some of the challenges African American college students face navigating social relationships and feeling a sense of connection including, “peer pressure,” “should I get high with this group of people so I could fit in”, “what do I do with my spiritual part and still be cool you know and fit in”, “and” “many other issues along with managing anxiety.” Lady Bug discussed how social relationships and involvement in campus social organizations or sports can add to anxiety symptoms describing “via friends,” and “boyfriends.” “I have a lot of students including “band,” “people” “in dance lines,” and “athletes.” “You have relationship issues,” “classwork,” and “now I have athletics and whatever on top of that so a lot of stress and pressure.” Lady Bug further explored how anxiety can manifest differently in dating relationships due to social conditioning regarding “what we teach them” as “you become a couple at a university” that “we don’t know how to handle the relationship because we don’t know how to deal with our anxiety.” “I am mad, suppressing mine,” “cussing,” “screaming,”
“and you want him to pat you on your back.” Lady Bug spoke to the vast expressions of anxiety for African American college students that exist per gendered social messaging.

Dr. Zora and Mr. Z identified societal factors. Dr. Zora connected how long-standing circumstances in the community and conditioning impact anxiety including “epic memory,” “others will say it’s from what we have seen in society that increases anxiety with African Americans.” “I believe it is the narrative apart from the biological,” “of what we’ve been told and how we are supposed to respond.” Mr. Z addressed some of the environmental factors including “we look at the negative consequences of the pandemic and how it effected everybody across the board.” Dr. Zora explained different ways in which African Americans in gangs experience anxiety “how they grew up,” “belongingness,” “once you are in and you can’t get out,” and “if you are going to live the next day.” Dr. Zora discussed that she “worked with both gangs, the biggest gangs, and with the African Americans gangs” where the “anxiety” “is environmental, emotional,” and “social.” Dr. Zora’s statement included the different contexts of anxiety for African Americans in gangs.

Five participants described performance-based factors including academic for African American women and men in college, and African Americans in general. Ms. A discussed academic challenges for college students and the connection to the presentation of anxiety including “abrupt changes” including “not doing well on their classes,” and “they have to hurry up and try to figure out how they are going to increase their GPA before graduation.” Dr. Zora had a similar perspective as Ms. A including “it’s impacts them academically.” I have many students that aren’t doing well in class.” Dr. Zora added, “and I see many freshmen more I see a few seniors having anxiety about graduating.” Lady Bug provided an additional situation for African American college students with “anxiety” and performance-based factors in the band in
terms of their schedule describing “they meet at nine every morning,” “then three-to five every
day;” “coming back to practice from to seven to who knows when.” “And I feel like still got to
do my schoolwork and I still got all these expectations.” Lady Bug explored what leads to
anxiety for African American college students regarding academics and life balance.

Jade provided an alternate perspective of how college students specifically African
American students who excel academically and how they deal with anxiety stating with “women
that overachieving,” “go-getter,” “perfect” mindset. Jade stated, “high performance high
achieving I notice a lot with Black women.” Jade connected their “anxiety” to “fear of not
performing well, not being enough, not meeting a certain criteria” “for themselves or a standard
that someone else have for them.” Jade identified how succeeding at all costs is a marker of
success for college students who are doing well academically with “pressure to perform or be
high achievers” where whether “experiencing anxiety or depression” “they connect pushing
through these emotions and things like a badge of honor.” Jade further connected that African
American college men want to succeed without as heavy of a burden stating, “they have a lot of
pressure on them as well but I it’s not as much not as intense as I feel it is for my Black women.”
Jade provided the “Black woman’s standpoint” by Collins (2022, pp. 25, 37, 42, 130) regarding
the particular challenges African American women in college experience with wanting the best
academically.

Cara discussed the realities that anxiety will have an effect on African Americans in
general related to performance:

But I see that when there are whether it’s sport directly or just general performance
areas. Now, that’s a different conversation especially if it’s their primary livelihood and if
you know they have an anxiety attack and their not able to do something that is expected
of them just understanding what that may look like and that I would say that happens across genders for people in high demand as well as performance areas.

Cara spoke to anxiety presentation regarding performance for African Americans in different gender groups.

Lady Bug, Dr. Zora, and Ms. A described the different adjustments that incoming and other college students experience as well as prior distressing situations. Lady Bug described the different adjustment factors including “anxiety for transition,” “homesick,” “past trauma and things that you are bringing,” “relationship issues” “brings the anxiety and brings this stress and this kind of depressive state.” Dr. Zora added a similar insight describing, “I see the majority freshman they are trying to find out who they are and if they do have any anxiety that they brought to school with them it manifests itself even more because they have responsibility for doing for themselves.” Ms. A added, “the connections that I made with that lot of our students experience anxiety because of you know finding out that they don’t have housing finding out like an abrupt change or something like they were not expecting.” Ms. A addressed that anxiety for African American college students consisted of the need to immediately adapt in their environmental context.

Health/Counseling-Related Factors

Health factors included for African American college students how the thought of visiting a medical provider can foster anxiety and health impacts of anxiety coping. Lady Bug addressed that “refer in the community,” “if you have Type I and you are under a lot of stress” and “if your blood sugar is high,” “or people say I hate going to the dentist” that all these factors “can cause anxiety.” Lady Bug’s viewpoint connects with the focus on physical health particularly “diabetes” via prior research findings by Hunter and Schmidt’s (2010, p. 213) where there is a
tendency to focus more on health as a cause of concerns rather than the anxiety. Jasmine discussed how college students may utilize substances to cope with anxiety that can lead to health consequences stating, “you get the students with anxiety who try to self-medicate with alcohol and drugs that’s not a good mix period.” “If you are taking psychotropic medications and you are taking alcohol and or drugs to disastrous results.” Jasmine looked at the potential health implications of unhealthy anxiety coping mechanisms when infused with more traditional approaches to anxiety.

Mr. Z and Cara focused on how cognition including how specific negative thoughts aid in the progression of anxiety for African Americans. Mr. Z described how thinking connects to anxiety with “I will just say this irrational thoughts are a big key but then when you have a history of experiencing in certain things that will cause anxiety and you don’t even know where it is coming from.” Cara added “there is also the consideration particularly for African American clients is sometimes if someone has learned to function with their anxiety over an extensive period of time it can feel uncomfortable in rewiring their perception about how they are functioning.” Cara spoke on how African Americans may have fixated approach to anxiety that they have come to normalize which may connect to the conceptual framework by Hunter and Schmidt (2010, pp. 213, 227-228) on the “underreporting of cognitive symptoms of anxiety.”

Counseling factors included how counseling attendance and not having consistency with self-help mechanisms connects to anxiety for African Americans. Lady Budy addressed how the thought of attending counseling fosters anxiety and the recognition that unable to avoid discussions of personal issues in the therapeutic space stating, “because just coming to therapy itself may create anxiety for you or for them. It’s just like you know the stigma of African American men you not wanting to come to therapy but just that it creates that anxiety.” Lady
Bug highlighted the ever present “stigma of mental illness” for African Americans from the conceptual framework by Hunter and Schmidt (2010, pp. 213, 225, 228) that impacts the prioritization of counseling and that represents a specific anxiety in consideration of gender for men in the population.

Lady Bug provided another perspective from her clinical experience and how people across socioeconomic status can experience anxiety with receiving therapeutic support:

An employee was found dead in her office at the hospital. People that work in the back they didn’t come to talk to me like a few of them came right. So, it is still kind of you know that stigma still can I trust you or I don’t need it. I’ll be ok. Sometimes mental health it’s still challenging across the board regardless of your economical background.

The “stigma of mental illness” prior finding by Hunter and Schmidt (2010, pp. 213, 225, 228) extends even with counseling hesitance with diverse socioeconomic variation according to Lady Bug.

Jade discussed from her clinical practice how an African American with an anxiety disorder experienced challenges when they don’t use their healthy relaxation tools:

But another thing with this client is meditation seems to help them more, so prayer and meditation specifically helps this client, and they notice that when they are inconsistent with their prayer and meditation their anxiety levels increase.

Jade considered the importance of continuity of anxiety coping practices to relieve anxiety symptom presentation.

Dr. Zora highlighted that there is a faith-based rationale for how African Americans associate anxiety with moral standards of behavior or faith-based punishment describing anxiety like “what I found is their thinking that it is something they did wrong,” “sin,” “anxiety is not
really mine it’s from Satan,” “and two things that I hear a lot is God is testing me and the devil is busy.” Dr. Zora provided a distinct perspective regarding how some African Americans have a religious/spiritual connotation of anxiety presentation.

**Theme Three: “Surprises” vs. “No Suprises” Regarding Anxiety Disorder Presentation**

*Experiencing “No Surprises”*

Six participants identified experiencing “no surprises” regarding their perception of anxiety disorders in terms of their level of awareness of this diagnosis. Mr. Z stated, “I can’t really say I am surprised by any of it because once you have the basic information as to what’s going on you know.” Cara had a similar perspective as Mr. Z adding “surprises, I don’t think there are necessarily surprises.” Jada’s viewpoint matched Mr. Z’s and Cara where she said, “no I don’t think I ran into any surprises.” Ashley Nicole perception was similar except where there is variation from her perspective in reference to certain anxiety disorders “no surprises that I would I say definitely I think like I said pretty with the anxiety I am seeing a lot of the same things until we get specific with the phobias is where I see a big difference.” Dr. Zora detailed how anxiety effects people across professions and the expectation of the interconnectedness of the diagnosis for African Americans. Dr. Zora stated, “I wouldn’t say it’s a surprise but’s it’s a confirmation that it spills over.” Dr. Zora described how anxiety “spills over” for African Americans “in leadership positions,” “physicians” with “patients,” “attorneys in court” “military” in the “home” environment “disrupting the family structure” and “professors” with students. Dr. Zora added “so even though many people say no I separate it you know I know I am dealing with anxiety, and it doesn’t impact me work and then the narratives that are told yes, it’s impacting you.” Dr. Zora addressed that anxiety has implications for African Americans.

*Experiencing “Surprise”*
Alternately, four participants expressed experiencing surprise regarding their perception of anxiety disorders. Ms. A described that it is different for her to hear from college men that they have gained insight about their anxiety describing her observations:

I will say I have been surprised at how many male college students have come to me and disclosed that they are experiencing anxiety which I think is great. I think is really great that they are able to recognize what anxiety is, and recognize, and disclose be able to you know comfortably verbalize.

Ms. A discussed how students are “coming to the center” or they’re coming to me directly to express that they are “worrying a lot about school,” different areas or thinking they have “anxiety” and wanting to know if their symptoms are anxiety. Ms. A’s perspective provides variation that African America college men and students in general don’t necessarily all fit under the conceptual framework by Hunter and Schmidt (2010) regarding anxiety verbalization hesitance.

Shasha discussed her positive experiences with having new insights working with African American clients and not narrowing her perception highlighting:

I am always surprised in a very good way. And but I don’t necessarily expect anything necessarily because each case is so different. But for me because we have such diversity in [region of state] people are just from so many different places around the world or the country. So, it is hard to even try to generalize because there is so much diversity even within the African American experience.

Ms. Sasha’s statement is in direct agreement with the variation in African American collective according to both conceptual frameworks (Collins, 2022; Hunter & Schmidt, 2010).

Jasmine emphasized three times “I am always surprised.” “And so, like I said as much as
I know people there is always something that surprises me.” Lady Bug provided insight regarding an area of potential surprise that is not related to anxiety presentation or contributing factors stating, “no, I think that what is eye-opening though is that they are wanting to get help and a lot of them will want to get help and they’ll seek services.” “They will even interview and but then they’ll stop.” Lady Bug’s viewpoint may add to the conceptual framework by Hunter and Schmidt (2010) that African Americans may feel more comfortable receiving support not related to mental health reasons that are more health affiliated.

Lady Bug provided a distinct perspective regarding her insights of the challenges and “surprise” regarding how potential clients perceive scheduling counseling:

I think that’s most surprising thing that we know we need help. We may reach out for the help and then we don’t get it and then the other piece is we may reach out for help and then we want it right then. So, then it’s my fault I think that is the most eye-opening maybe the most sad thing that it becomes your fault when you reach out that it has to be immediate.

Lady Bug provided an alternate perspective of how therapy expectations can change from hesitance to urgency when anxiety disorders present in African Americans.

**Theme Four: Pervasiveness of Anxiety for African Americans**

Five participants addressed the pervasiveness of anxiety disorders for African Americans. Cara stated, “anxiety has stemmed from that being one of the most prevalent issues with clients.” Ashley Nicole added generally, “well of course you know I’ve seen a lot more with the anxiety I see it across the board.” Mr. Z specified the frequency of anxiety across regions, “it’s hitting them whether you live on the east coast or the west coast or if you grew up you know in the suburbs or in the hood.” Ms. A addressed socioeconomic statuses where there is the highest
anxiety including “working class African American women who hold high position in companies,” “African American men who have leadership roles,” “middle class,” and “upper class.” Ms. A stated, “anxiety is very common amongst African Americans especially females.” Dr. Zora addressed, “and we haven’t even talked about African American and the biracial community a lot of anxiety with that as well.” Dr. Zora later discussed the frequency of anxiety amongst diverse gender identity with African Americans describing, “a lot of anxiety from being you know west coast to east coast I think a lot of it is regional.” “I am finding more anxiety among the LGBTQI community in the south versus what I found in the west coast.” Cara summarized, “but the confirmation that African American communities need support because of the prevalence in which anxiety shows up.” Cara’s perspective gives credence to this research that resources for anxiety are vital for African Americans given the rapid occurrence of anxiety.

**Major Themes for Research Question Two**

I identified themes that helped to better understand the behavioral health professionals’ positionality. (Saldaña, 2021).

**Table 3**

*Major Themes and Subthemes for Research Question 2*

<table>
<thead>
<tr>
<th>Themes and Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Comprehensive Preparation and Clinical Experiences</td>
</tr>
<tr>
<td>Levels of Readiness</td>
</tr>
<tr>
<td>Educational Experiences</td>
</tr>
<tr>
<td>Resources</td>
</tr>
<tr>
<td>Providing Presentations</td>
</tr>
<tr>
<td>Clinical Experiences/ “Nature of Work that I Did”</td>
</tr>
<tr>
<td>“Do this Research”</td>
</tr>
<tr>
<td>Having Specific Mentors vs. Not Having Specific Mentors</td>
</tr>
</tbody>
</table>

6. Diagnostic Process
Utilizing Assessment

“Developing Diagnosis”

Using the DSM and DSM-5

7. Life and Familial Experiences

Importance of Life and Familial Experiences

“Try to Stay Neutral”

8. “Feelings” vs. “No Feelings” Regarding Anxiety Diagnosis

“No Feelings”

Experiencing Challenging Emotions

9. Behavioral Health Professionals’ Perception of their Client’s Reaction to Anxiety Diagnosis

“Stigma of Mental Health”/Negative Reaction

Receptivity to Diagnosis

Different Reactions

10. Using Theory

Using CBT

Using Diverse Theoretical Approaches

11. “Open to Gaining New Knowledge”

12. Anxiety Experiences of Behavioral Health Professionals

13. Expressions of African American/Black Identity

14. Cultural Considerations

---

Theme Five: Comprehensive Preparation and Clinical Experiences

All nine of the participants identified specific steps with their readiness to provide clinical services for African American clients with anxiety disorders.

Levels of Readiness

The levels of readiness for most participants were that “very prepared” whereas a few participants identified that “pretty prepared” or “not prepared” initially. All nine participants were confident in what propelled them to work clinically with African American clients with...
anxiety disorders. Mr. Z stated, “anxiety of course is one of the areas that I have been trained that
I am knowledgeable about, and I am competent in so it kind of goes hand-in-hand.” Mr. Z later
echoed the same sentiments: “I feel very prepared.” “I mean you know when I say that you know
years of experience.” Cara’s perspective was similar to Mr. Z with Cara addressing, “I feel
relatively well-prepared I like to think that there not many things that clients can present with
that surprise me at this point because there are a lot of different ways that clients show up.”
Shasha expressed, “I feel very prepared.” “I feel like I am in the right place.” “Most of my work
was in the community that I am at right now.” “So, I am very thankful to be there.” Dr. Zora was
confident in her clinical work and time with clients expressing “oh 100%.” “It’s a lifestyle and
just being around people in general.” “Well lifestyle as far as getting more information.” “I think
it’s just living you know age.” “You know just having years of looking at different things.”
Jade’s response concurred with Mr. Z, Cara, Shasha, and Dr. Zora as Jade stated “Oh, very
prepared yeah.” The levels of readiness included how the various behavioral health professionals
were able to grasp anxiety disorder presentation with regard to their comprehensive preparation
that impacts their clinical practice with African American clients (Collins, 2022).

Ms. A and Jasmine highlighted their clinical effectiveness with African Americans with
anxiety disorders. Ms. A stated, “and I’ve also seen a lot of my success stories if you will
working with clients experiencing anxiety.” “At that particular time, I was interested in anxiety,
but I really didn’t know like what exactly my niche or my specialties were.” Ms. A provided a
snapshot of her clinical experiences and time spent in the behavioral health field stating, “I feel
like I am very prepared now,” “in mental health for 16 years,” “practicing as a therapist for 12
years,” and “pretty seasoned.”

Ms. A further described her preparedness for working with anxiety disorders:
So, I definitely feel prepared to work with clients who experience anxiety it is definitely one of my main specialties. And a lot of people tend to reach out to me for it whether it’s word of mouth. So, and so said that you do great with anxiety. Do you have any slots open for me or on one of the directories that I am on I highlight that I specialize in anxiety so.

Ms. A extended her experience of respect and her voice being heard in the counseling dynamic as the behavioral health professional who is an African American woman that connects with Collins (2022) Black feminist lens.

Jasmine communicated her understanding of interpersonal dynamics as part of her skillset stating:

[Mouthing I feel prepared]: I know people and I know relationships. So, once you build those relationships then you will get more out of people if not so once you understand what is going on than you can get make the plan to get the help that is needed even if it is something that I can’t provide.

Jasmine spoke to how her awareness of communication patterns aids in her conceptualization of supports for anxiety for African American clients (Collins, 2022).

Participants spoke to having clinical readiness to work with African Americans clients and learning along the way. Lady Bug addressed how she had to delve into the clinical work to aid in her readiness describing, “I don’t know if you ever worked at an HBCU campus but sometimes they just throw you in the trenches.” “You swimming until you find your way right and dig it out.” “I feel like in the trenches that I am prepared.” Lady Bug highlighted her unique experience in which there was support via prior research findings by Few (et al., 2003) on Black feminist thought.
Ashley Nicole addressed her belief in her clinical skills and provided an awareness of needed additional clinical learning stating, “I feel pretty prepared but if there are times, where I feel like it is out of my scope of work what I will try to do you know I am always about training and getting additional education and things of that nature.” Ashley Nicole stated, “but if I feel like it is truly out of my scope of work then I will you know refer them to another.” Ashley Nicole provided context that “refer” for mental health issues namely “personality disorder of something of that nature.” Ashley Nicole addressed that skilled, “but for anxiety I feel you know pretty confident and prepared but really, I put it you know I check in with the clients. Ashley Nicole added that there wasn’t a time where she was not ready to provide clinical services for African Americans with anxiety disorders stating, “not to my recollection.” “I can’t recall it being.” “No.” Ashley Nicole’s positionality included her ability to counsel African American clients with anxiety disorder and willingness for advancement in information (Collins, 2022).

Lady Bug and Ashley Nicole identified not initially having this notion of competence to work with African American clients with anxiety disorders. Ashley Nicole identified not having a sense of proficiency identifying the presentation of anxiety due to working as a “juvenile probation officer” in early stages of her career and not as a clinician stating, “a lot of what I can look back now and see didn’t have those skills you know and knowledge myself at that time because I wasn’t a therapist.” Ladybug provided a perspective that confident at present with her skills however initially not confident “when I first started doing it or like when you first become licensed or first get your private practice I did not feel as equipped or would I say as comfortable as doing it.” Lady Bug and Ashley Nicole showed that there can be an array of preparation narratives with anxiety disorders connected to the conceptual framework by Collins (2022).

**Educational Experiences**
Eight of the participants discussed how their educational experiences were essential regarding their steps to work clinically with African American clients with anxiety disorders. Five of the participants discussed how constantly learning is essential to their readiness to work with African American clients with anxiety disorders. Mr. Z stated, “we have to do continuing education all the time.” “So, I do all kind of little seminars, workshops, and stuff about it.” “I read numerous books on it, articles, and I work with it all the time.” Jasmine’s response aligned with Mr. Z’s as she connected her clinical ongoing learning to licensure requirements stating, “so you do a lot of we do professional development in-house here on campus and then with an LCSW…renewing your CEU’s every two years.” Ms. A added a similar perspective as Mr. Z and Jasmine that her ongoing learning is specific to “anxiety” related topics including attending “different trainings different conferences where the sessions are focused on anxiety.” Cara detailed how ongoing learning is essential in serving as a counseling center director and encouraging her “staff” to engage in training describing that “I am very much a supporter of in terms of my staff and myself of consistently engaging in professional development.” “I appreciate when it is supported by my employer or employers.” The participants espoused the information of a fluid process of learning to progress in anxiety awareness in the behavioral health professional role (Collins, 2022).

Ashley Nicole spoke to how ongoing learning and seminars are critical regardless of her race for competency working with African American clients with anxiety disorders:

I always like taking trainings the CEU’s I am trying to you know do different things to make sure that even though I am African American to make sure I am culturally sensitive to certain situations. I think a lot of time we as clinicians because we are people of color, we feel like oh we don’t need to take any additional trainings regarding that.
Ashley Nicole addressed the purpose she attends seminars includes wanting to “learn additional strategies and techniques that would be you know beneficial to the clients.” Ashley Nicole had awareness of her African American identity and the need for learning as instrumental to her positionality in connection to the conceptual lens by Collins (2022).

Cara and Ahsley Nicole discussed particular anxiety seminars. Cara provided an example of a seminar she attended included “a specific series of professional development for anxiety in collegiate mental health settings and how it has evolved over the past few years in particular with the implications of the pandemic and the socio-political climate that has impacted our student populations.” Ashley Nicole added another specific seminar discussing, “it was a cultural diversity training through PESI because they have some really good trainings” (PESI, 2023). Ashley Nicole added, “but I think you know it gave some really some good strategies and techniques just to deal with anxiety symptoms and behaviors.” Cara and Ashley Nicole highlighted anxiety seminars that aligned more with the prior conceptual model by Hunter and Schmidt (2010) A Sociocultural Model of Anxiety in African Americans.

Mr. Z, Dr. Zora and Cara spoke to “educating” their clients about their anxiety disorders using the terms “psychoeducation” or “psychoeducational.” Mr. Z used the concept of “my teacher hat comes on.” Mr. Z and Dr. Zora spoke to the client’s though process. Mr. Z addressed helping the client to “change their perspective on things and recognizing the power of their own minds and their own being and where they are now.” Dr. Zora addressed exploring with the client “why they think the way they do why they do what they do.” “What are the impacts in their lives?” Dr. Zora addressed that focus on with clients their “medical assistance to talk with their physicians.” Cara focused specifically on informing clients of how “anxiety can present itself,” “different approaches that are helpful,” and “being able to think for some African
Americans as they are in the learning process.” Cara added the necessity of learning about anxiety “how it can impact people across a lifespan and across sub-demographic areas for African American populations.” Cara expressed an understanding of the differentiation in the African American community (Hunter & Schmidt, 2010).

Lady Bug highlighted how counselors and the counselor education field has to evolve detailing “I feel like the counseling perspective the counseling profession or even CES right is a growth journey.” Lady Bug spoke to the importance of how “we grow as people, educators” and “students” stating the “student in 2023 is not going to be the student in 2030.” Lady Bug addressed that “everybody learns differently” when look at different modalities with her stating “when I say telehealth as far as school so remote may work for you in-person may work for you but then hybrid may work for somebody else.” Lady Bug spoke to the need for advocacy in the counselor education field which can extend to insights by Collins (2022) on Black feminist thought.

Lady Bug addressed the “CES instructor” stating:

Do I have to think outside of the box to help you be this student or am I going to be the professor that’s going to be like oh no this is how it is, and this is my way or no way and you can’t conform to this then. I feel like it’s always been open and growing and being 360 and being able to learn from your students or clients.

Some of the participants discussed pivotal moments during their formative educational experiences where they gained further insight about anxiety disorders for African Americans.

Ms. A described learning about anxiety disorder presentation and connection to relatives from her educational experiences in college particularly her “junior year, senior year core classes started to learn a lot about anxiety” and “junior year really getting into graduate school was when
I really started to learn about what anxiety looks like.” Ms. A further described a formative experience in her anxiety knowledge at the “HBCU” she attended for “undergrad and graduate school” in “one of my classes” describing, “I remember having this discussion about you know just women in our families and how they experienced anxiety and what it looked like and got on the subject about nerve pills.” Jade discussed the steps she took to work this population “through my training in the master’s program” stating “we focused a lot on anxiety and depression disorders so that’s where I learned the skill set to really work with clients with those specific disorders.” Jade added, “just like you I am also in a doctoral program” highlighting her advanced education. Lady Bug focused on how pursuing or earning her “master’s in mental health counseling” stating, “made me super conscious of the power of our words of our being intentional right and how we can create an atmosphere of anxiety for people unknowingly by our words by what we intend to say.” Laby Bug linked how awareness of communication is instrumental as a behavioral health professional to provide a safe counseling space for clients.

Dr. Zora and Jasmine who both hold Ph.D.’s in behavioral health fields had different viewpoints on how they incorporate African Americans and anxiety in their educator roles. Dr. Zora described her focus on African Americans, anxiety, and diversity which aligns with Collins (2022, pp. 29, 164-165, 269, 349) focus on “race.” Dr. Zora detailed the varied graduate programs where she serves as a professor including “doctoral ministry program” and “clinical mental health counseling” where she educates “master’s and doctoral students.” Dr. Zora discussed prioritizing “cultural competence” in the educator role and when “write curriculum” and “do curriculum development.” Dr. Zora discussed that utilize “workshops on” the “book called Posttraumatic Slave” “not as an expert as a reporter” (DeGruy, 2017). Dr. Zora focused on having a “master’s in forensic psych,” and how she “worked with the police department in
developing curriculum for their police academy” and how “something that is not emphasized cultural competency or how their perceived by somebody else.” Jasmine provided an alternate perspective that “teach social work courses so when I make reference to experiences, we just generally talk about mental health treatment” where not a specific focus on African Americans. Dr. Zora and Jasmine showed that there are divergent ways to approach discussions of anxiety and African Americans in educational space where there is not one universal perception for Black women (Collins, 2022).

**Resources**

Eight of the participants discussed whether they designed creative resources or wrote specific literature or not in their clinical practice in general with anxiety disorders or had materials specific to African American clients with anxiety disorders. Seven participants discussed that they did not create specific resources regarding anxiety disorders in general. Jade stated, “I haven’t created anything on my own.” Lady Bug had a similar response as Jade where Lady Bug stated, “so, I haven’t created anything like we do presentations at school.” Jasmine responded similarly as Jade and Lady Bug stating, “none that specifically that address anxiety disorders.” Participants Mr. Z, Ms. A, Ashley Nicole, and Cara addressed that they did not have publications related to anxiety disorders. Mr. Z stated, “but so, far as like published articles and things of that nature, “I haven’t really did any of that.” Ms. A discussed that, “I haven’t had the luxury to write a book yet; but I would love to whether it’s like a self-help book or workbook.” Ashley Nicole stated, “I haven’t done any brochures, or books, or anything of that nature.” Cara added, “I don’t necessarily make it broadly available in terms of publications.” Creative resources were not a major focus for most participants in this study in connection to their positionality regarding African Americans and anxiety disorders.
A few participants designed materials for their clinical work with anxiety disorders. Jasmine discussed during the interview “not” having creative resources regarding anxiety disorders in which she later emailed me several salient examples of innovativeness in creative resources implemented in her work on campus regarding anxiety. Jasmine provided me with eight flyers (one QR code with a wellbeing focus, three flyers on specific mental health topics with one with a range of behavioral health topics including anxiety, one flyer with a discussion event about anxiety presentation, and one flyer with a focus on behavioral health and athletes). Jasmine included three flyers with a focus on three distinct stress relaxation activities. Two of the flyers that Jasmine provided included specific speakers with a focus on a stress relaxation activity and a celebrity speaker and another featuring behavioral health/health professionals and a celebrity speaker. The participant was a featured speaker on a flyer. It was clear that Jasmine prioritized contemporary wellbeing approaches. Lady Bug identified that utilized “coloring sheets for test anxiety, stress, and anxiety” when working with college students. Shasha detailed that “creative resources well yes art is a very important avenue to take and mental health healing.” Shasha stated that “I have implemented an art wall” “to have students create art,” “a mini very mini library in the corner of our office” with resources “all mental-health related, and a “mental health resource binder.” Shasha addressed that “there is more to be done” regarding creative resources. Cara discussed materials she used to implement when working with African American clients with anxiety disorders stating, “it is more indirect but in the past being able to utilize a platform where information was readily accessible with articles with links to different resources.” Cara expressed changes in how used to communicate anxiety disorder information.

Cara and Jade both utilized handouts with African American clients with anxiety disorders. Cara stated, “I do in terms of maybe a list of resources.” “I believe that I do have few
examples that I could share.” Jade discussed having resources on anxiety disorders. Jade added, “I don’t for my college students I just use mainly worksheets if they need them Therapist Aid” (Therapist Aid, 2023). There was some use of written resource information in clinical practice.

_Providing Presentations_

Six of the participants discussed that they provide presentations on anxiety-related topics where seven participants spoke on presentations overall. Mostly all the participants reported that willing to send presentation materials for the interviewer for analysis. Mr. Z and Ms. A discussed that they had conducted “several” presentations at their HBCU. Specifically, Ms. A included that conducted a “lot of presentations on campus regarding anxiety” whether “a lot of classroom presentations,” and a “few churches in the local area.” Dr. Zora highlighted her presentation experience that “I do many presentations” which includes “conferences” and “corporate events.” Dr Zora addressed that her “presentations especially specific to African Americans” where once again she focuses on considerations regarding “race” (Collins, 2022, pp. 29, 164-165, 269, 349). Dr. Zora addressed including the “Post Traumatic Slave Syndrome” that “I haven’t done that in two years you know I do that” (DeGruy, 2017). Jasmine added at her HBCU campus of employment, “however, we have done presentations on collaborations.” Ashley Nicole stated that provide “training,” “community outreach,” and “presentations.” Ashley Nicole described an upcoming “training for first responders on cultural diversity and cultural sensitivity and the anxiety piece comes up in that.” Ashley Nicole explained “because as they are responding people’s response to them because of the anxiety levels because of the situations are heightened and I will be talking about how you know they need to be sensitive to that for that reason.” Lady Bug stated that “may do an event for testing anxiety.” Jade did not identify any specific presentations.
Behavioral health professionals spoke on different presentation experiences. Mr. Z described that he “created” an upcoming “faculty/staff training” and another for students with “data specifically on mental health and the frequencies, severities, and presentation and things of that nature.” Mr. Z discussed that the purpose of the presentations are to help “people understand “mental health, mental illness” and “what happens when you go to see a counselor and what’s some basic things they can do to help with their mental health.” Lady Bug described the varied types of “presentations” she provides and her colleagues on an HBCU campus including topics such as “mental health, suicide, and domestic abuse.” Lady Bug discussed that have workshops for events like “midterms, Ms. Sophomore” and “particular event.” Lady Bug identified specific student populations that provide “presentations” for including “organizations,” a recent “two-day” workshop for “master’s social work students.” Ms. A added that conducted “a lot of presentations in different settings throughout the years.” Cara added her interest and willingness to provide some more presentations stating, “welcome any opportunities to present both in professional settings through conferences or invitations to share” and included “non-professional settings.” The participants’ positionality connected with the provision of presentations.

Clinical Experiences/ “Nature of the Work that I Did”

Five participants discussed their clinical experience in different environments with African American clients with anxiety or anxiety disorders and their diverse roles. Mr. Z explained working with individuals across ethnicities in different workspaces including “outpatient,” “schools” and “referrals from everywhere” including “doctor”, “hospitals”, “courts,” “individuals,” and “parents” whether “young” or “old.” Mr. Z identified his two clinical roles including stating “own a private practice” and serve in the role of “Director of Counseling & Wellness at the university.” Lady Bug detailed her array of clinical experiences
stating, “I think it was more or less the nature of the work that I did geared me.” “I had my private practice in [name of city].” Lady Bug discussed providing “pro bono for a like a lot of people to as well” and “crisis work.” Lady Bug discussed that part of her positionality was her initial clinical work with “social services” in her “30s.” Lady Bug later discussed working in “disabilities and services” and how this can serve as a support for anxiety disorders informing clients of “504” for “ADHD,” “anxiety or depressive disorders” where she reported that people “know about ADHD more.” Dr. Zora spoke on the duration of her clinical experiences working with African Americans with anxiety disorders “where decades of experiences” for “45 years.” Dr. Zora discussed her background from a spiritual/faith-based perspective stating, “I did my doctorate in pastoral community counseling.” “I am a pastor as well as working with people working with leaders in the community pastors.” Dr. Zora identified her clinical practice from “counseling, psychotherapy, spiritual direction.” Dr. Zora detailed that, “I look from every single angle definitely mind, body, spirit” (“not having that peace not having that safe space that safe group of people”). Dr. Zora discussed the perspective of working with clients where there exits “consequences from dealing with gangs” with “not feeling that belongingness and the anxiety manifests itself to the point where they are isolating feeling as though they have to belong somewhere they get with the wrong crowd.” Dr. Zora discussed “dealing with narratives.” Dr. Zora discussed what is key to her clinical experience completing “my residency at the [treatment center did not disclose for confidentiality] in [state] so having that substance use and having that background and everything comes into play it’s so holistic.” Ms. A addressed “talking with some psychiatrists and psychiatric nurse practitioners who work with clients with anxiety” and Cara discussed “working with other colleagues” as part of consultation about providing clinical services for African Americans with anxiety disorders.
Participants discussed the significance of their experience working with African American clients. Mr. Z and Ms. A emphasized how they enjoy working with African American clients with Mr. Z describing his experience as “it’s actually great” and “it’s been a blessing” and Ms. A using the phrasing “definitely rewarding.” Mr. Z and Cara discussed the importance of “compassion” when working with African American clients. Cara spoke to the regard she has for her African Americans clients and how she wants to support through “empathy and understanding.” Cara addressed “wanting to ensure that the clients that I serve who are African American know that they have advocates available they have clinicians or providers available who understand and want them to be well.” Participants added that their awareness of anxiety disorders and how they can impact support for their African American clients (Collins, 2022).

Mr. Z and Jade discussed having a detailed history working with African American clients which includes their “lived experiences” in clinical practice with African American clients (Collins, 2022, p. 41; Damsgaard, 2021; Flood et al., 2019). Mr. Z highlighted the duration, interest, and appreciation for his clinical work with African American clients and regard for working with clients across races describing, “I have been working with African American population probably right at 15 years really from the inception of my counseling experience.” Mr. Z described his experience as “a blessing, having compassion for your brothers and sisters.” “I work with you know Caucasians, Latinos, White, Black, whatever, young old, it don’t matter.” Mr. Z recognized that African Americans “our people need a little bit more help.” Jade emphasized that a majority of her clinical background is with African American clients stating that “I don’t work with a lot of people outside of the African American population.” Jade discussed after her master’s program she had “more African American clients.” Jade’s insight was that “I really think just getting that experience and working with African American clients
regardless of their background really what has made me comfortable.” Jasmine confirmed her experience working at an HBCU with African American clients stating regarding her job setting.

Shasha on the other hand discussed that most of her clinical experience is not specific to biracial African American clients however may have some experience in that range addressing that “I personally cannot say I have a large amount of Biracial clients,” “more so of Hispanic” “fall into a biracial setting for example a Puerto Rican person will generally Indian, European and African are the three kind of avenues towards.” Participants had varied clinical experiences (Few et al., 2003).

Six participants spoke on their experience working with anxiety or anxiety disorders. Mr. Z highlighted his extensive experience stating, “I’ve worked with literally, I know 100s maybe even in the 1000s now of individuals and families too that have experienced anxiety disorders.” Lady Bug detailed her clinical experience with clients where “most of it was anxiety and stress of being a woman” and “not being able to navigate and not being able to manage.” Lady Bug identified specific client diagnoses including “depressive disorders, the anxiety disorders” “or whether it was PTSD which falls in that anxiety disorder because of the trauma they faced in the past or you know that was upbringing.” Ashley Nicole discussed her appreciation for her clinical experience with anxiety expressing, “I just I mean it’s a anxiety is one of things that I love working with.” “I am actually establishing a group to set up a group working with anxiety and so it’s something that I feel like we all struggle with a little bit.” Shasha echoed a response that was alike Ashley Nicole with Shasha stating, “not just say that this is just a regular job this is something I am doing because at the end of the day this is a real person with a family, and you know a job.” Shasha and Ashley Nicole spoke on their passion for treating anxiety disorders that connected to their positionality.
Participants Ms. A, Dr. Zora, and Lady Bug described specific positive impacts on their counseling of African American clients with anxiety disorders. Ms. A provided a detailed example of her clinical skills stating, “sure let me think there is quite a few.” Ms. A described a particular client in “community mental health” with “lot of distorted thinking, “panic attacks on a weekly basis always on edge, “wasn’t getting along with their peers,” and “relationship issues. Ms. A highlighted “success stories” including her client “no longer having panic attacks,” “getting married,” and being “able to reframe negative thoughts” after “nine months” of counseling. Ms. A added regarding her clinical effectiveness working with anxiety disorders after the “success story, I remember it definitely validated like hey ok anxiety yes this is one of my specialties” with “mild, moderate or severe cases.” Dr. Zora shed light on her experiences with African Americans with anxiety or anxiety disorders who experienced self-insight with “becoming aware,” “putting all the puzzle pieces together,” “having or even teaching techniques of how to ground themselves, how to breathe, how to meditate.” Lady Bug described experiences that were clinically beneficial for her clients including them expressing “I am trying to be like you,” “you are super intentional about what you say.” Participants knowledge of anxiety disorders was instrumental in them having clinically useful outcomes for their African American clients (Collins, 2022).

Lady Bug, Jade, and Jasmine discussed their clinical experience at an HBCU with anxiety. Lady Bug discussed with students “on a college campus a lot of it is anxiety a lot of it you know transition from HBCU’s.” Jade specified “my students having anxiety surrounding classes or tests.” Jasmine added, “we have done anxiety groups” at her HCU campus. Jasmine discussed the interactive activities she utilizes on an HBCU campus related to anxiety including “tabling events,” providing “stress balls, “evening programming,” “Wellness Wednesdays,”
“yoga,” “throw out the paint like activities, “paint and sipping is non-alcoholic (abstinence only campus)”, and “yoga.” Jasmine focused on the engaging ways she advocated for her clients at an HBCU (Collins, 2022).

“Do this Research”

Five participants described “research” as an important aspect of their background. Ms. A discussed how she is actively engaged in learning more stating, “but you know I do try to take time to research articles and things and see what’s out there about anxiety about African American women.” Jade and Dr. Zora’s research experience highlights their participation in this research study and topic. Jade identified her specific dissertation topic addressing “my study is on Black women.” “So, that’s my research focus that I am working on now.” Dr. Zora stated regarding her prior completed dissertation “my dissertation is on… and stress which folded into anxiety.” Lady Bug described the importance of research for working with African American clients with anxiety disorders and used the statement “want your research to be researchable right” describing if “if I wanted to pick up your research and do it that you gave me this blueprint to where I could pick it up and do it” “and see something else or find out something totally different.” Jasmine added “and then just personally when you’re interested in something you will research and get more information.” The participants’ perspectives aligned with insights by Collins (2022) on Black feminist thought with the imperative to pursue knowledge.

Having Specific Mentors vs. Not Having Specific Mentors

Four participants discussed either having specific mentors or not that were aspirational for them to provide clinical services to African American clients with anxiety disorders. Shasha detailed having a faith-based mentor namely “Bishop T.D. Jakes is somebody that I have watched over the years” describing that “he is not a psychologist” or “therapist” that “he is a
minister.” Shasha discussed that “he did talk a lot about healing from issues of anxiety which are really issues of trauma.” Shasha added regarding her faith-based mentor, “that is somebody that I would say did inspire me to work” and “he was someone that I think I looked up to and I still do look up to and respect.” Shasha provided a different perspective regarding mentorship.

Not all participants identified a specific mentor for their interest in anxiety disorders. Dr. Zora addressed that her interest in working with anxiety disorders did not emerge from a particular mentor expressing, “it was just a natural becoming rather than anyone encouraging me to do that and just seeing the impact that society and the world has on others was a push towards that.” Ashley Nicole expressed the reality of having to identify a specific mentor “would be really hard” that her mentors “most of they dealt with so many different things from anxiety to depression to PTSD.” Lady Bug added regarding her mentors, “probably not and I would say because we are like in the field together and with her husband, we worked at a behavioral health agency together.” Mentorship was not a major aspect of the behavioral health professionals’ positionality regarding anxiety disorders.

**Theme Six: Diagnostic Process**

All nine of the participants identified their specific way of diagnosing African American clients with anxiety disorders.

*Utilizing Assessment*

All of the participants discussed the different types of assessments that they utilize for diagnosing African American clients with anxiety disorders. The “GAD-7” was a common measure that Ms. A, Jade, Cara, Lady Bug, Jasmine, Ashley Nicole, and Dr. Zora implemented in their clinical work. Dr. Zora added that “usually, I don’t use a formal assessment at this time” and “when needed I use the Generalized Anxiety Disorder 7-item scale (GAD-7)”. Cara, Lady
Bug and Mr. Z all use the “Beck” where they had different terms for the measure with Cara calling it the “Beck Anxiety Scale,” Lady Bug identified it as the “Beck Anxiety tool” and Mr. Z called it the “Beck.” Cara identified using the “CCAP screen for collegiate mental health settings.” Mr. Z included assessments like the “Hamilton” “or basic rating scale.” Ashley Nicole provided a distinct perspective regarding how individuals may respond differently if they know what the screening is measuring where she stated, “I don’t have it labeled,” and “like some people it’s like they want to have certain diagnosis.” Black feminist thought was evident in that the participants had diverse manners in which assessments they utilized for African American clients (Collins, 2022).

Some participants added other measures that were not anxiety specific regarding screenings, assessments or information they utilized with African American clients with anxiety disorders. Jasmine, Cara, Lady Bug, and Ashley Nicole all implemented the “PHQ” measures with clients. Jasmine stating that the “PHQ-9 deals more with depression,” Cara identified the “broader PHQ scale that includes the depression scale as well being able to assess somatic symptoms,” and Lady Bug stated the “PH-9.” Ashley Nicole discussed that conduct the “comprehensive clinical assessment.” Ashley Nicole and Shasha both have “symptom checklists” where Ashley Nicole incorporates this resource. Lady Bug was the only participant who identified including the “MSE” and “suicidal scale” and specifically the “suicidal scale” with the college population. Ashley Nicole utilized the “PTSD questionnaire,” “mood questionnaire” and “different questionnaires.” Shasha was the only participant that did not implement some of the more traditional anxiety measures, spoke to the importance of the “biopsychosocial assessment” that have primarily as the predominant measure “for the most of my clients” in which she identified that “have a variety of different screenings.” Shasha had a
prior measure that implemented “called GAIN which stands for globalized assessment” stating that, “I don’t have access to” and “it was helpful.” Dr. Zora stated that “when needed I use the Mood Assessment Questionnaire.” Once again, participants had an array of assessments they utilized for African American clients showing the different ways they grasp anxiety presentation (Collins, 2022).

Shasha emphasized an alternative approach, “it is truly important like I said to pay attention to the story to what is happening in the lives of individuals and not make you know a quick judgment.” Shasha addressed “I think when it comes African Americans and anxiety disorder” for “my profession and anybody who works with individuals” “to truly listen.” Shasha addressed, “if you have the privilege to work with an individual for 45 minutes to 60 minutes now then this is the time for you to really get to the root of things, if possible, with this client.” Shasha added referencing “the story” “it can be very meaningful.” Shasha provided context “I can start to get some ideas as to what could have happened and what is contributing triggering some of the symptoms.” Shasha spoke further on her diagnostic process expressing that “I like to listen to all of the factors so that it is not one dimensional.” “If I am focusing only on the fact that an individual is an African American or is you know LGBTQ then I am missing the story.” Shasha used the phrase “cradle the story cradle it but keep it because its not yours you give it back.” Shasha spoke to the need for African American’s voices that links with work from Collins (2022) conceptual framework.

“Develop a Diagnosis”

Nine participants spoke on varied ways of diagnosing African American clients with anxiety disorders with seven identifying their specific steps. The participants took their diagnostic process seriously and gradually formulated the diagnosis with respect. Mr. Z and
Ashley Nicole discussed how they work through the diagnostic process from the start of treatment with “intake” and “history.” Mr. Z in assessing the client explores “what they have that is current” similar to Ashley Nicole who looks at the “current symptoms and behaviors.” Mr. Z added “based on that then, intake we’re going to develop a diagnosis” “based on “reports and reports from multiple resources.” Mr. Z discussed all that he takes into consideration regarding anxiety diagnosis including “self-reports and reports from other people,” “case notes,” from a “counselor” or “primary care physician.” Ashley Nicole added considerations of “I have other things like my mood disorders and different things to rule out certain other things.” “We have to go through the whole medical to make sure there is no medical reason for it.” Ms. A discussed that she formulated the anxiety diagnosis after more observation with “a couple of sessions” to monitor “anxiousness,” “feeling on edge,” and “worrying” “that is consistent for a couple of weeks” to see if “align with the diagnostic criteria.” Shasha added a process similar to Ms. A “I think it truly varies this is something that is different for everybody.” Cara stated, “there’s many ways to you know determine but if me like I said I do like to take my time and make a good clinical decision.” Cara further explained the care she places into diagnosing her clients stating, “it is a very clinically sound and thoughtful process while also understanding the impact.” Cara looks at “rapport” “and it’s helpful to talk with clients about the screening tool by itself is not the only thing that is used to make a diagnosis.” Lady Bug described how she provides space for her clients to be active in the diagnostic process describing “when I diagnose, too” that “we do it together I do it with my clients.” Lady Bug discussed further ,”when I come up with the diagnosis and tell you that and I let you read it and I let you see it and I let you say yes, I agree with that because you are fully a part of your treatment.” The participants’ diagnostic process was equitable in their considerations and regard for the clients (Collins, 2022).
Participants discussed the importance of noticing how the client presents in the counseling session to inform diagnosis for African Americans with anxiety outside of external resources. Lady Bug stated, “every time they come into that and I always and I feel that observational your observations are very keen.” Dr. Zora added, “yes, looking at just what the person is presenting and getting a baseline first to see if this is their actual everyday behavior or is this just something that’s occurring all the time.” Lady Bug described the specific physical and emotional symptoms to monitor as part of the anxiety diagnosis including “always shaking,” “clinched up,” “grabbed arm,” “biting your fingernail,” “start shaking,” “tapping your finger,” “they shut down why we shutting down right now.” Shasha concurred with Lady Bug with the need for the behavioral health professionals to notice what is taking place with the client outside of the printed material stating, “what is most important is to take these things seriously and not just say ok well my you know my DSM says this this and that so really you know pay attention.” Participants were attuned to the physical presentation of anxiety where they did not utilize a health-affiliated justification for diagnosis from Hunter and Schmidt (2010) conceptual model.

Cara and Dr. Zora looked at the importance of focusing on the cultural aspects of the client’s life that may be a part of the diagnostic impression for African American clients with an anxiety diagnosis. Cara detailed the significance of “cultural factors” not generalizing anxiety symptoms, processing the role of varied encounters including “family background,” “upbringing,” “different cultural communities, or subcommunities.” Cara provided client example from the “Caribbean culture” where their “experiences” “are actually typical behaviors they are not necessarily anxiety based.” Cara discussed the importance of the “clinical interview.” Cara and Dr. Zora were mindful of findings by Hunter and Schmidt (2010, p. 228) on sociocultural and “protective factors.”
Cara had helpful insights stating that:

It’s just the recognition of our threshold for experiencing things is not higher than someone else’s in terms of underdiagnosing or even sometimes misdiagnosing because the perception is different. Or it may be better understood in White communities which I think that goes back to the training piece from multicultural.

Dr. Zora’s perspective paralleled that of Cara’s when it comes to not painting this broad perspective of what an anxiety diagnosis is for African Americans stating, “there is again cultural competencies, so I am located in [city, state] and so there are a lot of assumptions already made.” “And so, when those assumptions are made then it can kind of tweak how the person is perceived and feeds into their diagnosis.” Dr. Zora and Cara’s perceptions are hoped for outcomes of the conceptual model by Hunter and Schmidt (2010) with the Sociocultural Model of Anxiety in African Americans.

Mr. Z and Shasha addressed not relying solely on other behavioral health “professionals” clinical impressions of their clients. Mr. Z discussed how he considers the anxiety symptoms the client and their coping more than external insight expressing, “I don’t know what these other professionals or individuals have done so I wait until they get in front of me.” “It is what they are presenting now, the history is important but also the current level of functioning is much more important.” Shasha added, “I try not to pay too much attention to what anybody else might have said about the individual or the situation.” Mr. Z and Cara spoke to the importance of their clinical insight with the diagnostic process of anxiety disorders.

Shasha provided a different perspective regarding looking at diagnosis from a spiritual lens “it’s about it’s something that’s new that’s cultivated.” Shasha added about her faith processing that “my heart as a believer it is important to me,” “believing in the Christian values,”
and “knowing that God has created us.” Shasha discussed that, “by having those beliefs that’s certainly cannot cloud my judgment in diagnosis but strengthen me and help me.” Spirituality was a part of Shasha’s positionality that she does not externalize unto her client’s perspective.

Dr. Zora and Jasmine identified initial diagnoses they may start off with clients. Dr. Zora provided her perspective on how she approaches the anxiety diagnosis “for me generalized anxiety disorder is usually my diagnosis unless it’s very extreme.” Dr. Zora discussed “that diagnosis of course it’s from the case conceptualization,” and “assessment” where emphasized “conceptualization.” Jasmine identified “so in the past I have and with any diagnosis I try to do I try to use the least one with the least amount of kickback” and “ones that are least restrictive.” Jasmine stated, “I want to start small and then we can work our way up if needed versus starting large and then you can’t get rid of that diagnosis.” Participants had divergent ways to approach diagnosis that shows there is not one singular perception (Collins, 2022).

Jade and Jasmine provided different perspectives regarding diagnosis in their clinical settings. Jade provided another aspect of how diagnosis can be conducted via “in the private practice realm” where “I always like to tell clients if they want an official diagnosis they want to go to a psychologist or if they have insurance, I refer them to someone else.” Jade stated, “we have to put in a diagnosis because it’s insurance.” Jasmine added at her HBCU stating, “I’ve worked in settings where we do diagnose but here, we don’t.” Jasmine later re-affirmed “we don’t diagnose.” There is realization that diagnosis may not be part of the participant’s clinical practice.

**Using the DSM and DSM-5**

Six of the participants addressed how the *DSM* and *DSM-5* (APA, 2013, 2022) are essential resources when they diagnose anxiety disorders in African American clients. Mr. Z
stated, “we are looking in the diagnostic in the DSM-5 and we understand that this is where you falling.” Jade discussed how she utilized the DSM early on in counseling during “intake,” “counseling sessions,” and for basic assessment “asking them questions based on anxiety disorder criteria and the DSM.” Lady Bug added how she uses the DSM-5 stating, “I pull out the DSM-5 the book right and I say, and I educate them” (APA, 2022). Shasha added, “so that is one way that I go about it of course I have my DSM that I have right by my side and so that is what I do.” “I can just line up with my DSM, so I use those two tools.” Ms. A added how “take a few sessions” and explore “what kinds of behavior that aligns with the DSM-5’s diagnostic criteria.” Dr. Zora described how she uses the DSM-5 when she diagnoses her clients with an anxiety disorder exploring “if it meets all the criteria of the DSM-5 using that always having that as a back-up” and “I look at the symptoms that the person is actually demonstrating using the DSM-5 for confirmation.” Dr. Zora suggested exploring “if it’s situational or is it an anxiety disorder that actually impacts their body where they are having palpitations and can’t breathe and feel faint.” Dr. Zora looked at exploring the different types of anxiety presentation in African Americans.

Theme Seven: Life and Familial Experiences

Importance of Life and Familial Experiences

Theme seven includes the importance of life experiences and “try to stay neutral” in terms of how their past and present encounters and circumstances have aided in their positionality regarding anxiety disorders amongst African Americans (Few et al., 2003). Nine of the participants discussed their life and experiences. Seven participants discussed how their life experiences connected with their perception of anxiety disorders amongst African American clients whether it was in general, in connection to family, or employment. Mr. Z described his early life experiences that “I grew up in the south in what is known as the Delta, “parents college
educated” and “they worked,” “six of us” “in a two-bedroom house” “in the early 80’s, “mom making our clothes, “and all kind of stuff.” Mr. Z addressed that “I can’t say that we were poor.” Mr. Z concluded, “I can remember that and so when we talk about systemic inequities.”

Mr. Z provided a hypothetical example of potential experiences he and his family could have that could connect to aspects of anxiety as an African American stating:

My wife is a Ph.D., and we are working hard and say for instance we buy a home and then one day we decide we want to sell our home. Our house is going to be appraised at a lower value that individual who is of another racial ethnic group, and they got the same house basically and the same area that is going to cause some worries financially and all kind of stuff.

Mr. Z later confirmed “of course, who I am going to influence how I think and what I do.” Mr. Z focused on his background including “race, gender, and class” and bias from those with more authority (Collins, 2022, pp. 29, 164-165, 260, 349).

Lady Bug described how her “family” was an influencing factor, “upbringing that children are meant to be seen and not heard.” Lady Bug discussed specific messaging such as “do as I say not as do, “I don’t care how you feel about it,” “you ain’t got to like it,” and you know about it you ain’t got nothing to say.” Lady Bug addressed that “for the African American community, when you say something back you are talking back right to be respectful.” Lady Bug addressed “my kids, I just created an environment, and I told them you can tell me whatever you want to tell me but there is an appropriate time and place to say it and it is the appropriate tone in which you do it.” Lady Bug added, “I apologize to my kids all the time right and then if I apologize and they don’t apologize I am not upset about it because they have to grow to learn how to apologize in that manner.” Lady Bug’s expression exemplifies that Black women’s
voices are to be regarded and heard and provided with support like for Black men via findings by

Ms. A was the first to discuss seeing specifically that women in her family cope with
anxiety where she grew up with “females in the family for the most part working very
ambitious.” Ms. A described “not knowing what it is growing up or being able to look back and
say ok” different family members “experienced anxiety like “mom, aunt, and grandma.” She
discussed “up until then, I thought it was normal or I thought that moms, or aunt or grandmother
whoever the family member was just in a bad mood.” Ms. A discussed her recognition of
“grandma saying I got to take my nerve pills” that was “actually some medication for anxiety.”
Ms. A spoke to “Black women’s lived experiences” within the familial context (Collins, 2022, p.
41; Damsgaard, 2021; Flood et al., 2019).

Ashley Nicole discussed varied aspects of who she is in connection to employment,
awareness of her family’s coping, and serving in the military. Ashley Nicole and Ms. A
identified noticing how their family copes. Ashley Nicole recognized the significance of the
steps she has made in life regarding her perception of anxiety disorders stating, “I don’t know I
just feel like I don’t know if it is my personality or family or military background.” Ashley
Nicole discussed her readiness factors as “my life, experiences come across a lot of people
whether it be personal with family members, friends or in work environments,” “professional
life.” Ashley Nicole identified “seeing how people family members, grandparents, and different
people struggle helped me to be able to relate and understand a little bit more people’s reluctance
to come to therapy.” Ashley Nicole added, “I’ve seen being in the military, I’ve been around
such a diverse population and so I think it gave me some insight in regards to that not just
African American but other cultures as well.” Ashley Nicole highlighted that her “military
experience just helped me to just see things differently.” Cara added a similar perspective regarding her background as Ashley Nicole, “and just knowing that there is support and that experience has been shaped both personally and professionally.” Ashley Nicole was able to include her past experiences that were different from African American women in the study where she was the only participant who spoke of serving in the military and that possibly part of her positionality (Few et al., 2003).

Shasha spoke in detail regarding her deep regard for “faith” and how the role of spirituality in determination and her ability to not to displace her beliefs unto her clients stating, “I think yes in the African American tradition faith has something that has been crucial” “that held people together in groups or individually” from “historical times.” Shasha described it as “part of the healing and it’s something that I think is still consistent today you know in my personal setting and professional setting.” Shasha was clear “that there is a separation of Church and state.” Shasha stated that her “faith” “as a clinician it is something that I think gives me hope and it helps me to continue to work” and “personally use my faith to keep going.” Shasha stated that “if I don’t if I can’t necessarily share my faith in my setting, I don’t need to.” Spirituality was a resounding part of Shasha’s perception of self and a impetus for her clinical practice.

Shasha also discussed her “biracial” identity and the need to explore this topic further regarding anxiety for individuals who are “biracial.” Shasha discussed in “my married into family there’s a lot of biracial children” and “being biracial is not something that’s new but definitely having these kinds of conversations is new.” Shasha reflected back on “I still remember a time when somebody that if you have a drop of you know Black blood in you yeah you are no longer White or something like that.” Shasha stated that “there’s more work to do.” Shasha’s inclusion of her “race” aligned with (Collins, 2022, pp. 17, 317; Hamilton-Mason et al.,
2009) conceptual framework with her speaking on the need for additional information regarding biracial communities.

Jade and Jasmine’s perceptions include that there are different experiences for African American women (Collins, 2022). Jade knew that her experiences were pivotal in terms of her perception; however, she was unable to identify one particular factor stating “do those aspects of self-influence?” “I am sure they do but maybe I don’t quite know exactly in what ways.” Jasmine acknowledged that her positionality is different from her clients stating “so as much as I can relate there are some privileges that I have, and I recognize that I can’t relate.” Jasmine addressed her self-awareness regarding her identity.

“Try to Stay Neutral”

Shasha and Dr. Zora both expressed not relying on the events specific to their life to navigate their clinical process with clients. Shasha addressed her boundaries stating, “I try to stay neutral in general.” “I think that my background does not influence my decisions, but it influences me as an individual for my experiences as a biracial person as a Latina as a Christian someone who believes in Christianity and the Bible a lot.”

Dr. Zora discussed that the priority focus is on the client not on herself stating:

But not so I try not to I use all my learning and academics and background. I very seldom thankfully I taught myself this and I think I have always been this way to be objective and not think about my own experiences it comes into play of course that’s natural but not that doesn’t influence how I see things. Because it’s not about me and everybody has different experiences, different journeys.
Dr. Zora’s perception of her focus with clients displays that there was not a singular perception of how positionality connects with the behavioral health professional’s perspective of anxiety disorders (Collins, 2022).

**Theme Eight: “Feelings” vs. “No Feelings” Regarding Anxiety Diagnosis**

Theme nine pertains to each of the nine participants.

**“No Feelings”**

Cara, Jade, Lady Bug, and Jasmine had “no” specific “feelings” about diagnosing their clients with anxiety disorders. Lady Bug stated, “I generally don’t have any feelings about it.” “I don’t have any problems like really diagnosing or feeling.” “I really don’t have any fear.” Jade expressed, “I don’t know if I have any feelings behind it.” Cara and Jasmine had similar perspectives. Cara added, “my feeling is that when a diagnosis is made it’s because it has been considered most appropriate for them.” Jasmine did not identify any emotions addressing, “with any other diagnosis I just want them to have options and getting the support that they need.”

Some participants did not describe an emotional connection regarding their perspective of anxiety diagnosis presentation with their African American clients.

*Experiencing challenging emotions*

Ms. A, Ashley Nicole, and Mr. Z all expressed that experienced some challenging emotions with diagnosing their African American clients with anxiety disorders. Ms. A and Ashley Nicole both expressed feeling some “anxiousness” in their diagnostic process as well as concerned regarding “labeling.” Ms. A discussed that the emotion “of anxiousness” has improved expressing “not as much as I used to experience.” Ashley Nicole specified her concerns with diagnosing stating “but in terms of the African American piece, I know you know worry about labeling especially our African American boys” more connected to “how they will
be impacted” not “the diagnosis itself.” Ms. A also expressed her dislike of diagnosing her clients with anxiety disorders stating, “I honestly hate to” but “diagnose for you know reimbursement for insurance companies.” “They label themselves as I am anxiety disorder so for that reason I hate to diagnose.” Mr. Z stated in terms of diagnosing African Americans in general, “I just say yeah it sometimes it just feels sad.” Mr. Z focused on not letting his emotions impact the way he provides anxiety diagnosis. Mr. Z stated, “you know now you try not to project that unto the client of course not.” Dr. Zora identified that she would experience feelings regarding the anxiety diagnosis with certain circumstances stating, “I just from what I shared you know if it goes too far yes if it’s used a person doesn’t receive what they need in the system.”

Some of the participants’ perspectives aligned with the “stigma of mental illness” from the conceptual framework by Hunter and Schmidt (2010, pp. 213, 225, 228) regarding the emotionality with the diagnosis.

Theme Nine: Behavioral Health Professionals’ Perception of their Client’s Reaction to Anxiety Diagnosis

Some of the participants identified different perspectives with their client concerns regarding how they would be seen by others because of their diagnosis and also their openness to diagnosis. This theme relates to seven of the participants.

“Stigma of Mental Health”/Negative Reaction

Five of the participants including Jade and Jasmine addressed the “stigma of mental health” and “stigma’ regarding anxiety diagnosis for African Americans connected to the conceptual framework by Hunter and Schmidt (2010, pp. 213, 225, 288) and implications regarding getting counseling, how cope, and sometimes negative outcomes. One of the five
participants Ashley Nicole identified that there is discomfort and less “stigma” regarding African Americans and anxiety diagnosis at present.

Jade focused on how anxiety disorders are sometimes a source of discomfort for some African Americans and other African Americans may be “ok with having a diagnosis” stating:

I think it just goes back to the stigma of mental health within the Black community. Those are the ones that have to come to therapy and their open to therapy, but it took them a minute to get there because of that stigma or they going to question are people going to think that I am crazy or something like that.

Jasmine provided a parallel perspective as Jade regarding how African Americans view anxiety diagnosis:

So, I think that in the African American community we downplay we want to pray away, or we want to minimize when we say hey something is just not right. What happens in our house stays in our house things like that perpetuates the stigma and it doesn’t get the help that we need.

Ms. A and Ashley Nicole focused on concerns regarding “label” with anxiety diagnosis. Ms. A added the significance of anxiety diagnosis stating “but, the most difficult part is preventing them from using that as a label internalizing it.” Ashley Nicole provided further context to African Americans “boys” and men’s concerns regarding judgment with anxiety stating, concerns regarding “how they’ll be labeled by others” and “be careful about giving diagnosis because sometimes people begin to utilize that as a crutch.” Ashley Nicole addressed the notion of “young boys” and “adult males” that are African American being “seen differently outside of therapy because of certain diagnoses” with emotions including “denial,” “being more worried,” “ashamed” or “feel guilty.” Ashley Nicole further emphasized African American
men’s though process that “I am a man I am supposed to handle all things, but I am struggling.” “I shouldn’t let stress get to me this way.” “I shouldn’t be worried about this.” “Stigma of mental illness” presents for African American clients with anxiety regarding their emotional expression about diagnosis (Hunter & Schmidt, 2010, pp. 213, 225, 228).

Ms. A, Jade, and Ashley Nicole explored the lack of receptivity about anxiety diagnosis that they are aware of from their client’s experience. Ms. A stated, “I’ve had some that have gotten very defensive with me were able to sit through it though.” Jade provided further context to how there are concerns regarding client’s receiving an anxiety diagnosis stating, “but I try not to diagnose just because I feel like some client, they take it that something is wrong but then other clients it’s different.” Jade later clarified how she phrases the anxiety diagnosis describing, “it’s not that I wouldn’t make the diagnosis.” “I would make note that it is an anxiety disorder.” “I may tell them it sounds like you are dealing with some anxiety or some nervousness.” “But I wouldn’t say hey you have anxiety disorder.” Ashley Nicole confirmed the lack of receptivity regarding an anxiety diagnosis expressing, “I can honestly say I have not had too many African American clients that have been you know wanting a diagnosis per se unless it’s been a situation where they are having some difficulties in the school setting or the work setting.” Stigma of mental illness” was a definite aspect of concern for African American clients across participants (Hunter & Schmidt, 2010, pp. 213, 225, 228).

Dr. Zora provided a distinct perspective of potential negative implications of anxiety diagnosis including “diagnosis it impacts them getting life insurance later and that’s from my experience with people who do life insurance,” “so the amount of insurance they’ll have is limited.” Dr. Zora poised a question stating, “what I do ask students how do you balance giving a diagnosis which may need further treatment with how systemic things are.” Dr. Zora considered
her positionality in lieu of “social justice” with regard for African American clients with anxiety disorders (Collins, 2022, pp. 54, 346).

**Receptivity to diagnosis**

Four of the participants identified that their clients were open to receiving an anxiety diagnosis. Dr. Zora discussed how her clients are open to diagnosis and that it provides relief stating, “the reaction usually is confirmation,” “the majority is ok,” and “I am not crazy this is real and then it’s yes, it’s real and how you deal with it.” Ms. A added, “I haven’t had anyone that I can remember that has you know just gotten very upset with me walked out of the session or anything like that.” Ms. A further described that have “some” clients “says thank you for letting me know” “and eventually be able to accept that hey this is the diagnosis.” Cara added “I have not that I can recall think of many client experiences where it where it has been a negative impact in understanding what’s happening for them.” Ashley Nicole discussed, “I have had some that are really honest and ok Ms. [last name] this is how I am feeling this is what is going on.” Ashley Nicole further explained how the different perspectives regarding African American clients and anxiety diagnosis has changed over time to be more optimistic stating “getting a little better know,” “and I think it’s also a diagnosis like that people it doesn’t hold the same stigma or that some of the other ones do.” Ashley Nicole added her perception that “people are getting more comfortable with addressing their anxiety issues,” and “we are making progress.” Ashley Nicole’s perspective connected with prior work on Black feminist thought by Collins (2022) on the advancement in information and awareness about anxiety.

**Different reactions**

Cara, Jade, and Dr. Zora discussed how their clients may have different reactions to anxiety diagnosis. Shasha and Jasmine expressed the need to explore the significance of anxiety
diagnosis and behavioral health. Cara identified that there are mixed perspectives regarding how her clients view their anxiety diagnosis addressing that “there are some professions where that may be understood differently it may be supported or perceived differently.” Jade and Dr. Zora had a similar perception where their clients address that “put a name” regarding acceptance of now knowing their anxiety diagnosis. Jade processed that “it depends on the client that I am working with honestly” regarding readiness for the anxiety diagnosis. Jade provided an alternate perspective stating, “and then others you know once I have a few sessions with them, I can kind of see that they’re not going to want the label or the diagnosis.” Dr. Zora added that there are varied perspectives; however, most people are open to an anxiety diagnosis addressing that, “you know some the majority when I say there are those who wear it that’s smaller minority” regarding the anxiety diagnosis.

Theme Ten: Using Theory

Six of the participants identified the theoretical lens they utilize when working with African Americans with anxiety disorders. Most participants utilized CBT, and some participants incorporated different theories.

Using CBT

Five of the participants identified that they utilize CBT. Mr. Z emphasized “Once again, I am a cognitive behavioral therapist.” Mr. Z later addressed how he utilizes CBT in a similar manner across clients stating, “well in general this is not just specifically with African Americans.” Mr. Z highlighted the client’s “thought processes,” “changing the way they think,” and “CBT triangle.” Mr. Z and Sasha both explored CBT “cognitive behavioral therapy” regarding “feelings and behavior.” Shasha spoke to how CBT is part of her clinical work and her awareness of theory explaining that “cognitive behavioral therapy teach that thoughts are related
to feelings and behavior.” Shasha added “what is happening what are the root beliefs what is you know the situation the experiences that exist prior to the you know whatever it is that we are thinking about.” Dr. Zora and Ms. A identified CBT as a frequent theory of choice. Dr. Zora discussed, “and I use cognitive-behavioral therapy the most because I want them to shift their perception.” Ms. A stated,” I utilize a lot of cognitive-behavioral therapy.” Ms. A later identified situations and populations in which CBT is a useful therapeutic approach stating, “let me reframe this that’s always a rewarding part for me when it comes to CBT.” Ms. A discussed that CBT “was fairly helpful” for “18 and up,” “older adults,” “mid-mid adulthood” “in community mental health.” Jasmine summarized the value of CBT with her counseling stating, “(CBT) cognitive behavioral that yields the biggest outcomes because when you know differently you do things differently.” Ms. A provided a unique perspective on if CBT is really relevant particularly for “college students” stating that “very outdated,” “not helpful,” “helpful but kind of outdated.” Ms. A provided further context describing “let’s try to come up with a thought to reframe that you know I don’t find it very helpful with a lot of college students.” CBT was a theory of choice with no focus on how it fits with “race, gender, and class,” African American racial identity, or sociocultural in terms of the prior conceptual frameworks regarding the participants’ perspectives (Collins, 2022, pp. 17, 317; Hamilton-Mason et al., 2009; Hunter & Schmidt, 2010).

**Using Diverse Theoretical Approaches**

Five participants discussed the varied theories that they utilized with their African American clients with anxiety disorders. Shasha focused on diverse theoretical approaches she implements with clients stating, “there is a variety of different options” including “solution-focused therapy,” “motivational interviewing,” “cognitive-behavioral therapy.” Cara discussed that a resourceful approach to use different theories including “mindfulness, “CBT,” and
“integrative” and “recognizing that even for African American clients that we are diverse within group.” Ms. A focused on the primary theories she incorporates with clients including “dialectical behavior therapy if it is like a severe case with anxiety has been definitely helpful with college students, “trained in EMDR” and “utilize a lot of EMDR” that “EMDR has been helpful.” Ms. A added that “EMDR is a little weird for a lot of my clients” and “they don’t feel as distressed anxiety is not as intense.” Dr. Zora added, “I use cognitive-behavioral therapy, narrative therapy, psychoeducation.” Jasmine stated “cognitive-behavioral therapy” and “strengths theory.” The participants utilized different theoretical approaches as part of their positionality when treating African Americans with anxiety disorders (Collins, 2022).

**Theme Eleven: “Open to Gaining New Knowledge”**

Behavioral health professionals addressed how they want to thrive in their respective fields and skills regarding creativity with their treatment of African American clients with anxiety disorders. Six participants discussed their areas of desired learning regarding anxiety disorders. Cara stated that “I want to continuously grow in support of meeting the needs of my clients,” “growing as a clinician no matter how long I have done this” as essentials for her that learning is an ongoing process. Lady Bug called attention to that “we have to be open and willing to learn more to not treat it as oh this isn’t anxiety, and so this is what is going to work this is going to fit for you.” “I think that you have to treat it every person differently and know that what worked for may not work for” “and not look at that person as a disorder,” “because we are not textbook people.” Lady Bug emphasized that “we have to always be open to gaining new knowledge.” Ashley Nicole opened up the perspective regarding learning and clinical experience underscoring that “meet them where they are and be as knowledgeable as possible to meet their needs” whether “offices or via telehealth.” Jasmine focused on her readiness to work with this
specific client population stating, “so you are always looking for new information to be the best that you can and provide the best support.” Jasmine later focused on her clinical insight, “but willing to avail myself to try to understand where the student is coming from” Shasha added the importance of awareness of anxiety disorder presentation in biracial African American clients highlighting, “I want to look into some more,” and “this is why I am really excited about this study that you are doing it’s bringing up a lot of questions.” Ms. A and Ashley Nicole highlighted wanting to produce written resources related to anxiety disorders and African Americans Ms. A stated, “I haven’t had the luxury to write a book yet; but I would love to whether it’s like a self-help book or workbook.” Ashley Nicole echoed, “but nothing published but I am working on it.” Participants expressed their interest in steps to advance anxiety disorder information and awareness similar to prior work by Collins (2022) on Black feminist thought.

Theme Twelve: Anxiety Experiences of Behavioral Health Professionals

Five participants discussed knowing that they have anxiety which contributes to their conceptualization of anxiety disorders from their experiences and also as behavioral health professionals which has helped them in working with African American clients with anxiety disorders (Collins, 2022).

Shasha spoke on the realities of having anxiety:

I am thinking to myself different moments that I have felt anxious or been in situations or you know different ways that I have experienced anxiety. I think I still struggle with it at times, and I am still trying to find you know strategies to overcome you know my anxiety issues.

Shasha later discussed her readiness to work with anxiety disorders with African Americans and her experience describing “working on my own issues with anxiety and different
things.” “So, it makes me every empathetic and able to recognize signs and green flags, red flags, and all that.” Shasha spoke to her ability to advocate for African American clients (Collins, 2022).

Ms. A and Jade focused on normalizing anxiety with their college clientele and dealing with anxiety. Ms. A was open regarding her anxiety experience stating, “I won’t say it’s easy to work with, but I guess because I have anxiety of my own.” “I found a connection with that and wanted to help people.” Ms. A later discussed her ability to be transparent regarding anxiety in the therapeutic space expressing, “over the past maybe five or six years I’ve become comfortable with sharing with my students hey Ms. [name] experiences anxiety sometimes it is ok.”

Jade provided further understanding of the parallels of anxiety for the client and the professional:

Because I have experienced anxiety you know with especially at the university with my students having anxiety surrounding classes or tests. You know I am not too far removed from master’s program. I am in a doctoral program as well, so I experience anxiety just like you all do. So, I am able to relate with them.

Ms. A and Jade’s viewpoints show that African American can experience mutual anxiety and encourage effective coping practices for their clients with anxiety (Collins, 2022).

Cara added the link between her anxiety and working with African Americans with anxiety disorders stating, “it has also emerged from personal experiences and anxiety related things as well.” Cara further detailed an encounter regarding anxiety treatment:

I can think of an experience that I had with a provider who did not have what I would consider that level of competency that I would want in a provider and understanding what it looks like when anxiety is more internalized what the impact is.
Cara added the importance of “being able to recognize that without it being dismissive of statements like everything is fine nothing is wrong.” “Let’s continue to watch and monitor.” Cara focused on how her own experience with anxiety can impact more progression in responsiveness to client’s anxiety (Collins, 2022).

Lady Bug discussed experiencing anxiety with balancing different roles and the pandemic and her ability to express her emotions expressing, “it becomes overwhelming like me even with school and work these last two weeks has been ridiculous.” Lady Bug stated, “I kind of scream.” “I be at home kind of yell.” People are used to it at my house and that’s how I get it out.” “You know COVID was high stress for everybody right and so I had anxiety.” “I mean I had a lot of people with anxiety, and I also worked.” The reality is that African Americans can experience mutual anxiety (Collins, 2022).

**Theme Thirteen: Expressions of African American/Black Identity**

A majority of the responses were African American women identifying their racial and gender identity as an important link to their work with African American clientele with anxiety disorders with one African American man identifying his racial identity. Jade, Dr. Zora, and Jasmine spoke about their identity where affirmation of them as African American women was essential with prior research on Black feminist thought (Collins, 2022, pp. 17, 317; Hamilton-Mason et al., 2009). Jade described how she was able to counsel African American clients with anxiety disorders stating “but, as for working within the African American community one it comes naturally because I am a Black woman myself and two just learning about cultural competence models is beneficial.” Dr. Zora also connected the utility of her background working with this population expressing, “so, a lifestyle of continuously learning and getting information being in the midst being in the environment and being an African American woman myself is
helpful.” Jasmine added, “so here I am older African American female and so that plays a part sometimes people’s first impression.” Jasmine highlighted another area of identity and positionality which is age.

Mr. Z expressed how his identity is central to working with African American clients with anxiety disorders:

Ok, so when you say experience there is so much, I can say naturally, myself being an African American and then an African American male which there is not a lot of us in the field any and everybody is coming to me you know looking for services.

Mr. Z identified his identity as one of the primary factors in counseling African American clients with anxiety disorder stating “nah, I can’t even say that I mean I’m Black that’s all it is too it.” Mr. Z further discussed his race and gender identity “so being an African American male when I work with African Americans and I see certain things and I hear certain thing, I am able to guess relate a little better than other individuals may be able to do that.” Mr. Z added “well, you know like I said I am a Black man so when I see my people struggling it just it makes me feel some kind of way.” Mr. Z echoed, “I mean once again, I am a Black man” where Black feminism includes Black men due to the focus on race, social class, and background (Adu-Poku, 2001).

**Theme Fourteen: Cultural Considerations**

Four participants included their perspectives on inclusiveness where three participants focusing on the salience of behavioral health professionals considering the client’s diverse backgrounds when providing therapy for African American clients with anxiety disorders. One participant focused on diversity in reference to behavioral health professionals and another participant Shasha focused on having critical consideration of “policies.” Shasha stated, “it’s
good if it continues along the line of exploring where people are from what does that mean that are the cultural norms, what are the values and all of that is important.” There is utility in Shasha’s perspective connected with prior work on learning the divergent personal and life narratives and experiences in lieu of Black feminist thought (Collins, 2022; Few et al., 2003).

Ashley Nicole emphasized that behavioral health professionals must include a consideration of diversity in background and life experiences of clients addressing that:

But the cultural piece is also really important because we have to be culturally sensitive in certain situations. And even though I am a woman of color that doesn’t mean that I understand all of that so that’s why I try to make sure I get that training to just kind of help me to meet all my clients where they are.

Ashley Nicole displayed that “Black woman’s standpoint” includes the life encounters and experiences of varied people including Black women (Collins, 2022, pp. 25, 37, 42, 130).

Jasmine focused specifically on working with students at a university and the significance of the focus on background and variation:

Correct and so not all of our students are African American, and then you also have to look at the different the racism within African. So, the one thing that is interesting about college life is that you have a melting pot of people coming together maybe for the first time and they have to learn each other.

Jasmine espoused gaining cultural awareness considering variation in life experiences (Collins, 2022; Few et al., 2003).

Cara highlighted the importance of having African American behavioral health professionals stating, “we are underrepresented as professionals.” Cara provided further context:
And there is often a demand from clients that exceeds the number of professionals that maybe available who can provide a multicultural competent experience for clients not just clients of color. But certainly, being able to provide opportunities where there is a that can make a difference for some clients to know that or to have a shared identity with who they are meeting with.

Cara spoke to the mutual experiences with culturally diverse communities and communities in general and perhaps civic engagement includes having behavioral health professionals of different cultural backgrounds to provide clinical services (Collins, 2022).

Shasha emphasized the necessity of focusing on “that policies truly matter, protect people, make a difference in the lives of individuals” when providing clinical services for African American clients with anxiety disorders. Shasha added:

I have to be knowledgeable of you know what is happening in terms of policy and how it influences people and then try to you know not necessarily let it cloud my judgment too much as a clinician. But let it be known that an individual exists within you know systems and so these systems are influenced by policies, social policies, different policies.

Shasha grasps that “policies” may change and the need to maintain awareness (Collins, 2022).

Summary

An overall finding of this research study is that the researcher was unable to identify one singular perception of how behavioral health professionals perceive the manner in which anxiety disorders present amongst African American clients which is not the outcome with the hermeneutic phenomenological approach (Dibley et al., 2020; Heidegger, 1962/2013).
Furthermore, there is not an all-inclusive positionality that aligns with perception of anxiety disorder presentation for African American clients (Dibley et al., 2020; Heidegger, 1962/2013). There were 14 themes in this research study. Themes one through four for research question one including description of anxiety disorder presentation, “contributing factors” to anxiety disorders for African American adults, “surprises” vs. “no surprises” regarding anxiety disorder presentation, and pervasiveness of anxiety for African Americans. Themes five to 10 for research question two included comprehensive preparation and clinical experiences, diagnostic process, life and familial experiences, “feelings” vs. no feelings” regarding anxiety diagnosis, behavioral health professionals’ perception of their client’s reaction to anxiety diagnosis and using theory. Themes 11 to 14 for research question two are “open to gaining new knowledge,” anxiety experiences of behavioral health professionals, expression of African American/Black identity, and lastly cultural considerations. In chapter five, I explored the association between the results and salient research literature and theoretical frameworks. There was a focus on the implications for behavioral health professionals working with African Americans clients with anxiety disorders in their clinical practice and for current graduate students in behavioral health graduate programs. The final focus included limitations from the perception of the researcher.
Chapter 5

Discussion

The discussion includes a final focus on the research study purpose and exploration of the results in connection with the pertinent journal articles, texts, and theoretical frameworks (Peoples, 2021). Further dialogue included implications for both current behavioral health professionals and future graduate students in behavioral health fields when working with African American clients with anxiety disorders. There was a focus on the limitations and delimitations that the researcher identified throughout the research process, and recommendations for pertinent research exploration. I included my introspection of the research experience and final concluding thoughts.

Purpose

The research study’s purpose was to explore the value of the participant and researcher grasping the phenomena of behavioral health professionals working with African American clients with anxiety disorders (Gadamer, 1975/2013; Heidegger, 1962/2013). Further purpose of this research study was to glean what it means for behavioral health professionals to engage in the diagnostic process, their use of screenings and assessments, and therapeutic approaches for African Americans with anxiety disorders. An added significance of this study was to have further information regarding how behavioral health professionals think and process how anxiety disorder symptoms present for this population across socioeconomic status and gender. There was consideration of their steps of preparation and the role of their background with their lens in the area of anxiety disorder symptom presentation.

Philosophical Foundations
Hermeneutic phenomenology had a connection to my research study to decipher the meaning of nine behavioral health professionals’ “lived experience” with the same phenomenon of working with African American clients with anxiety disorders through counseling, diagnosis, and assessment (Damsgaard, 2021; Dibley et al., 2020, pp. 46, 56; Flood et al., 2019; van Manen, 2014, 2016, pp. 25, 61). In tandem, sociogenic phenomenology was instrumental in this research study to provide consideration of the behavioral health professionals’ race, social, and systemic barriers for this study to provide added cultural depth (LaViscount & Jeffers, 2021).

Considerations included that eight of the participants in this research study were African American and one participant was biracial.

**Research Findings Related to Literature**

The discussion process consisted of me focusing on the identified themes from the research study in connection to the nine research participants. I utilized an “analytic memo” where I specifically typed the connection to the research literature after listening to and reading each interview transcript three times for the participant’s specific and key experiences utilizing the *hermeneutic circle* (Saldaña, 2021; van Manen, 2016; Vanderpot, 2018; Wharne, 2019). My processing of the connections between the participant’s verbalized expression of their answers to the interview questions and connection to my literature review which aligned with the essential aspects of interpretation in hermeneutics (Dangal & Joshi, 2020; Dahlstrom, 2010; Gadamer, 2013; Heidegger, 1962/2013).

There were 14 themes in this research study that I identified that had a connection to my research questions (Dibley et al., 2020; Saldaña, 2021). I addressed themes with my peer debriefer and provided with a theme summary table for the peer debriefer’s feedback (Spall, 1998). My research questions were (1) How do behavioral health professional’ perceive the
presentation of anxiety disorders among African American adult clients across socioeconomic status and gender? (Dibley et al., 2020; Saldaña, 2021). Additional themes have a connection to my second central research question: (2) How does behavioral health professionals’ positionality influence their perception of the presentation of anxiety disorders amongst African American adult clients? (Dibley et al., 2020; Saldaña, 2021). The major themes for research question one for perception of anxiety disorder presentation are: (a) description of anxiety disorder symptom presentation in African American adults, (b) “contributing factors” to anxiety disorders for African American adults, (c) “surprises” vs. “no surprises” regarding anxiety disorder presentation, and (d) pervasiveness of anxiety for African Americans. The major themes for research question two regarding positionality and anxiety disorder presentation are (e) comprehensive preparation and clinical experiences, (f) diagnostic process, (g) life and familial experiences, (h) “feelings” vs. “no feelings” regarding anxiety diagnosis, (i) behavioral health professionals’ perception of their client’s reaction to anxiety diagnosis. More themes include (j) using theory, (k) “open to gaining new knowledge,” (l) anxiety experiences of behavioral health professionals, (m) expressions of African American/Black identity, and (n) cultural considerations.

Description of Anxiety Disorder Symptom Presentation in African American Adults

All nine of the participants in this research study were able to describe how anxiety and anxiety disorders present amongst African American adults in which they provided a thorough perspective of anxiety disorder symptom presentation from their clinical lens and wealth of knowledge to enhance the current research. Furthermore, this research study included a focus on race, different socioeconomic statuses, and gender not in the sole qualitative exploration of social worker’s perception of anxiety disorders regarding individuals with lesser earnings (Stout &
“Race, gender, and class” were under consideration in this study in terms of research questions alignment with the focal point in Black feminist thought (Collins, 2022, pp. 17, 31; Hamilton-Mason et al., 2009).

There was an exploration of how African American women across studies presented with specific phobia and social phobia (Chapman et al., 2012; Petrie et al., 2013). 71% of African American women from the middle class and upper SES presented with anxiety disorders including the former anxiety disorder, primarily *simple phobia* (Neal-Barnett & Crowther, 2000). One participant Ashley Nicole agreed that African American clients and people across cultures experience “phobias” referencing clients’ phobias including “phobias with needles,” “bridges,” “social anxiety” and performance anxiety with “speaking in public,” and “COVID pandemic.” Interestingly, Hunter and Schmidt (2010) did not find any empirical literature on African Americans and specific phobia presentation.

A clear message that has come across the findings of this research study from prior literature is that African American’s processing of their anxiety will impact their verbalization of their anxiety symptoms (Carter et al., 1996). One participant Ashley Nicole clearly offered her perspective of how African Americans grasp their anxiety symptoms due to the minimization of their anxiety symptoms and their reluctance to use the term “anxiety” which provides context to prior work by Carter et al., 1996. Ashley Nicole spoke on how African Americans pause to confront that they have these anxiety symptoms which lead to challenges for behavioral health professionals recognizing anxiety disorders. Ashley Nicole repeated the motto of some African Americans with the notion to “keep moving.” Ashley Nicole’s perception aligns with Hunter and Schmidt’s (2010, pp. 213, 22-278) Sociocultural Model of Anxiety in Arican Americans where African Americans are less likely to verbalize “cognitive symptoms of anxiety.”
Furthermore, insights by Carter et al., 1996 were prevalent in line with the results of this research study in connection to African American men and how their anxiety perception impacts their verbalization of symptoms. In fact, four participants provided context to African American’s reservations about acknowledging that they have anxiety. Ms. A identified that African American men will not communicate their anxiety via “shut down or isolate themselves” to prevent the appearance that they are unable to cope. Lady Bug and Ms. A provided a perspective that African American young adults and men’s reservations to speak on anxiety stem from external factors regarding messaging that African American men are not able to communicate their emotions and need to learn to suppress their feelings. Ms. A and Lady Bug used similar terminology of “suck it up” about the dismissive manner in which African American men are treated regarding communicating anxiety. Dr. Zora addressed that African American men do not want to appear helpless and suppress their feelings. As we highlight messaging Cara added how African American men must also deal with the “question of their masculinity” with anxiety acknowledgment. Interestingly, prior research has not included a focus on African American men’s communication of anxiety with only a focus on middle class African American women who were dismissive of their anxiety symptoms (Neal-Barnett & Crowther, 2000, p. 134). African American men’s reservations about expressing anxiety links to viewpoints on the “stigma of mental illness” from the conceptual framework in which “gender” is a future consideration of the model (Hunter & Schmidt, 2010, pp. 213, 225, 228, 230).

In addition, it was imperative to explore the variation across African Americans in measuring anxiety disorders in this group which aligns with the perspective of six of the participants in my research study and the utility of recognizing anxiety disorder presentation across African Americans (Chapman et al., 2015b). In fact, three participants including Shasha,
Ms. A, and Ashley Nicole encouraged looking at the diversity of anxiety presentation for African Americans. There was further exploration on distinctions in general anxiety symptom presentation across other African American groups. Cara added that there are diverse understandings of anxiety with diverse gender identity. Ms. A and Jasmine focused on distinct anxiety symptom presentation for African American men and diverse anxiety occurrences for African American women. Dr. Zora used the metaphor “gumbo” to explain the diversity of anxiety disorder presentation for African Americans in incarceration. The participants’ perspectives shed light on the fact that there is variation amongst African Americans with the presentation of anxiety (Hunter & Schmidt, 2010).

Five participants addressed how it is still challenging to distinguish particular anxiety symptoms for African Americans a finding that aligns with the limited prior research on specific anxiety disorder presentation in African American client populations (Brown et al., 1999; Carter et al., 1996; Hopkins & Shook, 2017; Hunter & Schmidt, 2010; Mendoza et al., 2012; Moitra et al., 2014; Neal-Barnett & Crowther, 2000; Neal & Turner, 1991; Williams et al., 2013). The participants’ perceptions aligned with prior research by Hunter and Schmidt’s (2010, p. 230) that behavioral health professionals will experience challenges with identifying features of “GAD, social anxiety, and panic disorder.” Cara identified obstacles with recognizing anxiety for racially diverse groups due to these groups hiding their anxiety which connections to some of African Americans not wanting to disclose anxious thinking (Hunter & Schmidt, 2010). Jade clarified that anxiety exists within African Americans whether it is visible or not. Jasmine expounded regarding African American college students that we need to know what the underlying features of their anxiety are. Cara further explored a gap in anxiety knowledge regarding anxiety disorder presentation amongst African American seniors that connects with
research findings by (Jiménez et al., 2022) that there is not a distinction for concerns like anxiety for Black, Caucasian or American Indian senior citizens where it is hard to measure variation in anxiety across race and gender. The future aim of Hunter and Schmidt’s (2010) model is to explore gender in connection to anxiety that is currently missing. Shasha was poignant in consideration if society desires to have a grasp of anxiety disorders. Dr. Zora concluded on the need for knowledge and awareness regarding “anxiety and anxiety disorders what that is and what it’s not” a finding that aligns with prior work by (Collins, 2022) on the fluid process of learning with Black feminist thought.

The presentation of anxiety disorders for African Americans includes describing more physical symptoms throughout most of the literature (Gordon et al., 2015; Heurtin-Roberts et al., 1997; Hunter & Schmidt, 2010; Neal-Barnett et al., 2011a; Vanderminden & Esala, 2019). It was quite clear from my interviews with Ms. A and Ashley Nicole that there are physical descriptors of anxiety disorder presentation particular for African Americans, hypothetical perception from Dr. Zora, and commonalities in physical health symptoms per Dr. Zora and Jade. Participants in this study did not have a tendency like in other studies (Hunter et al., 2012; Hunter & Schmidt, 2010; Vanderminden & Esala, 2019) to overlook physical symptoms in anxiety diagnosis in lieu of a health-affiliated justification. Dr. Zora provided a hypothetical perspective from the movie Equalizer with the featured African American actor Denzel Washington with “eyes darting everywhere” and “hyperaware” as part of the movie script (Fuqua, 2014) Furthermore, African Americans with anxiety disorders present with more physical health issues in which three participants confirmed these health matters in my research study (Banks et al., 2006; Johnson & Lawrence, 2013; Neal-Barnett & Crowther, 2000; Oh et al., 2022). Ms. A identified specific physical health symptoms and health issues regarding anxiety for African Americans including
“abdominal pain discomfort, fibroids or cysts that are reoccurring.” Ashley Nicole added other physical health symptoms including “having a lot of headaches just high blood pressure high cholesterol.” Only one research study included a focus on African American young adults that were in good physical shape who experienced anxiety prior to a stress test and increased blood pressure reaction (Pointer et al., 2012). Ashley Nicole further identified “hives or rashes” as physical anxiety symptoms. Ms. A highlighted specific physical indicators of anxiety for African American women including “abdominal or gastrointestinal issues,” “digestive issues,” “reproductive issues too like fibroids, cyst on the ovaries or cyst somewhere in the reproductive area, ulcers.” Furthermore, Ms. A identified that mostly all of her clients with anxiety have stomach concerns or pain considering the frequency of her counseling African American women. Thus far there has only been an exploration of African American men presenting with severe health issues in addition to their anxiety diagnosis or anxiety and not African American women (Banks et al., 2006; Johnson & Lawrence, 2013). Ms. A reported that a frequent physical health concern for African American men is “headaches.” Lady Bug addressed a specific health diagnosis with a potential for anxiety namely “Type I diabetes” where there is particular focus on this health issue via the conceptual framework by Hunter and Schmidt (2010, p. 213) rather than anxiety presentation. It was interesting that the research participants provided more specific physical health symptoms of anxiety and health issues that were different than actually in the empirical research (Gordon et al., 2015; Johnson & Lawrence, 2013; Vanderminden & Esala, 2019). Researchers did not identify if there were similarities or variation across socioeconomic status in anxiety symptom presentation for African Americans (Heurtin-Roberts et al., 1997; Hunter & Schmidt, 2010; Vanderminden & Esala, 2019). Only the participant Dr. Zora provided insight that African Americans whether wealthy or experiencing economic challenges encounter
the same physical health symptoms of anxiety including perspiration. Dr. Zora’s perspective takes into consideration “class” from the Black feminist thought lens (Collins, 2011, pp. 29, 164-165, 260, 249). On the other hand, one research study includes that somatic anxiety symptoms were similar for African Americans and European Americans (Hopkins, 2018). Two participants provided a similar sentiment as Hopkins (2018) that anxiety symptoms are comparable across populations including Jade expressing that the physical symptom of sweating that African Americans and other racial and cultural populations experience and Ashley Nicole identifying sleep problems which is not unique to African Americans. Headaches were the only health issue that two participants in this research study namely Ms. A and Ashley Nicole identified. Perspiration/sweating was the only physical health symptoms that Dr. Zora and Jade identified in the interview.

There was agreement with Jade’s and Ashley Nicole’s perspectives and the research of alike anxiety symptoms across populations considering that there were similar somatic symptoms regarding anxiety African Americans and European Americans in the literature (Hopkins, 2018). Jade provided the description of routine anxiety like panic attacks, sweating and nervousness and that the same across diverse groups including African Americans. Ashley Nicole related somatic symptoms namely sleep problems, and other specific emotional symptoms that were comparable for Africa Americans and other diverse groups. A distinction is that one participant Ashley Nicole even identified parallels in emotional health symptoms between African Americans and other races that was not in any of the literature. Ashley Nicole actually found that there was no variation in the presentation of specific phobia across cultures regarding the pandemic in which there was a distinction particularly regarding specific phobia
between African Americans and Caucasians in prior research (Chapman et al., 2008). Ashley Nicole and Jade’s perspective connected to the conceptual framework by Hunter and Schmidt (2010) that anxiety presentation in African Americans may not vary much from Caucasian Americans.

“Contributing Factors” to Anxiety Disorders for African American Adults

The findings of the research study added to the information on the presentation of the presentation of anxiety disorders amongst African American clients considering that all nine of the participants identified contributing factors to anxiety disorders.

Neal-Barnett (2003) highlighted the notion of stress as factor that leads to anxiety for African American women that was also a response from the behavioral health professional’s perception of their client’s experience and even witnessing other’s experiences (p. 27). Two participants highlighted the obstacles that African American women face in connection to anxiety which considers the collective challenges that African American women experience in their life (Collins, 2022). Mr. Z identified that Black women experience challenges like Black men and his observations from his family. Mr. Z used a quote in chapter four to emphasize that Black women have it exceptionally hard. Ashley Nicole addressed how racially diverse women and her connection to the community and all the obstacles that “causes a lot of anxiety.” The perception of stress from text by Neal-Barnett (2003) connected to Ashley Nicole’s perception of racially diverse women “always on edge on guard” from her counseling experience (p. 27).

A common finding that was evident amongst four participants and in the research is that anxiety presents for African American women with the *Strong Black Woman* (SBW) race-gender schema with their perseverance beliefs to fulfill home and work tasks despite heightened anxiety which connects to the shared barriers that African American face with their array of roles
in connection to Black feminist thought (Collins, 2022; Neal-Barnett & Crowther, 2000; Neal-Barnett et al., 2011a; Watson & Hunter, 2015). Four participants namely Dr. Zora, Ms. A, Lady Bug, and Jade discussed the multifaceted and diverse responsibilities African American women face and the stressors they taken on. Ms. A highlighted that SBW “causes a lot of anxiety” from her lens which connects with prior research findings by Neal-Barnett (et al., 2011a) that African American women recognized that the notion of strength was a potential cause of anxiety and panic symptoms due to beliefs others place on them, hassles, navigating life with little help, and self-doubt that behavioral health professionals in this study were unable to address with their perceptions. Dr. Zora used the phrase busyness which stood out regarding African American women. Lady Bug discussed further issue from her experience of observing the recipients of her counseling services inability to let go of all the roles. Jade explored the association with anxiety for African American college women describing “pressure to overperform or be high achiever” where there is a willingness to succeed despite “anxiety or depression” “like a badge of honor.” Jade’s research is also on Black women. Cara added how people are dismissive of African American women’s anxiety. Neal-Barnett (2003) confirms that the Strong Black Woman is likely to experience anxiety (p. 22).

Seven participants spoke to the significance of family including early experiences, parenting impact, familial role in terms of lack of engagement and familial communication which aligns with the focus on family influences with the literature review. More negative impacts from family were a risk factor in this study according to participant’s perspectives in contrast to the prior research literature (Assari et al., 2018; Carter et al., 2001; Chapman & Woodruff-Borden, 2009; Mounts et al., 2006). Lady Bug and Mr. Z both grasped how the home environment is impactful in anxiety development for youth. Lady Bug had an overall
understanding of how anxiety can connect to familial factors. Lady Bug identified specific risk including parental addiction and if youth were “sexually, mentally or physically abused.” Mr. Z identified the home context with “single-parent household,” parental intense work schedule, and having to be their own monitor as a youth as risk factors for anxiety and specifically the development of panic disorder later in life. There is no research to connect the development of panic disorder spoken by Mr. Z and home environment. Research is absent about African American fathers’ role in their children having anxiety disorders, biological or sociologically which was pretty much across all of the participants except for Mr. Z (Chapman et al., 2012). Mr. Z was the one participant to focus on the role of the man not in the household and that what leads to anxiety is the mother solely taking on the parental role. There were added parental impacts of anxiety. Lady Bug described two scenarios where there were specific parental influences leading to anxiety for African American college students regarding communication issues and another with parental lack of acceptance of gender presentation of the college student in the LGBTQIA community and the connection to anxiety that contrasted with prior research findings by Carter (et al., 2001 p. 566) that “protective, strict, and demanding” parents did not influence African American college student’s anxiety. Furthermore, Ashley Nicole explored how messaging early on for African American men impacts anxiety for them later in life. Hunter and Schmit (2010, p. 228) model considered “extended family support” as a “protective factor” for African Americans where there is not exploration of what the familial role looks like in connection to anxiety.

Family cohesion during late adolescence through self-regulation encouraging awareness and monitoring is a protective factor against anxiety issues in young adulthood (Augustine et al., 2022). Thus, a healthy parenting style may influence internal monitoring for adolescents to have
fewer anxiety issues as young adults (Augustine et al., 2022). Augustine et al., 2022’s research was relevant to identify the anxiety concerns in non-cohesive or healthy parenting environments through the responses of the participant’s perspectives who primarily work with African American college students. Messaging that African American college students received prior to college from their parents was impactful with Jasmine identifying that some African American college students seek help for anxiety in college due to parental dismissal of their symptoms.

Neal-Barnett (2003) highlighted that trauma was an experience that contributed to anxiety for Black women. Jasmine identified a friend who connected the role of “anxiety” and “childhood trauma” and messaging similar to the Neal-Barnett (2003) work. Lady Bug discussed that she would observe anxiety in youth clients age up to age 18 due to experiences of abuse in the familial household. There was a connection to prior abuse and adverse childhood experiences (Hernandez et al., 2022).

Self and group-focused internalized racism were indicative of heightened anxiety for African American adults that matched what one participant Dr. Zora recognized was “intra-racism” that she sees quite often when counseling biracial African American clients that is directed at the parent from the dominant culture (James et al., 2021, pp. 1335, 1345; Sosoo et al., 2020, pp. 570, 575, 577). There was variation amongst African Americans and their life experiences according to the prior conceptual frameworks (Collins, 2022, Few et al., 2003; Hunter & Schmidt, 2010).

One participant Mr. Z shed light with his verbalization using the terms “discriminated, oppressed,” which parallels and is quite evident in the research that African Americans experience higher levels of discrimination that link to anxiety symptoms in this population (Banks et al., 2006; Mouzon et al., 2017; Sosoo et al., 2020; Soto et al., 2011; Williams et al.,
Discrimination was also seen a leading to anxiety for Black women (Neal Barnett, p. 27). Mr. Z identified “oppression, racism, and microaggression” as “the largest contributors to anxiety disorders amongst African Americans” which was supported in the research literature with clients of color presenting with anxiety due to experiencing “discrimination, racism or microaggressions” (Chapman et al., 2013, p. 170). Mr. Z’s viewpoint aligns with prior research findings by Kelly (2006) on behavioral health professionals needing to listen to their client’s encounters with racism and perspectives by Collins (2022) on the Black feminist lens regarding inequities that African Americans encounter in life.

African Americans perspectives on anxiety impact how they verbalize and address their symptoms (Carter et al., 1996). Insights by Carter (et al., 2016) align with the behavioral health professionals’ awareness of how their clients view how outsiders may think or feel about their anxiety. Two participants Ashley Nicole and Cara provided relevant points regarding how their African American clients with anxiety disorders don’t feel they are able to verbalize their anxiety due to prior socialization and there is a link to how people view them regarding anxiety which extends to findings by Hunter and Schmidt (2010, pp. 213, 225, 228) which extends to the “stigma of mental illness” regarding their thinking. Ashley Nicole addressed the challenges for African Americans to acknowledge their experiences with “phobias especially in our small rural communities.” Cara added that African American men grapple with how they see themselves vs. what people notice about them.

A further indicator of anxiety for African Americans is those who cannot accept doubt which is a potential risk for anxiety (Liao et al., 2016). Ms. A elaborated on this perspective describing that African Americans in employment spaces whether “middle class, upper class”
face “impostor syndrome that triggers anxiety” in which African Americans can have divergent life narratives and experience shared barriers with anxiety (Collins, 2022).

There was a connection between perfectionism and anxiety for African American college students from prior research findings by Chang (2017) and Jade’s perspective of African American women in college. Perfectionism contributed to higher anxiety for African American college students at a Midwestern university, where a majority of the study participants were women (Chang, 2017). Jade provided a perspective of perfectionism amongst African female college students from her experiencing working at an HBCU in the southeast describing their desire to succeed that supersedes the experience for African American male college students. There were no prior research studies on the connection between perfectionism and anxiety for African American college students in the southeast and or at HBCU’s (Chang, 2017).

Additional socioenvironmental factors included performance-based issues. Finally, African Americans were concerned with not accomplishing their goals to prevent harsh judgment (Chapman et al., 2008, 2011). Findings by Chapman et al., (2008, 2011) aligned with how one participant Jade described her African American college women clients their need to strive where anxiety consists of how these students measure their accomplishments internally. Chapman et al., (2008) findings included a focus on African American college students where 45% of the participants where African American with 69% of those participants being African American women. However, the environment in the research study would be different than an HBCU considering that over 50% of the participants were White at a “large, public Midwestern University” with no specific focus on the racial, gender, or sexual identity of students in general at the university and the study was not in the southeast (Chapman et al., 2008, pp. 764).
Chapman et al., (2011) study had a focus on African Americans in the general population and not specifically applicable to college students.

Added socioenvironmental factors include social. African Americans with flexibility challenges and a lack of comfort are more likely to experience anxiety provocations and social anxiety (Manning et al., 2017). Anxiety provocations were more noticeable with Dr. Zora and Lady Bug’s perspective of African American college students (Manning et al., 2017). Some of these challenges include trying to traverse social relationships with college students and considerations of whether they need to use substances for belongingness and how to display different aspects of themselves per Dr. Zora’s perspective. Lady Bug focused on the time management, interpersonal obstacles, and balancing academics for students in band and athletics. African American college students who struggled with social engagement, were timider, did not recognize the importance of interpersonal relationships, felt uncomfortable communicating with strangers, and were prone to have heightened anxiety (Mounts et al., 2006). Findings by Mounts et al., (2006) aligned with Dr. Zora specifying social anxiety symptoms for college students entering a campus space. There was a contrast with Hunter and Schmidt (2010) study in that Lady Bug and Dr. Zora did not equate social anxiety with concerns about minority status.

Health factors are another consideration with anxiety for African Americans. Dental anxiety can relate to the specific phobia in the DSM-5 and DSM-TR (APA, 2013, 2022; Sokoto et al., 2022). Lady Bug discussed for African Americans that “going to the dentist that creates anxiety right.” Prior findings from Sokoto (et al., 2022) that 44% of Black women had dental anxiety supports Lady Bug’s findings. In contrast to Hunter and Schmidt’s (2010) model, Lady Bug did not associate the dental anxiety itself as a health affiliated concern that outweighs the anxiety.
African American men and women often do not get anxiety treatment (Brenes et al., 2008; Chapman et al., 2011, 2012; Neal-Barnett & Crowther, 2000; Neal-Barnett, 2011a). One participant Lady Bug used similar phrasing three times that just the thought of counseling attendance “creates anxiety” and concerns individuals have with processing in counseling. Lady Bug gave added insight that from her clinical work that individuals were unwilling to get counseling after an immediate crisis in a medical environment and that people in diverse socioeconomic statuses will not get the counseling support where she focused on “class” as in Black feminist thought (Collins, 2022; Hamilton-Mason et al., 2009). Only one study mentioned socioeconomic status which was only a focus on African American women in the “middle class” (Neal-Barnett & Crowther, 2000, pp. 129, 134-135). Most African American women and Caribbean women met with a behavioral health or healthcare professional for anxiety disorders, but only 25% in the last year (Jones et al., 2020.) There was no indication from my research study of estimates of African Americans who met with behavioral health professional considering that this is a qualitative investigation.

Obstacles to treatment for anxiety disorders include stigma and cultural mistrust for some African Americans, impacting their ability to seek therapy or medication management due to analyzing health professionals’ intentions (Johnson et al., 2009; Moitra et al., 2014). One participant Lady Bug clearly identified the stigma African American men experience regarding the prospect of attending counseling related to Hunter and Schmidt (2010, pp. 213, 225, 228) research on the “stigma of mental illness” and cultural mistrust in the Sociocultural Model of Anxiety in African Americans with not receiving behavioral health services. Interestingly, the research literature primarily focuses on African American women as Johnson et al., (2009) was a
research study with a focus on all African American women and study by Moitra et al., (2014) focused on 96% African American women for that racial group in the study.

There were different perspectives on anxiety coping. There is some yet limited empirical evidence that African Americans do not complete anxiety disorder treatment (Jonassaint et al., 2017; Obasaju, 2009). Jade discussed how a client would get off track with their “coping skills” in reference to challenges with anxiety. Neal-Barnett (2003) addressed that Black women utilized their faith to cope with anxiety. Religion may help African Americans with anxiety (Hodge et al., 2022; Neal-Barnett & Crowther, 2000). African Americans with different anxiety disorders whether agoraphobia, social phobia, or general anxiety disorder prayer was a coping source for African Americans (Hodge et al., 2022; Taylor et al., 2021). Jade spoke on a clinical experience with a client where “prayer and meditation” was a resource for the client and in conjunction reduced the client’s anxiety. “Religiosity” in the conceptual framework by Hunter and Schmidt (2010, p. 228) was a “protective factor.” Dr. Zora discussed messaging African Americans receive to “pray.” Dr. Zora discussed having served in the clinical field for “45 years” and that a pastor. Jasmine discussed the varied campus outreach and talks she participated in at her HBCU even providing flyers.

“Surprises” vs. “No Surprises” Regarding Anxiety Disorder Presentation

Insights by Carter et al., 1996 insight was prevalent in line with the results of this research study that African American perspectives on anxiety will impact how they communicate their anxiety symptoms). Interestingly there was distinction in perception with Ms. A describing African American men’s willingness to express their anxiety which contrast with prior work by Hunter and Schmidt (2010) that African Americans would not express their anxiety symptoms on purpose or due to a health justification. Prior findings by Chapman (et al., 2015b) that
included the utility of exploring the variation of anxiety disorders across African Americans aligned with Shasha’s viewpoint that no overarching anxiety presentation for African Americans where there was dissimilarity. Shasha’s perception aligned with Hunter and Schmidt (2010) findings regarding variation amongst African Americans with the presentation of anxiety. Jasmine supported this perspective that “always surprised” regarding anxiety symptom presentation for African Americans. Jasmine’s perceptions connected with Hunter and Schmidt (2010, p. 230) model that behavioral health professionals may not readily identify features of some anxiety disorders.

**Pervasiveness of Anxiety for African Americans**

Extensive studies underscored that anxiety disorders present less often for African Americans which is not reflective of my research study (Breslau et al., 2006; Gibbs et al., 2013; Himle et al., 2009; Hofmann & Hinton, 2014; Kantor & Kantor, 2020; Mays et al., 2018; Russell et al., 2022). Most of the participants in this research study had an alternate perspective where they emphasized the pervasiveness of anxiety disorders for African Americans. Ashley Nicole identified that anxiety is increasing throughout different cultural populations. Mr. Z spoke on the fact of anxiety increases in different environments and regions of the United States. Ms. A focused on how anxiety presents more for African American men and women in administrative jobs and particularly “middle class, upper class.” Prior research on African American women likely to have anxiety disorders aligned with participant’s perception of the pervasiveness of anxiety disorders (Jones et al., 2020; Neal-Barnett & Crowther, 2000). Ms. A and Mr. Z spoke on how anxiety often presents for African American women. Dr. Zora added how anxiety frequently presents for biracial African Americans. There were similarities with findings by Parra et al., (2023) on Black young adults not in sexual majority groups like bisexual, pansexual
and gay having more anxiety and Dr. Zora’s perception that increased anxiety for African Americans with diverse gender and sexual identity. A further connection is that Black sexual minority men (BSMM) have increased anxiety compared to heterosexual African American men and women (Graham et al., 2011). According to Mays et al., (2018) African American men were among the least likely Black male groups to present with anxiety disorders or long running anxiety disorders. However, prior findings from Mays et al., (2018) differed from Ms. A and Cara who addressed that African American men experience anxiety and may be more lowkey acknowledging their anxiety.

There was some variation in the research regarding the pervasiveness of anxiety disorders where Black active-duty military individuals in the army, air force, navy, and marine corps were less likely to have an anxiety disorder diagnosis for panic disorder, generalized anxiety disorder or agoraphobia (Russell et al., 2022). Further information is when Ashley Nicole addressed that her clients in the military experience anxiety however, they primarily have PTSD.

**Comprehensive Preparation and Clinical Experiences**

All nine of the participants described how their comprehensive preparation and clinical experiences were instrumental in their perception of anxiety disorders amongst African American clients due to their enriching experiences and educational prowess that broadens the available research. Six participants discussed the significance of their experience working with African American clients with anxiety disorders where there insights about anxiety disorders were imperative in clinical outcomes for their African American clients (Collins, 2022). However, there were research studies where the behavioral health professionals’ background did impact the clients with anxiety disorders without referencing the client’s race, ethnicity, and gender (Lawrence et al., 2015; Stout & Maldonado, 2017). Conversely, the six participants in
this research exhibited a clear awareness of their client’s “race” regarding their perception of anxiety disorders and essential factors in providing clinical services to this population which connected to (Collins, 2022, pp. 17, 317; Hamilton-Mason et al., 2019) focus on Black feminist thought. Interestingly, Mr. Z and Cara both identified compassion as key for African American clients with anxiety disorders. Mr. Z and Cara both discussed that African American clients need support with Mr. Z highlighted the need for added support for this group. Mr. Z and Ms. A exhibited enthusiasm regarding providing clinical services for African American clients with anxiety disorders. Jade addressed that she has provided clinical services to predominantly African American clients across diverse life circumstances. Jasmine highlighted that she has experience at an HBCU where the reality is that all nine participants are currently providing counseling to African American clients at an HBCU which was a study recruitment requirement where they have mutual experience with helping their clients progress (Collins, 2022). Shasa identified that she had mostly not worked with biracial clients in which she still has an interest in working with this group where she had clients of other diverse racial groups. There was not a reference to biracial African American adult clients and anxiety disorders in the research literature under review.

Furthermore, this study included an exploration of actual behavioral health professional clinical practice with their clients and not merely hypothetical situations to consider how to apply in everyday settings particularly at universities (Joy & Bartholomew, 2021; Lawrence et al., 2015). In fact, six which is most of the participants specifically discussed providing clinical services for clients with anxiety or anxiety disorders. Mr. Z emphasized that he provided clinical services to a plethora of clients. Lady Bug explored how she worked with varied populations whether general public, African Americans, and college students. Four participants discussed
providing clinical services with Jade and Jasmine on a college campus and Ashley Nicole and Shasha highlighting their passion for clinical practice. Ms. A provided an actual description of a client’s clinical progress.

This study goes beyond conjectural situations like prior research findings by (Joy & Bartholomew, 2021; Lawrence et al., 2015) to clinical experiences across a diversity of work-related environments and campus spaces. Mr. Z and Lady Bug both discussed providing clinical services in private practice where Mr. Z works presently, and Lady Bug did in the past. Mr. Z described working with individuals across ethnicities in different workspaces including “outpatient, schools,” and as a director of a HBCU counseling center. Laddy Bug also works in disability services at an HBCU and provides crisis intervention, provides “pro bono” services for several people. African Americans, whether women or both women and men, did display some receptivity for meeting with behavioral health professionals (Brown et al., 1999; Mays et al., 2018; McCall et al., 2020; Williams et al., 2021). In fact, participants in this study described that there were positive outcomes counseling African American clients. Stout and Maldonado’s (2017) study of behavioral health professionals’ perception of clients in poverty with anxiety highlighted the behavioral health professionals’ skills working with anxiety disorders as one factor in successful treatment experience. Ms. A provided a specific scenario where she worked with a client who made several growth-oriented steps including helping the client eliminate their panic attacks, change their negative thinking and the client was able to start a marriage. Ms. A was inspired after her client’s growth with anxiety that anxiety was indeed an area of her clinical skillset where could work across anxiety symptom presentation. Lady Bug expressed how her mindfulness of language she uses with client has aided her treatment process and receiving positive feedback from clients regarding her clinical demonstration of skills. Dr. Zora added how
her clients grow in counseling focusing on mindfulness and “connection between mind, body, and spirit” in her clinical provision of services where her clients can become aware of the cause of their anxiety symptoms. There was movement towards information and awareness around anxiety disorders in alignment with the conceptual framework by Collins (2022) and some contrasts with Hunter and Schmidt’s (2010, pp. 213, 225, 228) model in that all African Americans do not experience “stigma of mental illness” or issues with receiving behavioral health services.

**Diagnostic Process**

All nine of the participants identified their specific way of diagnosing African American clients with anxiety disorders. Unlike findings by (Carter et al., 2012; Johnson et al., 2007; Parkerson et al., 2015) behavioral health professionals in this study did not identify any challenges measuring anxiety for their African American clients or that any of the anxiety measures were not precise for their clientele. The *Generalized Anxiety Disorder 7-Item (GAD-7; Spitzer, 2006)* is a frequently utilized and accurate assessment of general anxiety for different communities and clinical locations, including hospital, community, and medical settings (Johnson et al., 2019). Findings by Johnson et al., (2019) connected with my research study in that the “GAD-7” was a common measure that a majority of the participants six namely Ms. A, Jade, Cara, Lady Bug, Jasmine, Ashley Nicole, and Dr. Zora utilized in their clinical work. However, Johnson et al., 2019 had no specification of the effectiveness of the GAD-7 was for communities of color. Across clinical studies the GAD-7 was a solid measure of reliability whether across a large group of African American college students mostly women, African American and Latino college students, and African American college students mostly women (Kirakosian, 2018; Ramos et al., 2023; Robinson et al., 2010). An issue is that the prior research
studies on college students were in “southern California” only with no focus on the overall university factors regarding race or diverse gender/sexual identity (Kirakosian, 2018, p. 17). One research study regarding college students including African American was in Houston which is not part of the southeast and did not include sexual identity or “socioeconomic factors” (Robinson et al., 2010, p. 253). Interestingly, one research study including African American college students did take place in the southeast in “central Virginia” (Ramos et al., 2023, p. 497). African American college students varied widely from other racial groups on the GAD-7 score and there were concerns regarding the exactness of the GAD-7 for African Americans (Parkerson et al., 2015). However, regarding research findings by Parkerson et al., (2015) there was no way to measure this factor in my qualitative research study. The GAD-7 had strong reliability for African American senior citizens with lower earnings to determine if GAD is present and was a useful measure for marginalized communities across socioeconomic status (Shrestha et al., 2020). However, no participants in the research study identified if they used the GAD-7 specifically for African American senior citizens.

The BAI across different versions was a reliable measure of anxiety symptomatology for African American college students in the southeast, south, and Midwest (Chang, 2017; Chapman et al., 2009 DeLapp et al., 2016; Lee et al., 2015; Williams et al., 2018). Three participants identified using the Beck with no specifics on the particular version of the measure. An interesting factor was that behavioral health professionals in this study all work at HBCU’s in the southeast in which there was no evidence in the research literature that any of the prior studies were conducted at HBCU’s in the southeastern region (Chang, 2017; Chapman et al., 2009 DeLapp et al., 2016; Lee et al., 2015; Williams et al., 2018). The BAI was a reliable measure in general for college students and African American and Caucasian-American college students
(Chapman & Woodruff-Borden, 2009; DeLapp et al., 2016; Williams et al., 2018). The BAI (Beck & Steer, 1990) was also a reliable measure for African American graduate students (Lee et al., 2015). The BAI may be beneficial for African Americans with revisions to measure anxiety more adequately (Chapman et al., 2009). Participants did not specify the particular age group they incorporated this anxiety measures with at their university.

Namely one participant Mr. Z identified incorporating the Hamilton screening with African American clients. It was found in one research study that the HAM-A had strong reliability of .80 to .93 for African and Caucasian Americans, with even more robust reliability for African Americans with generalized anxiety disorder, with no major distinction amongst both populations and featured in only one study for African Americans (Markell et al., 2014). The reality is that the research study did not focus on African American college students and there is no mention if the study was in the southeastern United States (Markell et al., 2014). A further concern in the research literature is not knowing if the HAM-A measures anxiety appropriately for African Americans (Marks et al., 2022; Porter et al., 2017; Shear et al., 2001).

There is credence for behavioral health professionals to diagnose African Americans properly with anxiety disorders considering that African Americans experience a more severe progression of anxiety disorder symptoms that include lesser abilities to carry out daily tasks and decreased psychosocial functioning (Himle et al., 2009; Moitra et al., 2014; Sibrava et al., 2013). Licensed professional counselors and licensed clinical social workers were missing from the research literature on anxiety diagnosis and African Americans where the only behavioral health professional in these studies were psychiatrists (Hunter & Schmidt, 2010; Stockdale et al., 2008; Vanderminden & Esala, 2019). Eight participants verbalized varied approaches to anxiety disorder diagnosis with seven participants providing their different steps which aligns with
insights by Collins (2022) on black feminist thought through the diverse diagnostic approaches and equity in consideration and respectfulness of African American clients. There was a contrast with participants in this study and a conjectural study Joy and Bartholomew (2021) of anxiety disorders where some behavioral health professionals had the same perspective about anxiety disorders across race or socioeconomic status, where their perspective of systemic issues did not impact their diagnostic assessment. Participants in alignment with prior findings by (Himle et al., 2009; Moitra et al., 2014; Sibrava et al., 2013) described their diagnostic process and their grasping of all pertinent factors when it comes to the focus on African American clients in this study. Participants in this study focused on inequities, “race, gender, and class” (Collins, 2022, p. 17, 317; Hamilton-Mason et al., 2009). One participant Jasmine underscored that there is no diagnostic process at her HBCU however, prior clinical spaces included the diagnostic process. Jade provides her clients with a referral for an anxiety diagnosis. Two participants Mr. Z and Ashley Nicole described utilizing the intake. Two participants Ashley Nicole and Dr. Zora identified using assessment. Mr. Z discussed inclusion of background, “reports from multiple sources,” client insights and prior therapeutic documentation or information from their medical providers. Ashley Nicole added the “whole medical” and Dr. Zora added her utilization of “case conceptualization” and careful consideration. Lady Bug described how she reviews the DSM-5 with her clientele to create that sense of awareness (APA, 2022). Ms. A., Shasha, and Cara focused on their mindfulness and patience in the diagnostic process and soundness of approach.

However, most behavioral health professionals diagnosed the clients in the conjectural scenarios with GAD even when the symptoms due to environment (Joy & Bartholomew, 2021). It was fascinating in clinical experiences that two participants provided more general anxiety diagnoses for their clients. Dr. Zora identified GAD are a primary diagnosis except if the client’s
symptoms are severe. Jasmine spoke on prior experiences where she provided a diagnosis that was “least restrictive” however unable to diagnose at her university.

**Life and Familial Experiences**

Life experiences were essential to all nine participants in the study when it came to their perception of anxiety disorders. Seven participants provided context to how their life experiences connected with their perception of anxiety disorders amongst African American clients where the “lived experience” connected to hermeneutic phenomenology and Black feminist thought where all of the participants were from communities of color, most African American, one biracial, eight women and one man (Collins, 2022, p. 41; Damsgaard, 2021: Flood et al., 2019). Pugach and Goodman (2015) highlighted the importance of behavioral health professionals’ awareness to process their socioeconomic stressors and the impact of discrimination and their financial position on the client’s self-perception and worldview with women in poverty (50% African American) with anxiety and other mental health disorders. Participants in this study focused on their perception treating clients in different socioeconomic statuses that is key (Collins, 2022; Hamilton-Mason et al., 2019). Mr. Z focused on his upbringing and “systemic inequities” which was an extension of (Collins, 2022, pp. 25, 37, 42, 130; Adu-Poku, 2001) “Black women’s standpoint” that can be applied in this study to centering the Black male’s perspective. Mr. Z and Lady Bug discussed that their life experiences had an impact. Ms. A and Ashley Nicole discussed how observation of family members and their coping and particularly women. Ms. A., Ashley Nicole, and Cara both focused on the influence of the “personal and professional.” Jade and Ashley Nicole were unable to identify specific aspect of her experiences that inspired their perception of anxiety disorder symptom presentation. Lady Bug discussed her parenting and modeling healthy communication to not lead to anxiety. Shasha distinctly and thoroughly
emphasized that faith and spirituality were instrumental for her and how she does not place her beliefs onto her clients. Shasha spoke on being biracial and the need for more progress on this topic in society. Shasha and Dr. Zora were clear they do not use events specific to their life to navigate their clinical process with clients.

**Behavioral Health Professionals’ Perception of their Client’s Reaction to Anxiety Diagnosis**

African American perspectives on anxiety impacting how they verbalize and address their symptoms aligns with the behavioral health professional’s perceptions of their client’s reaction to anxiety diagnosis as well as symptoms (Carter et al., 1996). Dr. Zora provided context on the mixed perspective identifying “because what I’ve found is some appreciate having a diagnosis because it’s like ok, I can put a name to what I am feeling, and others may wear it and use it as a excuse for behavior.” Dr. Zora identified that her clients who internalize the anxiety diagnosis are the “smaller minority” where the “stigma of mental illness” does not fit all African Americans with anxiety disorders (Hunter & Schmidt, 2010, pp. 213, 225, 228).

Five of the nine participants identified the “stigma of mental health” related to Hunter and Schmidt’s (2010, pp. 213, 225, 228) framework regarding anxiety diagnosis showing the more unfavorable viewpoint that includes “stigma of mental illness.” Stigma is a reality in research on anxiety disorders and African Americans regarding treatment (Hunter & Schmidt, 2010; Johnson et al., 2009; Moitra et al., 2014). Jade summarized how African Americans respond regarding if there is a negative connotation of anxiety diagnosis stating the “stigma of mental health within the Black community” related to Hunter and Schmidt (2010) framework
regarding concerns how others view them with connects to African Americans thoughts regarding anxiety. Jade discussed that positive connotations of an anxiety diagnosis are when clients are receptive to know what anxiety disorder they might have in counseling. Two participants Ms. A and Ashley Nicole described the stigma in terms of how African Americans can tend to use the realization of having an anxiety diagnosis as a self-indictment of a flaw regarding self, lack of openness to having an anxiety diagnosis and the tension. Ashley Nicole and Ms. A highlighted the lack of openness to having an anxiety diagnosis or the tension it brings up for their clients from their lens. Ashley Nicole discussed that African American males whether youth or adults use words like “ashamed or guilty” connected to emotionality aspect of the conceptual framework by Hunter and Schmidt (2010) with their conceptualization of their gender identity to think that they can deal with all of the anxiety without having any concern. One participant Jasmine identified the denial regarding anxiety symptoms. The prior research literature on whether African American clients have negative reactions to anxiety diagnosis focus on that they are least prone to use medication management or met with a behavioral health professional (Brenes et al., 2008; Chapman et al., 2012; Hunter & Schmidt, 2010; Neal-Barnett et al., 2011a).

Five of the participants identified that their clients were open to receiving an anxiety diagnosis. There was no prior empirical understanding if African American clients are receptive to anxiety diagnosis only that they will meet with behavioral health professionals (Brown et al., 1999; Mays et al., 2018; McCall et al., 2020; Williams et al., 2021). Dr. Zora and Ms. A discussed how they have clients who have an open perspective regarding anxiety diagnosis. Ms. A and Cara could not identify any clients who had concerns regarding an anxiety diagnosis. Ashley Nicole discussed that some clients are open regarding their anxiety symptoms. Ashley
Nicole provided an outlook of more acceptance regarding anxiety diagnosis where the stigma is decreasing over time. Dr. Zora discussed that it gives some clients a sense of normalization regarding awareness of their anxiety diagnosis and that they want to cope.

Cara, Jade, and Dr. Zora discussed how their client’s may have different reactions to anxiety diagnosis. Dr. Zora believes that most people are receptive to an anxiety diagnosis. Shasha expressed the need to explore the significance of anxiety diagnosis for the client. Cara looked at anxiety diagnosis and connection to the client’s overall wellness.

**Using Theory**

Most behavioral health professionals who were participants in this research study utilized cognitive behavioral therapy in their clinical work with African American clients. In fact, six participants including Mr. Z, Shasha, Jasmine, Dr. Zora, Ms. A, and Cara identified cognitive behavioral therapy as either their main theoretical approach or one of their diverse theoretical practices. Participants like Mr. Z possessed a comprehensive knowledge of CBT, the connection to thoughts, and his use of the “CBT triangle.” Mr. Z and Shasha both identified the connection between “thoughts” and “feelings.” Mr. Z, Dr. Zora, and Ms. A focused on the importance of clients engaging in alternate thinking. Interestingly, the use of cognitive behavioral therapy (CBT) is one effective treatment for African Americans with anxiety (Carter et al., 2003; Jonassaint et al., 2017; Markell et al., 2014). Jasmine supported the utility of the theory stating, “cognitive behavioral yields the biggest outcomes.” Ms. A identified populations where there was utility of CBT “18 and up,” “older adults,” “mid-mid-adulthood.” CBT was a helpful treatment approach for African American women (Carter et al., 2003; Friedman et al., 1994; Markell et al., 2014). Conversely, Ms. A provided a distinct viewpoint regarding CBT and college students using the phrasing “not very helpful” and “helpful but kind of outdated at this
There was no prior research on the effectiveness of CBT with African American college students with anxiety disorders at HBCU’s or at other universities across the review of the literature on CBT and African Americans (Carter et al., 2003; Friedman et al., 1994; Jonassaint et al., 2017; Markell et al., 2014)

**Expressions of African American/Black Identity**

This research included eight African American and one biracial participant where there has been no other research study that had all behavioral health professionals providing their perception from communities of color (Joy & Bartholomew, 2021). It is vital in Black feminist thought to uplift the voices of the research participants who are mostly African American and women with one biracial and one male participant to add their conceptualization of anxiety disorders (Collins, 2022; Few et al., 2022). In fact, in one study, most behavioral health professionals who provided their perceptions with conjectural scenarios of anxiety disorders were white (Joy & Bartholomew, 2021). Stout and Maldonado (2017) did not inquire regarding the race of the behavioral health professionals in their study for confidentiality reasons in which we are unable to ascertain the influence of their background. Two participants Jade and Dr. Zora focused on their identity as “Black/African American women in connection to their ability to counsel African American clients with anxiety disorders. The one African man in this study Mr. Z focused on his identity as “African American male” and “I am black” that is integral to his work with African American clients with anxiety disorders as well. Interestingly, the research literature includes only medical doctors or psychiatrists in consideration on positionality and therapeutic decisions regarding anxiety that does not include other behavioral health professionals in this study (Lawrence et al., 2015).

**Cultural Considerations**
It was essential to understand the role of culture in understanding anxiety disorders for African American adults where three of my study participants focused on the salience of behavioral health professionals considering the diverse backgrounds of African American clients with anxiety disorders in counseling that aligns with Black feminist thought (Carter & Sbrocco, 2018; Chapman et al., 2011; Collins, 2022; Gordon & Teachman, 2008; Graham et al., 2013). Ashley Nicole, Shasha, and Jasmine spoke to the salience of diversity. Ashley Nicole emphasized the notion of “culturally sensitivity” as important with clinical work in the behavioral health professional role. Ashley Nicole spoke to the necessity of “training” and not assuming. Socio-cultural factors provide perspective on behavioral health professionals’ assessment and diagnosis for African Americans considering the root causes (Carter & Sbrocco, 2018; Chapman et al., 2012, 2013, 2015a; Hopkins & Shook, 2017; Lacey et al., 2015; Sibrava et al., 2013; Soto et al., 2011; Vanderminden & Esala, 2019). Shasha and Jasmine spoke more to the socio-cultural factors connected with Hunter and Schmidt’s (2010) model. Shasha highlighted “policies” and understanding the background, culture and areas of significance for African Americans. Jasmine added that need to consider the “racism within African” in light that not all students are of the same race at the HBCU. It was important to focus on James et al., 2021; Sosoo et al., 2020 findings on self and group-focused internalized racism. Conversely, there has been research that provides no certainty of African American anxiety improvement per cultural awareness of the behavioral health professional (Carter et al., 2003, 2012). Cara added that important to aid in learning regarding anxiety symptoms in diverse populations to help with recognition of anxiety symptoms. Cultural awareness was a vital part of each of the behavioral health professional’s clinical practice working with African Americans with anxiety disorders (Collins, 2022; Few et al., 2003).
Finding Related to Theoretical Frameworks

There were two conceptual frameworks for this research study, including Hunter and Schmidt (2010) A Sociocultural Model of Anxiety in African Americans and Black Feminist Thought (Collins, 2022). I grasped from the black feminist thought perspective that there is a multiplicity of understanding and learning from the array of perspectives from the participants in my research study that is not a one-sized approach to the perception of anxiety disorders (Collins, 2022; Few et al., 2003). Black feminist thought was a framework to encourage the importance of listening and receiving each of the behavioral health professional’s communication of their anxiety disorder perception amongst African American clients (Few et al., 2003). This research study included “Black women’s lived experiences” in which most behavioral health professionals were women specifically African American women and one who was biracial (Collins, 2022, p. 41; Damsgaard, 2021; Flood et al., 2019). Black feminist thought also includes Black men (Collins, 2022). There was one African American male behavioral health professional in this research study. “Race, gender, class, and sexuality” were part of the communication in the research interview to gather the behavioral health professionals’ perspectives of African American clients and to gather if these four concepts had influence on the behavioral health professionals’ life experiences (Collins, 2022, pp. 17, 317; Hamilton-Mason et al., 2009). Seven participants discussed how their life experiences connected with their perception of anxiety disorders whereas two participants discussed not using specific life events to navigate their clinical practice with African American clients.

Black feminist thought in aspect one and two connected to several of the behavioral health professionals in this research study and their lens in terms of the similar inequities African American women experience and “Black woman’s standpoint” (Collins, 2022, pp. 25, 37, 42,
Seven of the nine participants gave voice to African American women’s experiences with anxiety in which six of these participants were African American women and one an African American man. Connections include the notion of “Black superwoman syndrome” from Ms. A and fellow participants Dr. Zora, Lady Bug, Jade and Cara that spoke on the same concept. Ashley Nicole expressed her race and gender and challenges which Mr. Z added perspective. Dr. Zora spoke specifically to messaging over time regarding African American women not to communicate issues and how the pressure to excel impacts anxiety. Ms. A addressed physical health symptoms that were unique to African American women and their anxiety experiences.

Added connections to Black feminist thought were in how three women participants addressed their African American/Black identity and gender (Collins, 2022). Four of the participants discussed the importance of their Black identity. Mr. Z expressed “being an African American male” and “I mean I’m Black that’s all it is too it.” Ashley Nicole also focused on the salience that she is “culturally sensitive” with her race and gender.

A distinct difference with findings by Hunter and Schmidt (2010) was the focus on sociocultural factors like physical health symptoms for African American clients with anxiety disorders where participants in my research did not presume that physical indicators of anxiety were physical health ailments instead deciphering that it was physical features of an anxiety disorder.

Three of the behavioral health professionals Lady Bug, Mr. Z, and Ms. A found that the emotional/mental health presentation of anxiety includes African American adults “experiencing fear.” There was a connection between the research findings by Hunter and Schmidt (2010) that African Americans have more fears regarding their anxiety. The exception was that most
participants did not identify “fear” as a particular emotional/mental health presentation symptom of anxiety for this population.

There was much alignment with the conceptual framework by Hunter and Schmidt (2010, pp. 213, 224, 227-228) regarding sociocultural factors including “stigma” across the behavioral health professionals in the research study (Hopkins & Shook, 2017). There was confirmation from prior work by Hunter and Schmidt (2010) with a on how marginalized populations maybe unwilling to discuss their anxiety symptoms because of cultural mistrust from varied behavioral health professionals. Lady Bug discussed that the thought of attending counseling fosters anxiety for African Americans and how people across socioeconomic statuses may be hesitant to receive therapy. Jade and Jasmine addressed the stigma regarding African Americans and anxiety diagnosis. Ms. A and Ashley Nicole addressed how African Americans will categorize themselves regarding anxiety diagnosis. Ashley Nicole discussed that many African Americans are not open to having an anxiety disorder. Dr. Zora discussed “distrust” regarding anxiety for African Americans in the LGBTQ community and implications. Ms. A focused on African American men not acknowledging their anxiety much and for Cara how African American men may see anxiety as in misalignment to their perception of their gender identity. Ms. A and Jade explored how there are clients that have a negative reaction regarding anxiety diagnosis. However, Ashley Nicole identified some improvement in perception of anxiety diagnoses now.

Other connections to the model by Hunter and Schmidt, (2010, pp. 213, 224, 228) are the matters of “racism” under sociocultural factors (Chapman et al., 2012; Hopkins & Shook, 2017; Moitra et al., 2014; Sibrava et al., 2013; Soto et al., 2011). Mr. Z highlighted “oppression, racism, and microaggression” as “the largest contributors to anxiety disorders” and “cultural systemic factors” with discussions. Cara and Dr. Zora addressed that it is imperative to focus on
cultural aspects of the client’s life that may be a part of the anxiety diagnostic impression for African American clients. Ashley Nicole added the importance of “cultural sensitivity” with an upcoming workshop that she will provide, and that this awareness is a key component of the workshops she attends. Dr. Zora highlighted the significance of “cultural competency” in her clinical and academic roles. Dr. Zora discussed that her perception of anxiety disorders is from “mind, body and spirit, every angle.”

Findings from Black feminist thought and A Sociocultural Model of Anxiety in African Americans (Collins, 2022 & Hunter & Schmidt, 2010) aligned with behavioral health professionals in this research study. Aspect three of Black feminist thought included a focus on the encouragement of civic engagement and progression and aspect four about advocacy and contributions (Collins, 2022). Aspect five includes awareness and aspect six included equity from the behavioral health professionals’ perception (Collins, 2022). The behavioral health professionals in this research study in connection with the conceptual framework by Hunter and Schmidt’s (2010) highlighted a focus on their client’s culture and the necessity of open communication about anxiety. Shasha, Ashley Nicole, and Jasmine discussed that it is essential to have conversations about the client’s life circumstances with the client. Suggestions included the counselor’s exploration of sociocultural factors including the client’s upbringing with the assessment, theoretical approaches, treatment planning, and counseling with African American clients (Carter & Sbrocco, 2018; Chapman et al., 2012; Chapman et al., 2013; Chapman et al., 2015a; Hopkins & Shook, 2017; Moitra et al., 2015; Sibrava et al., 2013; Soto et al., 2011). Shasha exemplified this approach with her emphasis on the consideration of the client’s story as part of assessment and the meaning and value within the client’s life experiences. Ms. A’s interest in primary care doctors needing to focus on anxiety with physical health symptoms of
African American clients was recognizing equitable treatment regarding advocacy and inclusion of into the physical healthcare realm connects to Black feminist thought and A Sociocultural Model of Anxiety in African Americans (Collins, 2022 & Hunter & Schmidt, 2010). Lady Bug’s focus on the significance of supporting accommodations for “disabilities and services” in consideration of anxiety and African American college students another cultural awareness aspect. Further considerations by Cara were needing behavioral health professionals that are African American and astute awareness of “policies” from Sasha when looking at the social change aspects of the field.

**Implications**

Implications included a focus on how this study will augment current research studies on clinical imperatives for behavioral health professionals to remain a strong awareness of anxiety disorder symptom presentation in their clinical work whether assessing, counseling, diagnosing or treating African American clients with anxiety disorders across socioeconomic status and gender. Implications for health promotion and wellness outreach were imperative to focus on in this study. Further implications for this research study included how counselor education programs can continue to provide or enhance their clinical preparation for their graduate students in exploring their perception of anxiety disorder symptom presentation across socioeconomic status and gender. This research study was significant in that it shed lights on how behavioral health professionals’ background whether race, age, gender, helped to shape or not their perception of anxiety disorders whereas prior research studies did not reference either the client’s race, ethnicity, nor gender (Lawrence et al., 2015; Stout & Maldonado, 2017). The findings of this study provided more information regarding how anxiety disorders present for African American men regarding symptoms and in connection to socioeconomic status that was not
included regarding a critique of prior anxiety disorder research (Chapman et al., 2012; Gordon et al., 2015; Johnson et al., 2009; Markell et al., 2014; Neal Barnett & Crowther, 2000; Neal-Barnett et al., 2011b; Petrie et al., 2013). Hopefully, the present research will inspire behavioral health professionals across fields to really reflect on their positionality including and not limited to racial identity, life and clinical experiences, social class, familial background, and needed areas of growth to see whether or not it connects with their clinical work with African American clients (Carter & Sbrocco, 2018; Carter et al., 2012; Chapman et al., 2012; Hopkins & Shook, 2017; Lawrence et al., 2015; Sibrava et al., 2013; Soto et al., 2011). It was needed to include the participants’ voices considering their wealth of clinical experience working with African American clients at HBCU’s regarding their recommendations in alignment with question (13) regarding recommendations for current and future graduate students and professionals in behavioral health fields.

**Implications for Behavioral Health Professionals**

Research results in this study include the description of anxiety disorder symptom presentation in African American adults including the variation in presentation of anxiety and physical and cognitive presentation of anxiety. Behavioral health professionals may miss diagnosing GAD, PD, or SAD without a focus on the physical and cognitive symptoms of anxiety (Hunter & Schmidt, 2010). It is imperative to know the variation in anxiety for African Americans to aid in therapeutic resources and counseling designed for this population (Hopkins & Shook, 2017). Participants focused on the importance of awareness that there are varied anxiety disorder symptoms and exploring the origin of anxiety disorder presentation. It will help if the behavioral health professionals can inform African American women of the signs of anxiety (Carter et al., 2016).
Findings from this research study included that behavioral health professionals perceive the presentation of anxiety disorders among African American adult clients across socioeconomic status and gender through the lens of socioenvironmental factors. Behavioral health professionals can explore how “societal messages” impact African Americans regarding internalized racism to aid in treatment interventions (Sosoo et al., 2020, p. 577). It will be important for behavioral health professionals to ask their clients about their encounters with discrimination to conceptualize the connection between discrimination and GAD symptoms (Soto et al., 2011). Behavioral health professionals also need to consider the impact of “everyday discrimination” for African American seniors (Mouzon et al., 2017, p. 7). It is imperative to explore the relationship of racism to anxiety for African Americans in the therapy (West et al., 2013). Behavioral health professionals should help African American women cope with encounters due to African American identity by supporting them when they express their feelings and focusing on help-seeking (Greer, 2011). These behavioral health professionals can also focus on coping skills that help African Americans deal with prejudicial encounters in a healthy manner with social situations (Buckner & Dean, 2017). Behavioral health professionals should include “values” interventions in therapy when working with African Americans in areas of with racism (Graham et al., 2015, p. 54). Another area of cultural significance is language regarding what are culturally appropriate or more mindful terms to use across spaces.

Participants in this research study discussed the importance of counseling skills as part of the recommendation of current and future graduate students in the behavioral health field and behavioral health professionals who provide clinical services for African American clients with anxiety disorders. Participants highlighted the importance of current and future counselors to display the ability to “be open,” “authentic” and show “compassion” and that “competent.”
Participants discussed processing considerations that African American take in issues rather than communicating issues externally and emphasized normalizing anxiety for African Americans.

Other research study findings include that the comprehensive preparation and clinical experiences including level of readiness and educational experiences that were part of the behavioral health professionals’ positionality as well as their willingness to learn regarding their perception of the presentation of anxiety disorders amongst African American clients. More awareness of perinatal anxiety disorders can help decrease the stigma of Black maternal behavioral health (Hernandez et al., 2022). Diagnostic process was also a part of the study results with where Mr. Z asked a helpful clarification question whether looking at “feeling or process” with diagnosis where it will be beneficial for all behavioral health professionals to consider their emotionality and the manner in which they diagnose African American clients with anxiety disorders. It is imperative that behavioral health professionals assess African American clients for anxiety for suicide prevention within this population (Assari et al., 2013).

There are further suggestions for treatment approaches for African Americans. Mindfulness may be resourceful for African Americans to work through anxiety symptomatology (West et al., 2013). It will help to look at fostering familial bonds to help and reduce stressful communication for African Americans with social anxiety disorder (Levine et al., 2015). Behavioral health professionals should use “positive psychology” and more affirming resources to help African American seniors to reduce their anxiety symptoms (Carden et al., 2022, p. 858). Findings in the research study included spiritual factors. It is imperative for behavioral health professionals to focus on the importance of religion for African American clients to understand the impact on anxiety for this population (Hodge et al., 2022).
There are specific imperatives when providing clinical services for African American women. Behavioral health professionals can focus on ways to enhance African American women’s self-esteem which may help with a potential reduction in mood and anxiety symptoms (Hernandez et al., 2022). It is essential to explore loneliness in the provision of clinical services for African American women with anxiety (Chang, 2018). There can be more exploration regarding the utility of sister-circles for anxiety treatment for African American women (Neal et al., 2011a; 2011b). It is essential to focus on increasing African American women’s self-compassion when they present with *Strong Black Woman Schema*, to help with anxiety (Liao et al., 2020). An essential component in counseling is having therapies that address co-occurring “depression and anxiety” in African American mothers and the impact on the children’s wellbeing and protective factors (Boyd & Tervo-Clemmens, 2013, p. 9).

**Implications for University and College Counseling Centers**

Behavioral health professionals at university and college counseling center need to explore *sociocultural* variables when meeting with Black college students (Dean et al., 2018). Behavioral health professionals can inform African American college students of the impact of “social connectedness” and “intolerance of uncertainty” with “racial microaggressions” anxiety and encourage social engagement within their community and look at what can cope with (Liao et al. 2016, p. 245). **Staff in** college counseling centers and wellness program can explore *anxiety sensitivity* and *emotional nonacceptance* in African American college students and provide them with information on what can lead to behavioral health issues including anxiety and to work on effective mechanisms (Manning et al., 2017).

**Implications for Health and Wellness Outreach**
“Wellbeing” initiatives will be important due to the connection between anxiety, “racial discrimination” and “health” for African Americans (Carter et al., 2016, p. 702). Educational outreach on family cohesion is essential to serve as a protection against anxiety issues for African American youth to adjust regarding later life (Augustine et al., 2022, p. 8). It will be imperative to focus on health promotion regarding decreasing the effect of discrimination on anxiety for African American seniors (Carden et al., 2022). Churches could be a great resource to educate African American senior citizens about behavioral health services and educate members on endorsing behavioral health services (Nguyen, 2018). Potentially university/campus health or wellness educators if a position at the college/universities may be useful in providing education on the presentation of anxiety for African American college students and students in general.

It will be helpful for healthcare professionals to screen if their African American clients have allergies and infections that correlate with anxiety disorders (Oh et al., 2022). Doctors can assess African American mothers for stressful circumstances and abuse if there is potential “maternal depression and anxiety” (Mitchell & Ronzio, 2011; p. 1272).

**Implications for Behavioral Health Graduate Programs**

Findings from this research study included that comprehensive preparation and clinical experiences including level of readiness and educational experiences were part of the behavioral health professionals’ positionality that influences their perception of the presentation of anxiety disorders amongst African American clients. It is imperative that behavioral health graduate programs include coursework that is culturally relevant on anxiety disorder symptom presentation for African Americans and communities of color in courses in general, diagnostic, and multicultural counseling courses. There is realization that no one course can provide all the information on a specific cultural group; however, a specific course that has a focus on
counseling, diagnosis and assessment with different racial groups should be a consideration. Additionally, counselor education programs can consider innovative creative resources that may prove helpful in how their graduate students conceptualize anxiety disorders considering that most participants did not identify the utilization of creative resources outside of mostly presentations or handouts. Participants discussed the lack of diversity with having African American behavioral health professionals which could be imperative for behavioral health graduate programs to consider initiatives to enhance diversity regarding students, faculty, and staff.

**Limitations and Delimitations**

**Limitations**

A limitation is that I reached out to counseling centers at 68 HBCU’s and was only able to recruit nine participants in total where I did not have more behavioral health professionals in the study (Peoples, 2021). However, a particular number of participants is not the goal of hermeneutic phenomenological research (Dibley et al., 2020). There were three prospective participants that scheduled interviews and did not attend the interview and one of the three we tried to reschedule and there was not the same time availability for the interview. I was able to recruit participants across different states in the southeast but not able to recruit participants from every state in the southeast despite calling or sending emails to be reflective of licensed mental health professionals across the southeast (Dibley et al., 2020). Thus, there was no way to know if other behavioral health professionals at HBCU’s would agree with the perceptions of behavioral health professionals in this study considering that not a quantitative investigation. I was able to recruit one African American male participant despite reaching out to other behavioral health professionals who were men at HBCU counseling centers where not balanced in terms of diverse
gender identity (Dibley et al. 2020). A major limitation of this research study comparable to the research literature was not having many men in research studies on anxiety which was an issue regarding my data collection (Chapman et al., 2011, 2012, 2015b; Durkee & Williams, 2015; Johnson et al., 2009; Markell et al., 2014; Perkins et al., 2022; Petrie et al., 2013). A limitation was that I did not disclose that I worked as a counselor/wellness educator at an HBCU which may have been beneficial in recruitment efforts.

Other limitations were about some variation in diversity of participants. In addition, there were no behavioral health professionals in this research study who were of other racial backgrounds outside of African American or biracial in which it would have been helpful to see if they had similar or dissimilar perceptions of anxiety disorder presentation. In addition, there were no licensed psychologists, psychiatric nurse practitioners or psychiatrists in the study to learn more about their perception of how anxiety disorders present amongst African American clients across socioeconomic status and gender. I did reach out to behavioral health professionals who were psychologists in the study and was unable to successfully recruit these professionals for the research study. I am not aware of how many psychiatric nurse practitioners or psychiatrists are employed at HBCU campuses considering that no specific surveys or guides with this information. I did try to recruit one psychiatrist in which the email did not successfully go through to this behavioral health professional.

A limitation of my research is that the research involves my interpretation that is not necessarily reflective of how all behavioral health professionals may perceive anxiety disorders amongst African American clients (Gadamer, 1975/2013; Heidegger, 1962/2013). However, it was imperative for interpretation in hermeneutic phenomenological research for myself as researcher to acknowledge assumptions and experience of the phenomenon under study which I

Another potential limitation may have been concerns about interviews via Zoom although it was through Zoom HIPPA in which no one expressed this concern. I pondered if some lack of participation in the study might be due to not wanting a recorded interview and video where with audio alone there might be more receptivity for prospective participants.

**Delimitations**

There were delimitations of the research study connected to areas where I did not conduct research. I am now finding that it may have been helpful in my IRB to have included student health departments at HBCU’s to ascertain if their campus health professionals provide diagnosis, treatment or medication management for African American clients with anxiety diagnoses or symptoms. It would be interesting to see if any of their behavioral health professionals worked in their student health departments. I recruited only at HBCU’s in the southeast where it may have been helpful to gain perspectives from behavioral health professionals across the United States where there might be different experiences (Summers & Lassiter, 2022). There might be other environmental influences in various parts of the country that connect to anxiety experiences for African Americans and the behavioral health professionals who provide clinical services. Additionally, I did not interview behavioral health professionals who work with African American clients at PWI’s or other institutions where they
may have varied perceptions of anxiety disorders and different backgrounds. Furthermore, African American clients at PWI’s or other institutions may have different experiences due to not being the majority on these university campuses (Durkee & Williams, 2015; Manning et al., 2017; Perkins et al., 2022). The reality is that much of the research on African American college students and anxiety takes place at PWI’s where unable to know if anxiety presents in a parallel fashion for students at HBCU’s (Chao et al., 2012; Cokley et al., 2013; Mounts et al., 2006; Salami & Walker, 2014).

There were some delimitations of my interview guide questions (Peoples, 2021) and one demographic question. I could have rephrased one of my interview questions on anxiety disorder presentation to anxiety symptoms focusing on physical, emotional, behavioral, cognitive, and social symptoms of anxiety for more specific responses from participants. I think my interview guide should have included specific questions about anxiety for African American college students, within the church, criminal justice center, young adults, middle-aged adults, seniors, individuals with disabilities, and athletes. I could have added a question specifically focused on the participants’ experiences working with African American college students with anxiety disorders at HBCU’s. I should have asked each participant their thoughts about anxiety and hurricanes for African Americans considering that all participants worked at HBCU’s in the southeast. Furthermore, researchers highlighted that African American college students had more fears of weather elements and water regarding specific phobias (Chapman et al., 2008). Only one participant asked for the interview questions prior to the interview where other participants had to answer questions without knowing the questions in advance. I unknowingly left one group off question 14 of the demographic questionnaire where some participants were able to identify that they worked with this group when they filled out the questionnaire. I was able to ask the few
participants who completed the demographic questionnaire right before the start of the interview if they worked with the particular population that I wanted included in the questionnaire as representation is an important aspect of this study.

A delimitation was not focusing on the role of disability services for African American clients across participants where focused on this topic with one participant. (Boveda & Annamma, 2023). It would have been helpful to explore further the anxiety experiences of African Americans who receive accommodations for disability services on a university campus or general population. (Boveda & Annamma, 2023).

**Recommendations for Future Research**

There is a need for more research on African Americans and anxiety disorders (Hunter & Schmidt, 2010). It is critical to have collective of researchers and funding across varied spaces that can supplement the available research on African Americans and anxiety disorders (Neal & Turner, 1991). Researchers need to explore more about the treatment of anxiety for communities of color rather than focusing only on Caucasian populations (Carter et al., 2012). There is a definite need to explore the experiences of African American clients with anxiety disorders whether both parents are African American, biracial, or multiracial to appreciate the array of anxiety experiences. Another critical area for research is exploring the anxiety disorder presentation of African Americans across professions whether lower earnings, blue-collar, middle-class professionals or those that are wealthy to further gage if there are connections or variations across socioeconomic status. It is crucial that there is further research on anxiety disorder presentation for African American men (Chapman et al., 2011, 2012, 2015b; Durkee & Williams, 2015; Markell et al., 2014; Perkins et al., 2022; Petrie et al., 2013). It will be beneficial in future explorations of the *DSM* if symptoms like “fibroids, “cysts” “ulcers,” from Ms. A’s
lens, headaches from Ms. A’s, Cara, and Ashley Nicole’s lens, “gastrointestinal” from Ms. A and Cara’s perspective, and “high blood pressure” and “high cholesterol” from Ashley Nicole’s lens would be under consideration for anxiety disorders (APA, 2022). Research studies with current samples that consider African Americans and anxiety disorders will be instrumental in recognition of the obsolete yet clinically informative studies (Jackson et al. 2004 National Survey of American Life, as cited in Assari et al., 2013; Bijou & Colen, 2022; Carden et al., 2022; Himle et al., 2009; Hodge et al., 2022; Johnson-Lawrence et al., 2013; Jones et al., 2020; Lacey et al., 2015, 2021; Levine et al., 2015; Mays et al., 2018; Mouzon et al., 2017; Oh et al., 2017, 2021, 2022; Soto et al., 2011; Taylor et al., 2021).

A qualitative and quantitative exploration of anxiety disorder presentation in African American college students at HBCU’s, PWI’s and other institutions would be a valuable research consideration. It will be essential to have anxiety studies with more African American men in college due to lack of focus on in the research (Donovan & West, 2015; Lee et al., 2015; Manning et al., 2017; West et al., 2013). Anxiety disorder research with African Americans mostly includes a location in the Midwest that does not reflect necessarily African American college student’s anxiety in the southeastern United States (Chapman & Woodruff-Borden, 2009; Manning et al., 2017; Mounts et al., 2006; Salami & Walker, 2014; Watson & Hunter, 2015).

It is essential to have further research on how behavioral health professionals conceptualize anxiety for African Americans across diverse backgrounds. Quantitative research studies may be helpful to explore a vaster range of behavioral health professionals’ perception of anxiety disorder presentation for African Americans and students of other racial backgrounds at HBCU’s, PWI’s, and other institutions. A recommendation is for future researchers to potentially recruit behavioral health professionals of diverse gender identities as well to gather their
perceptions. There could be usefulness of expanding recruitment in future research to include past behavioral health professionals who worked at HBCU’s for several years who and who would have a wealth of knowledge. In addition, it would help to explore how master’s level graduate students in behavioral health fields perceive anxiety disorders amongst African American clients to see how faculty in behavioral health graduate programs can foster growth in their student’s competencies in diagnostic and mental health courses.

Added areas of research around social anxiety disorders regarding social anxiety and African Americans are important (Carter et al., 2014; Manning et al., 2017). Research on anxiety sensitivity and emotional nonacceptance connection to social anxiety for Afam college students will be helpful to explore (Manning et al., 2017, p. 680). Future research can help to decipher how anxiety presents in African American college student populations (Manning et al., 2017). It is imperative for the creation of an assessment that can decipher “performance and interaction anxiety” for African Americans (Carter et al., 2014, p. 642). It is imperative to know what leads African Americans to leave individual and group counseling prematurely for social anxiety (Obasaju, 2009).

Researchers need to investigate the influence of racial identity on encounters of racism for African Americans and anxiety (West et al., 2013). Future research should include a focus on the mental health effects of discrimination “online and off-line” for Black young adults (Perkins et al., 2022, pp.8-9). It will be important to know the “types of discrimination” in lieu of anxiety to aid in interventions (Hopkins, 2018, p. 74).

There are other areas of needed research exploration. It is important to explore gaps in the behavioral health services community to provide greater access and therapeutic modalities to address behavioral health disparities to achieve parity amongst people of every ethnicity (Hunt et
It will be helpful to know in the future if responses to “stress tests” where there is heightened anxiety causes “hypertension” long term (Pointer et al., 2012, p. 5). There is a need for longitudinal research on reading religious information and role with anxiety disorders for African Americans (Hodge et al., 2022). Further research on perinatal mood and anxiety disorders and self-esteem for women is essential (Hernandez et al., 2022). There was no research literature on hurricanes and anxiety for African Americans which would be an interesting area of exploration. Lastly, my perception is that there is a need to have a specific anxiety instrument for African Americans to capture the symptoms of anxiety disorders due to the need to measure anxiety for this population and precisely per prior research. (Assari et al., 2013; Johnson et al., 2007; West et al., 2013).

**Personal Reflections**

I am thankful for the diversity of experience of all nine of the participants, the participants willingness to take part in my research, and the depth they added to this research study. All nine of the participants were sincere, knowledgeable, culturally astute, and clearly valued working with African American clients with anxiety disorders and all clients in general. My research participants provided space for me to have a thought-filled research experience full of invested interest in my research topic. Each research participant was an inspiration to me in their attention to the therapeutic process. It was significant to have both counselors and social workers in the research study as we need the team-oriented approach across behavioral health professions.

I focused on diagnosis of clients prior to this research study and continue to focus deeply on diagnosis. The research has helped me to explore further physical symptoms of anxiety for clients and to educate clients on these symptoms as well. I can use a **Sociocultural Model of**
Anxiety in African Americans as part of my case conceptualization about African American clients with anxiety and to process the role of “stigma” in how clients identify or do not disclose their anxiety symptoms (Hunter & Schmidt, 2010, pp. 213, 227-228).

My hope is that my research will inspire emphasis on proficiency in diagnosis and assessment of anxiety disorders and mental health diagnosis in general for African American clients (Hunter & Schmidt, 2010). Furthermore, the intent is that the outcome of my research study will inspire more adeptness in anxiety diagnoses and mental health diagnosis take place for all races, gender, and socioeconomic statuses. At present, per the Council for Accreditation of Counseling and Related Educational Programs (CACREP), diagnostics and assessments are not on the list of one of the core categories for coursework in doctoral programs (CACREP, 2023). I believe there needs to a focus on African Americans and anxiety as well as other racial and cultural populations in psychodiagnosis courses in master’s level and doctoral counselor education graduate programs. It is imperative to have at least one course on diagnosis in doctoral counselor education programs to continue the conversation on multicultural considerations about diagnosis and assessment. Furthermore, behavioral health graduate programs in general can look at employing faculty who have research interests in counseling, evaluation, and diagnosis across diverse racial populations.

This research journey has been insightful for me in terms of learning more about anxiety disorders and varied cultural components that are imperative. I reflected on my own clinical experience working with African American clients with anxiety disorders, provision of informational resources and wellness programming at an HBCU throughout my data collection. Jasmine asked me about my perception of anxiety disorders amongst African American clients which I appreciated. I addressed that the research literature had an influence on my perception.
and that there could be varied ways to view anxiety. I will continue to use my voice and writing to help inform and educate people about anxiety disorders, mental health, and wellness, and diversity awareness. I will continue to look at ethnicity, diversity in identity, and socioeconomic variation across topics considering my passion for counseling, African American history, and wellness. My continual hope is that behavioral health professionals across racial and cultural backgrounds will work together to hear, ask questions of clients, read books and research literature, and grasp that there is variation in communities of color to gain greater insight into how anxiety or mental health conditions present individually and with smaller to larger populations.

**Conclusions**

Chapter five included a focus on the purpose and philosophical foundations of this study with a hermeneutic phenomenological approach. There were several implications from this research study for behavioral health professionals, implications for university and college counseling centers, implications for health and wellness outreach, and implications for behavioral graduate programs. There was inclusion of the limitations and delimitations from the researcher’s lens. Consideration of future research can enhance the field and present research on African Americans, anxiety disorders, and behavioral health professionals’ perceptions considering that African Americans are a salient part of the United States and culture in general. Research results/findings were (a) description of anxiety disorder presentation, (b) “contributing factors” to anxiety disorders for African American adults, (c) “surprises” vs. “no surprises” regarding anxiety disorder presentation, and (d) pervasiveness of anxiety for African Americans for research question one. More results five to fourteen for research question two were (e) comprehensive preparation and clinical experiences, (f) diagnostic process, (g) life and familial
experiences, (h) “feelings” vs. “no feelings” regarding anxiety diagnosis, (i) behavioral health professionals’ perception of their client’s reaction to anxiety diagnosis and (j) using theory. Lastly, results were (k) “open to gaining new knowledge,” (l) anxiety experiences of behavioral health professionals, (m) expression of African American/Black identity, and (n) cultural considerations. Findings from this study will hopefully lead to further dialogue and training for clients, behavioral health professionals, and people on African Americans and anxiety disorders in behavioral health graduate programs, university and college counseling centers, community mental health agencies, and in the criminal justice system.
References


https://doi.org/10.1037/sah0000162


https://doi.org/10.1016/j.beth.2013.04.011


https://doi.org/10.46743/2160-3715/2022.5027


https://doi.org/10.1016/j.janxdis.2007.08.003


https://doi.org/10.1016/j.janxdis.2008.12.003


https://doi.org/10.1080/07317115.2017.1291547


https://doi.org/10.1177/0739986304269164


https://doi.org/10.1007/978-90-481-8845-1_17


DeLapp, R. C. T., Chapman, L. K., & Williams, M. T. (2016). Psychometric properties of a brief version of the Penn State Worry Questionnaire in African Americans and European

https://doi.org/10.1037/pas0000208


https://doi.org/10.1017/S1742058X21000011


https://doi.org/10.4135/9781529799583


https://doi.org/10.1080/09518390050211565


https://doi.org/10.1177/0095798414543014

anxiety and depressive symptom changes following primary care intervention.  


Flanders, C. E. (2015) Bisexual health: A daily diary analysis of stress and anxiety, basic and

*Applied Social Psychology, 37*(6), 319-335.

https://doi.org/10.1080/01973533.2015.1079202


competence. *Advances in Health Sciences Education: Theory and Practice, 24*(3), 489–

501. https://doi.org/10.1007/s10459-019-09879-4

Fricker, M. (2013). “How is hermeneutical injustice related to ‘white ignorance’ Reply to José

Medina’s “hermeneutical injustice and polyphonic contextualism: Social silences and

shared hermeneutical responsibilities.” *Social Epistemology Review and Reply Collective, 2*(8), 49-53


White patients with panic disorder and agoraphobia. *Hospital & Community Psychiatry, 45*(8), 798–803.

Furukawa, T. A., Katherine Shear, M., Barlow, D. H., Gorman, J. M., Woods, S. W., Money, R.,


interpretation of the Panic Disorder Severity Scale. *Depression and Anxiety, 26*(10), 922–

929. https://doi.org/10.1002/da.20532

Fuqua, A. (Director). (2014). *Equalizer* [Film]. Sony Pictures Home Entertainment


Bloomsbury Revelations. (Original work published 1975)

Gibbs, T. A., Okuda, M., Oquendo, M. A., Lawson, W. B., Wang, S., Thomas, Y. F., Blanco, C.


Results from the national epidemiological survey on alcohol and related conditions.


https://doi.org/10.1111/j.1755-5949.2009.00079.x


https://doi.org/10.1007/bf00911313


http://dx.doi.org/10.4324/9780429056963-4


https://doi.org/10.1177/0095798414522297


https://doi.org/10.1037/fam0000070


https://psycnet.apa.org/doi/10.3102/0013189X07309471


281


African Americans. *International Journal of Hypertension.*

https://doi.org/10.1155/2012/268013


https://doi.org/10.1080/02770903.2022.2062673


https://doi.org/10.1177%2F160940691101000405

https://doi.org/10.1177%2F2156869318811435


[Doctoral dissertation, University of New Orleans]. University of New Orleans Theses and Dissertations. https://scholarworks.uno.edu/td/2509

https://doi.org/10.17744/mehc.43.1.03


Williams, A. D. (2010). *Exploring the theoretical and philosophical framework that influence private practitioner’s mental health treatment of middle class-African American* [Doctoral dissertation, Clark Atlanta University]. DigitalCommons@Robert W. Woodruff Library, Atlanta University Center.


Appendix A

IRB Approval Letter

THE UNIVERSITY of
NEW ORLEANS

INSTITUTIONAL REVIEW BOARD

Memorandum

Principal Investigator: Christopher T. Belser
Co-Principal Investigator: Chantel K. Gant
Date: June 9, 2023
Protocol Title: Behavioral Health Professionals' Perception of Anxiety Disorders Amongst African American Clients
IRB Number: 01Jun23

The Institutional Review Board for the Protection of Human Subjects in Research (IRB) has deemed that the research and procedures of the above-named protocol are compliant with the University of New Orleans and federal guidelines and meet the standard for expedited IRB review according to:

A. Research activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the following categories, may be reviewed by the IRB through the expedited review procedure authorized by 45 CFR 46.110 and 21 CFR 56.110. […]

6. Collection of data from voice, video, digital, or image recordings made for research purposes.

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Review of the submitted protocol indicated that all procedures are in compliance with 45 CFR 46. Any changes to the procedures must be reviewed and approved by the IRB prior to implementation. All approvals are valid for one year and can be renewed upon request.
I wish you much success with your research project. If you have any questions, please do not hesitate to contact me at 280-7481.

Sincerely,

Roberto Refinetti, PhD
IRB Chair
Appendix B

**Recruitment Letter**

Dear Participant:

My name is Chantel K. Gant and I am a doctoral candidate conducting research under the direction of Dr. Christopher T. Belser in the Counselor Education program at the University of New Orleans. I respectfully request your participation to explore behavioral health professionals’ perception of anxiety disorders amongst African American clients with approval from the Institutional Review Board (IRB) at the University of New Orleans (IRB#01Jun23).

Study participation requirements include:

1. Have at least a master’s degree in counseling, social work, counseling, clinical or health psychology, psychiatric nursing or psychiatry.
2. Active license in behavioral health fields including counseling, social work, counseling, clinical or health psychology, psychiatric nursing or psychiatry.
3. Currently working as a licensed behavioral health professional at a Historically Black College/University (HBCU).

Participation in this research study will include an initial interview that will be 45 minutes to 90 minutes via HIPPA Zoom for interviews with research participants outside of the Greater New Orleans and via hand-held audio recorder for interviews in the Greater New Orleans area. Questions will focus on your experience and background counseling, diagnosing or prescribing medication for African American clients with anxiety disorders. Researcher will ask you to submit flyers or brochures for groups, programs, presentations, and services they provide to see if they are in areas of anxiety, anxiety disorders, or working with African American clients (Ardevol, 2012; Rose, 2016). There will be a follow-up interview. I will provide all research participants with a copy of the interview transcripts.
Please email me at ckgant@uno.edu if you want to participate in this study. I am grateful for your willingness to participate in this research study. Please provide dates and times that you will be available to interview from June to August of 2023.

Sincerely,

Chantel K. Gant, MEd, LPC-S, LAC, NC
Appendix C

Recruitment Email

Dear Prospective Participant:

My name is Chantel K. Gant and I am a doctoral candidate conducting research under the direction of Dr. Christopher T. Belser in the Counselor Education program at the University of New Orleans. I respectfully request your participation to explore my dissertation titled “Behavioral Health Professional’s Perception of Anxiety Disorders” amongst African American clients due to your current role as a licensed behavioral health professional at a Historically Black College/University (HBCU) in the southeast. The study has approval with the Institutional Review Board (IRB) at the University of New Orleans (IRB#01Jun23). Participation would include a 45-minute to 90-minute interview and a follow-up interview via HIPPA zoom. Your participation in the study is voluntary.

Please email me at ckgant@uno.edu if you want to participate in this research study and your available time(s) to interview during the months of July and August of 2023. I will email you a consent form and confirmation of interview after receive signed consent form. Thank you for your time and consideration.

If you have any questions concerning the research study, please call contact the principal investigator, Christopher Belser (Assistant Professor) at the University of New Orleans. The contact number is 504-280-5684 and email ctbelser@uno.edu.

Sincerely,

Chantel K. Gant, MEd., LPC-S, LAC, NCC
Appendix D

Phone Script

Greetings, (Title or Name of Prospective Participant):

Hello, my name is Chantel K. Gant and I am a doctoral candidate conducting research under the direction of Dr. Christopher T. Belser in the Counselor Education program at the University of New Orleans. I wanted to know if you are available now for me to inform you more about my dissertation research or if there is a more suitable time to call.

If prospective participant not available to talk at the time-I want to know if there is a preferred time or day to contact your or if email is your preferred form of communication.

If no interest in follow up- Thank you and have a great day.

If prospective participant can talk at the time of the call-My dissertation is titled “Behavioral Health Professional’s Perception of Anxiety Disorders” where the study has approval with the Institutional Review Board (IRB) at the University of New Orleans (IRB#01Jun23). I reached out to you due to your current role as a licensed behavioral health professional at a Historically Black College/University (HBCU) in the southeast. The study participation would include a 45-minute to 90-minute interview and a follow up interview via HIPPA Zoom. Your participation in the study would be voluntary.

If no plan to participate in the study- I want to thank you for allowing me to communicate regarding my research. All the best!

If plan to participate in the study- I wanted to know if this study is one in which you would potentially want to participate if I can email you a consent form. What is your preferred email to send the consent form? If you do sign the consent form for the research, please email me the completed form at ckgant@uno.edu. Please email me your available time(s) to interview during the months of July and August of 2023. I will email you confirmation of the interview time after I receive the signed consent form. I appreciate your willingness to hear more about my research study and potential participation. Please contact me if any questions regarding the research study.

If you have any questions concerning the research study, please call contact the principal investigator, Christopher Belser (Assistant Professor) at the University of New Orleans. The contact number is 504-280-5684 and email ctbelser@uno.edu.

Sincerely,

Chantel K. Gant, MEd., LPC-S, LAC, NCC
Appendix E

CONSENT FORM

LETTER OF CONSENT FOR ADULTS

Dear Participant:

Background: I am a doctoral candidate conducting research under the direction of Dr. Christopher T. Belser in the Counselor Education program in the Department of Educational Leadership, Counseling, and Foundations at the University of New Orleans.

The title of this research study is “Behavioral Health Professionals’ Perception of Anxiety Disorders Amongst African American Clients.”

I respectfully request your participation to explore behavioral health professionals’ perception of anxiety disorders amongst African American clients. Your participation is requested due to you currently working in the role of a actively licensed behavior health professional at a Historically Black College/University (HBCU).

Purpose of the Study: The purpose of this study is to explore behavioral health professional’s perception of anxiety disorders amongst African American clients. As research, I seek to understand more how behavioral health professionals assess, diagnose, counselor or prescribe medication management for African American clients with anxiety disorders. Specifically, this research study aim is to explore the behavioral health professional’s positionality working with African American clients across varied anxiety diagnoses.

Procedures: Participation in this study will involve one initial interview and a follow up face-to-face semi-structured audiotaped interviews. A consent form will be provided for permission to audiotape. Interview duration will be 45 to 90 minutes in length per interview. I will conduct interviews via HIPPA Zoom for interviews with research participants outside of the Greater New Orleans area who are located in the Southeastern region of the United States and via hand-held audio recorder for participants in the Greater New Orleans area (Stout & Maldonado, 2017). Researcher will take notes during the interview. A pseudonym will be used prior to the initial interview and throughout the research process and only the informed consent will have your name which will remain confidential (Monaro et al., 2022; Stout & Maldonado, 2017; Williams, 2010). All collected information will store on a computer, and only the researcher can access the data (Stout & Maldonado, 2017). I will remove information before submitting the proposal of any participant case illustration with specific identifying information (ACA, 2014) (G.5.a). I will use a password-protected laptop and place files that can lock in a locked file cabinet without access by anyone except the researcher (Williams, 2010). I will delete all interviews after transcription and completion of the study (Stout & Maldonado, 2017).

Voluntary Participation: Your participation in the study is voluntary. If you choose not to participate or withdraw from the study at any time, there will be no penalty. No compensation will be provided for participation.
**Risks:** There is no assumed risk in the study. You will disclose information reflecting upon your experience of working with African American clients with anxiety disorders that may involve processing your feelings and thoughts regarding your clinical practice. You do not have to answer any question that are discomforting for you. As researcher, I can stop the interview at any time if you become uncomfortable. Due to the study topic, you may need to process feelings or thoughts with a behavioral health professional. As the researcher, I will provide you with the necessary referral for behavioral health services if needed. The following crisis numbers are available:

Emergency contacts include calling 911 for behavioral health or physical emergencies. The 24-hour SAMHSA confidential treatment referral line is 1-800-662-4357. Metropolitan Crisis Response Team 24 Hour Number is 504-826-2675 and Jefferson Parish Mobile Crisis Team 24 Hour Number is 504-832-5123. The 24 hour National Suicide and Crisis Lifeline is 988. If a participant reports suicidal thoughts, plans or ideation will receive immediate crisis services and referral and will not be included in study.

**Research:** The results of this study may be published for a journal article, manuscript, will be used for my dissertation, and may be presented at workshop, conference or summit. Your name will not be submitted nor published, in any publications or presentations as confidentiality is of the utmost important in this research study. I will utilize peer debriefing for review of study interview transcripts and findings (Janesick, 2007).

**Benefits:** Although there may be no direct benefit to you, the possible benefit of your participation is adding to the research literature on behavioral health professional’s experience with African American clients with anxiety disorders. This research can aid in anxiety research to focus on anxiety disorder treatment, diversity, and clinical practice. Emerging themes from this study can inform clinical practice initiatives for anxiety disorder treatment for African Americans, programming and outreach for college/university counselor at HBCU’s and graduate and psychiatry students in behavioral health or psychiatry fields.

**Study Questions:** If you have any questions concerning the research study, please call me at [504-458-8268] or email me at ckgant@uno.edu or call Dr. Belser at 504-280-5684.

Sincerely,

Chantel K. Gant, MEd., LPC-S, LAC, NCC  
Doctoral Candidate  
Counselor Education Program  
Department of Educational Leadership, Counseling, and Foundations  
University of New Orleans

By signing below, you are giving consent to participate in the above study.

________________________  _________________________  ____________
Appendix F

Demographic Questionnaire

Greetings, your time and responses are respectfully requested, and your participation in answering the demographic questionnaire is voluntary. Responses will inform the researcher if you meet the requirements for the study before scheduling interviews. If a potential participant is no longer interested in the study, the participant can withdraw with no consequence.

Date of Questionnaire: ____________________________

1. What is your age? (Please check the response that applies to you)
   - □ 18 to 25
   - □ 26 to 35
   - □ 36 to 46
   - □ 47 to 57
   - □ 58 to 64
   - □ 65 and above

2. What is your racial background?

3. How would you define your gender?

4. What is your highest level of education? (Please check category(s) that apply)
   - □ High School
   - □ Associates Degree
   - □ Some College
   - □ Bachelor’s Degree
   - □ Master’s Degree
   - □ Education Specialist Degree (Eds.)
   - □ Doctoral Degree
   - □ Pursuing Doctoral Course Work
   - □ Medica Degree
   - □ Other ____________________________

5. Please check the license(s) that you currently hold as a behavioral health professional (Please add other licenses if not included. The National Alliance of Mental Illness (NAMI), (NAMI, 2017)
   - □ Licensed Addiction Counselor
   - □ Licensed Clinical Social Worker
6. Please write any behavioral health certifications that you have below:

7. How long have you worked as a licensed behavioral health professional? (Please check your response in the list below):
   □ Less than a year
   □ 1 to 4 years
   □ 5 to 9 years
   □ 10 to 15 years
   □ 15 to 20 years
   □ Over 20 years
   □ Other ____________________________

8. What behavioral diagnoses do you work with most often (spend 50% or more of your time providing, clinical assessment, therapy, counseling, or medication management)? (Please check all of the diagnoses that apply) (American Psychiatric Association, 2022, pp.11-12)
   □ Anxiety Disorders
   □ Bipolar and Related Disorders
   □ Depressive Disorders
   □ Dissociative Disorders
   □ Elimination Disorders
   □ Feeding and Eating Disorders
   □ Neurodevelopmental Disorders
   □ Obsessive Compulsive Disorders
   □ Personality Disorders
   □ Schizophrenia Spectrum and Other Psychotic Disorders
   □ Sleep-Wake Disorders
   □ Somatic Symptom and Related Disorders
   □ Substance-Related and Other Disorders
9. How long have you provided assessment, counseling or medication management for African Americans with anxiety disorder?

- Less than a year
- 1 to 4 years
- 5 to 9 years
- 10 to 15 years
- 15 to 20 years
- Over 20 years
- Other

10. What is your current job title? (Please fill out below):

11. What is your current job setting? (Please check off response that apply or write the response that best matches your job setting?)

- College Counseling Center at Historically Black College/University
- College Counseling Center at a Predominantly White Institution
- Community Mental Health Agency
- Correctional Facility
- Counseling Professional Organization
- Employee Assistance Program (EAP)
- Hospital
- Medical Clinic
- Private Practice
- Recovery Residential Facility
- School (Elementary, Junior or High School)
- Substance Abuse Treatment Program
- Other (please specify):

12. What are your specific job related duties? (Please check off task(s) you complete most often at your place of employment?)

- Assessment
- Case Management
- Counseling
- Consultation
- Diagnosis
- Medication Management
- Outreach
- Presentations
- Referral
13. What population of clients do you work with in terms of age group?
   - [ ] Children
   - [ ] Adolescents
   - [ ] Young Adults (Age 18 to 25)
   - [ ] Adults
   - [ ] Senior or Geriatric Population

14. What population of clients do your work with in regards to racial background please check all that apply:
   - [ ] American Indian or Alaska Native
   - [ ] Black or African American
   - [ ] Hispanic or Latino
   - [ ] Middle Eastern or North African
   - [ ] Native Hawaiian
   - [ ] White or Caucasian American
   - [ ] Biracial or Multiracial (please describe) ________________________________
   - [ ] Other ________________________________
Appendix G

Interview Script

Interview Date: __________________________

Researcher Introduction

Thank you for participating in the study. The specific nature of this study is to understand behavioral health professionals’ perception of the presentation of anxiety disorders amongst African American clients. This interview is part of my data collection for my dissertation. Your interview responses are confidential, and all videotaped and audiotaped interviews and notes will be kept in a secure location. Study participation is voluntary and if you no longer want to participate there is no consequence from withdrawing participation. Please feel free to ask questions, and I look forward to interviewing you today.

Opening Questions

1. Tell me about what motivated you to become a behavioral health professional?
   - Any mentor in behavioral health
   - Any fun facts

2. What interests you in working with anxiety disorders?

Main Questions

3. What do you think about anxiety disorders in general?

4. Please describe your experience working with African American clients with anxiety disorders?

5. What does it mean to you to diagnose African American clients with one of the anxiety diagnoses in the Diagnostic and Statistical Manual of Mental Disorders?

6. What screenings, assessments or information do you utilize to diagnose African American clients with anxiety disorders?

7. What counseling or therapeutic interventions do you utilize when working with African American clients with anxiety disorders?
8. Tell me about the referrals or resources you provide for African American clients with anxiety disorders?
   • When do you make referrals and how?

9. How prepared do you feel working with African American clients with anxiety disorders?
   • Steps to feeling prepared
   • If you don’t feel as prepared, what preparations would be useful?

10. What is your overall perception of how anxiety disorders present amongst African American clients?
    • Symptom presentation across gender? Across socioeconomic status?
    • Confirmations/Surprises

11. How has your background influenced your perception of anxiety disorder presentation with African American clients?
    • Ethnicity, age, gender, sexual orientation, language, socioeconomic status, educational background, etc.

12. What creative resources in terms of flyer, brochures, presentations, journal articles, books, clinical practice website information that you have created or wrote for your clinical practice experience with anxiety disorders?
    • Would you be willing to bring those materials to the follow up interview?

13. What are your recommendations for current and future graduate students in behavioral health fields or behavioral health professionals working with African American clients with anxiety disorders?

14. What else would you like to discuss about African American clients and anxiety disorders?

   Interviewer Response: Thank you for taking the time out and answering these questions. Your responses are quite helpful. I work with clients with anxiety disorders, and you have opened up a more comprehensive perspective on your experiences, expertise, and openness to participate in this study.

References
National Alliance of Mental Illness (2020, April). *Types of mental health professionals.*

Retrieved from [https://www.nami.org/learn-more/treatment/types-of-mental-health-professionals](https://www.nami.org/learn-more/treatment/types-of-mental-health-professionals)
Appendix H
Thank You Email

Dear Participant:

Thank you for taking the time out to interview and provide your perspective which is instrumental for this research study. It was an enriching dialogue to add more awareness to this topic.

Sincerely,

Chantel K. Gant, MEd, LPC-S, LAC, NCC
Doctoral Candidate, Counselor Education
University of New Orleans
Appendix I

Peer Debriefing Confidentiality Form

I, ______________________ agree that I will maintain “confidentiality” of interview transcripts, reflexive journal, findings, and materials that Chantel K. Gant provides for her research study titled, “Behavioral Health Professionals’ Perception of Anxiety Disorders Amongst African American Clients” that will be utilized for peer debriefing purposes only for data analysis and reflection.

All interview transcripts will have no identifying name or information and will only consist of interview number or pseudonym where there will be no disclosure from the peer debriefer of any information from the interview transcripts.

The peer debriefer will not upload the interview transcripts to any third-party services.

The peer debrief agrees to not disseminate any documents regarding this research study to anyone else or to duplicate any research materials.

The peer debriefer agrees to not upload any research “related documents” for this study to one-drive or any cloud-based storage services.

The peer debriefer will maintain all research “related documents” for this study in a “secure location” where only the peer debriefer has access to the materials.

The peer debriefer agrees that no research “related documents” for this study will be saved on their computer, laptop, electronic devices, flash drive or any other location for later use and not digitally stored where all information is immediately deleted from computer or laptop as well as “hard drive” at the completion of the study.

______________________        _________________________
Peer Debriefer Signature                   Peer Debriefer Printed Name

Date

References:

Agreement. [Form]. *University of New Orleans Theses and Dissertations.*

https://scholarworks.uno.edu/td/1695


https://scholarworks.uno.edu/td/2509
Vita

The author was born at Keesler AFB in Mississippi and grew up in New Orleans, Louisiana. She received her Bachelor of Science degree in psychology from Xavier University of Louisiana and Master of Education degree in professional counseling from the University of Georgia. Her job experiences include currently working at a HBCU counseling center for over 13 years where she has served in roles including counselor, associate director, and wellness educator/counselor. Her prior job experience included working in the substance abuse counseling field. She has credentials as a licensed professional counselor and a board approved supervisor, licensed addiction counselor, and national certified counselor. Her experiences include providing several presentations on varied behavioral health topics, coordinating campus wellness programs, and serving as advisor for peer health educators and a student mental health organization.