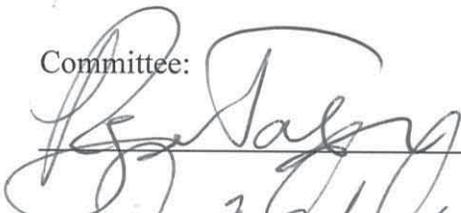


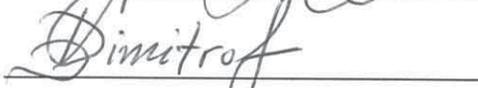
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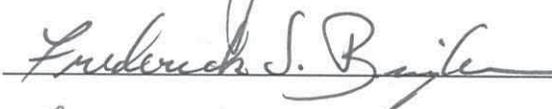
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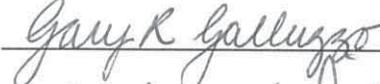
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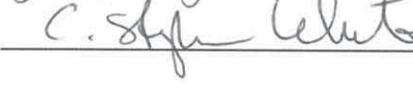
Committee:


_____ Chair






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_____ Dean, College of Education and Human
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Fairfax, VA

The Relationship between Racial Identity Schemas, Cultural Mistrust, and Help-Seeking
Attitudes as Predictors of Prospective Black Clients' Willingness to Seek Counseling
from White Clinicians

A Dissertation submitted in partial fulfillment of the requirements for the degree of
Doctor of Philosophy at George Mason University

by

Nicole L. Woodard
Master of Education
Teachers College, Columbia University, 2008
Master of Arts
Teachers College, Columbia University, 2008
Bachelor of Arts
University of California, Irvine, 2006

Director: Regine Talleyrand, Associate Professor
College of Education and Human Development

Spring Semester 2014
George Mason University
Fairfax, VA

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DEDICATION

This research project is dedicated to my father, Pedro Woodard. Though you've been gone for 25 years, your love continues to pour down from Heaven as a comforting shield. I can only hope to accomplish as much as you did when you graced this Earth. I love you endlessly. This project is also dedicated to my mother, Pamela Johnson, my grandparents, John and Ann Johnson, and my doggy babies, Sage, Pepper, and Cinnamon. Each of you have remained my foundational rock and my abundant river of unyielding, persistent love, support, and encouragement. My love for you is to the core. I am because we are. This is for you.

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ABSTRACT

THE RELATIONSHIP BETWEEN RACIAL IDENTITY SCHEMAS, CULTURAL MISTRUST, AND HELP-SEEKING ATTITUDES AS PREDICTORS OF PROSPECTIVE BLACK CLIENTS' WILLINGNESS TO SEEK COUNSELING FROM WHITE CLINICIANS

Nicole L. Woodard, Ph.D.

George Mason University, 2014

Dissertation Director: Dr. Regine Talleyrand

Historically, people of African descent have been characterized as a population plagued with higher rates of mental illness when compared to their White counterparts. Yet, evidence exists that Blacks are less likely to use mental health services when compared to all other racial and ethnic groups in the United States. Potential factors for Blacks' lack of utilization of mental health services include cultural and racial mistrust of the mental health system, stigma associated with mental health, and educational barriers. However, research in this area is greatly lacking. The current study aimed to examine the potential impact of cultural mistrust, racial identity schemas, and help-seeking attitudes on the willingness of prospective Black clients to seek professional mental health services from a White clinician or a clinic primarily staffed by Whites.

This study examined racial identity schemas, cultural mistrust, help-seeking attitudes, and demographic variables (e.g., race/ethnicity, gender, etc.) as related to prospective Black clients' willingness to seek counseling from a White clinician. The nationwide sample consisted of 740 self-identified African American or Black adult participants (335 males, 405 females). Each respondent completed the following instruments: Attitudes Toward Seeking Professional Psychological Help Scale – Short Form (ATSPPHS-S), Client Willingness Scale (CWS), Racial Identity Attitude Scale (RIAS-B), Cultural Mistrust Inventory (CMI), and Background Information Questionnaire (BIQ). Four hypotheses were tested using descriptive statistics, reliability analyses, one-way ANOVA, chi-square analyses, Pearson correlation, multiple regression, and a variant of structural equation modeling called path analysis. Findings of the one-way ANOVA revealed that participants who completed the electronic survey, and who were college educated, had more positive help-seeking attitudes than those participants who completed the surveys by paper and those who had little to no college education. Findings of the chi-square analysis revealed a significant difference in primary coping mechanisms by sex, consideration of counseling by sex, and prior counseling experience by sex. Findings also revealed a statistically significant relationship between participants' educational attainment and survey formatting, and student status and survey formatting. Pearson correlation resulted in significant relationships for client willingness with help-seeking attitudes, racial identity schemas, and cultural mistrust. Racial identity, help-seeking attitudes, and cultural mistrust significantly predicted prospective Black clients' willingness to seek counseling from a White clinician. Finally, path analysis revealed a

statistically significant direct effect of cultural mistrust, racial identity schemas, help-seeking attitudes, and consideration of counseling on the willingness of Black clients to seek counseling from a White clinician. Results from this study could assist practitioners and researchers in isolating specific factors that influence Blacks' perceptions and utilization of mental health systems.

CHAPTER ONE

Introduction

Throughout history, some research has reported that people of African descent have been plagued with higher rates of mental illness when compared to their White counterparts (Breslau, Kendler, Su, Gaxiola-Aguilar, 2005; Buser, 2009; Institute of Medicine, 2003; Robin & Regier, 1991). For example, Blacks have higher incidences of phobias and somatization complaints, such as pain, gastrointestinal, and sexual and pseudo-neurological symptoms when compared to other ethnic/racial groups (Parham, 2002). Further, Blacks are overrepresented among patients diagnosed with schizophrenia (Whaley, 2012). Some research suggests that higher incidences of mental illness amongst Blacks may be due to contextual factors, such as family rearing (Schnittker et al., 2000), general stress (Pieterse, Carter, & Ray, 2013; Kessler, 1997), race-related stress (Pieterse & Carter, 2007), racism (Carter, 2007; Williams & Mohammed, 2009), and racial discrimination (Ashburn-Nardo et al., 2007; Jones, Cross, & DeFour, 2007; Lee & Ahn, 2013; Rivas- Drake, Hughes, & Way, 2008). Moreover, misdiagnosis, labeling, and brainwashing (Thompson, Bazile, & Akbar, 2004); over-diagnoses (David, 2010); cultural mistrust of mental health systems (Irving & Hudley, 2005; Phelps, Taylor, & Gerard, 2001; Terrell et al., 2001; Thompson et al., 1990; Whaley, 2001a, 2001b), lack of education regarding mental health services (Hines-Martin et al., 2004), stigma or shame

(Constantine, Chen, & Ceesay, 1997; Knipscheer & Kleber, 2001; Narikiyo & Kameoka, 1992), and culturally inappropriate assessments (Whaley, 2011) can potentially serve as barriers for seeking psychological treatment. Consequently, it is no surprise that Blacks are less likely to use mental health services when compared to all other racial and ethnic groups in the United States (O’Sullivan et al., 1989; Sanders-Thompson, Bazile, & Akbar, 2004; Sue, 1977; Snowden, 1999; Sussman, Robins, & Earls, 1987; Whaley, 2001). Furthermore, Obasi and Leong (2009) assert that psychological help-seeking barriers (e.g., cultural mistrust, disclosure of personal information to strangers, difference in worldview, etc.) may be triggered as experiences of psychological distress increase, thus leading to a more negative attitude toward seeking mental health services.

Given the prevalence of certain contextual factors and potential psychological help-seeking barriers, negative views of mental health maintained by Blacks might inadvertently be reinforced. For prospective Black clients, disparities in the accessibility, availability, and utilization of psychological services is well documented (Snowden, 1999; Sue, 1988; Sue et al., 1991; U.S. Department of Health and Human Services, 2001) and may have contributed to the feelings of mistrust that some Blacks have toward Whites and White-dominated systems, coupled with the limited number of Black counseling professionals (Whaley, 1998a, 2001).

As a result of these potential barriers for Blacks, it may be important to examine, in depth, the factors that contribute to a Black individual’s decision to seek mental health assistance, specifically from a White clinician or a clinic primarily staffed by Whites. The

next section will discuss several sociocultural factors that could potentially contribute to Blacks' perceptions of the mental health care system in the United States.

Factors Related to Blacks' Attitudes Toward Mental Health

Researchers have examined many factors that contribute to the attitudes of Blacks toward the mental health system. For the purpose of this study, cultural mistrust, racial identity schemas, preference for a clinician's race, and attitudes toward psychological counseling will be introduced as significant contributors that may influence Blacks' approach to seeking mental health services.

Attitudes Toward Seeking Help and Cultural Mistrust

According to Terrell and Terrell (1981) cultural mistrust might be used to explain why Blacks underutilize some mental health facilities. Cultural mistrust is described as the "theoretical level of suspiciousness and distrust Black people exhibit toward White educational systems, political activities, business interactions, and interpersonal and social contexts" (Terrell et al., 2009, p. 299), or simply the extent to which Blacks mistrust Whites (Terrell & Terrell, 1981). Attitudinal studies suggest that mistrust of clinical investigators is strongly influenced by sustained racial disparities in health, limited access to healthcare, and negative encounters with healthcare providers (Boulware et al., 2003; Halbert et al., 2006; Lichtenberg et al., 2004). There is a wealth of literature that explains the reasons in which people of color mistrust medicine, in general, and the mental health system, in particular. One of those reasons are associated with the troubling history of racism entrenched in medical research, diagnosis, and clinical management (Adebimpe, 1981; Bell & Mehta, 1980; Bell et al., 1985; Bhugra & Bhui,

1999; Corbie-Smith, Thomas, & St. George, 2002; Sue, 1999; Williams & Williams-Morris, 2000). More discussion of this topic will be covered in Chapter Two.

Although issues, such as mistrust, impact each Black individual differently, mistrust underlies Black psychological development and is important in establishing a cultural context for the counseling interaction (Ahia, 1984). Specifically, several theorists propose that Blacks' mistrust of Whites is a healthy, adaptive characteristic in that it allows an individual to be aware of the negative components of the Black experience in America, such as racism and discrimination (Grier & Cobbs, 1968; Newhill, 1990; Sue, 1981; White, 1980). Conversely, Bell and Tracey (2006) found that due to the demographic composition of the United States, a certain degree of trusting Whites is necessary for psychological health and daily functioning of Black individuals because of Blacks regular interaction with Whites in many settings (e.g., schools, business, etc.). Other researchers have found that Blacks with high levels of cultural mistrust had lower expectations of White clinicians and were less disclosing to White clinicians (Thompson et al., 1994). Watkins and Terrell (1998) found that highly mistrustful Blacks rated a White clinician less favorably on measures of clinician genuineness, self-disclosure, acceptance, trustworthiness, outcome, and expertise than did Blacks low on mistrust. Subsequently, another issue to consider is the clinician's race since Black clients' unwillingness to disclose to White clinicians may have a significant impact on a Black client's preference for their clinician's race (Townes, Chavez-Korell, & Cunningham, 2009).

Preference for Race of Clinician and Attitudes Toward Seeking Help

Another reason why Blacks may not access mental health systems may be due to the fact that a limited number of Black mental health professionals are working within the field. Black psychologists represent just under two percent of the mental health profession (APA Online, 2007), so the chance of seeking psychological help from a Black psychologist is nearly impossible in many parts of the country due to “hyper-segregation: a five-dimensional measure of a minority group’s residential segregation patterns with regard to evenness, exposure, concentration, centralization, and clustering” (Wilkes & Iceland, 2004, p. 23). For example, one out of every four Black people live in New York, Georgia, and Florida; three-fifths of the Black population reside in 10 states; 40 percent live in the south; 56 percent live in cities; and Black people are the only racial or ethnic group that reside in conditions of concentrated poverty across all five dimensions of hyper-segregation simultaneously (Massey, 1990; Massey & Fischer, 2000; U.S. Census Bureau, 2001; Wilkes & Iceland, 2004). Therefore, with the limited number of Black counseling professionals (Whaley, 1998a, 2001), prospective Black clients considering counseling services have very little chance of seeing a Black mental health clinician, regardless of their preference for a Black clinician (Townes, Chavez-Korell, & Cunningham, 2009).

For years, researchers have offered research participants a choice between a Black clinician and a White clinician, whereas the vast majority of prospective Black clients have no such options available (Townes, Chavez-Korell, & Cunningham, 2009). Thus, many prospective clients that consider counseling will have to see White clinicians since

78.8 percent of White men and 80.7 percent of White women make up the counseling profession (ACA Online, 2010). Though Black clients may be forced to see a White clinician, they may be unwilling to disclose sensitive and personal information to a White clinician based on issues of mistrust (Ridley, 1984). Several authors have suggested that when examining minority attitudes toward counseling or preferences for an ethnically similar clinician, Black racial identity could be a useful construct to explore given that it pertains to how a person internalizes his or her racial group membership (Atkinson, 1983; Casas, 1984; Cimboric et al., 1981; Jackson & Kirschner, 1973; Parham & Helms, 1981).

Attitudes Toward Seeking Help and Racial Identity Schemas

Racial identity has been linked to the psychological well-being of African Americans (Horowitz, 1939; Sellers et al., 2003). Racial identity can be defined as a “sense of group or collective identity based on perception that one shares a common racial heritage with a particular group” (Helms, 1990; Phelps, Taylor, & Gerard, 2001, p. 210). According to Constantine, Warren, and Miville (2005, p. 490), racial identity schemas (formerly known as stages, statuses, or attitudes) are defined as “the dynamic cognitive, emotional and behavioral processes that govern a person’s interpretation of racial information in her or his interpersonal environments.”

Austin, Carter, and Vaux (1990) examined whether racial identity impacted Black students’ attitudes toward counseling and counseling centers. Their findings suggested that a relationship exists between racial identity schemas and attitudes toward counseling, particularly, the effectiveness of counseling and the counseling process, such that Black students with predominantly Pro-White/Anti-Black racial identity schemas perceived

counseling as an effective source of help. Therefore, it appears that how one identifies with their racial group membership may impact how they view the counseling process. Researchers have also associated racial identity with cultural mistrust by assessing their impact on a Black client's preference for their clinician's race. They found that Blacks' high levels of cultural mistrust of Whites and White culture was positively correlated with the Immersion-Emersion state of racial identity schemas, which is defined as a rejection & disdain of White people and White culture (Townes, Chavez-Korell, & Cunningham, 2009).

Racial Identity Schemas and Cultural Mistrust

Shelton and Sellers (2003) found that Blacks, whose race was a central component to their identity, were more likely to attribute an ambiguous discriminatory event to race compared to Blacks for whom race was a less central component of their identity. This can be problematic in the cross-cultural counseling relationship because attributing discriminatory attitudes on the part of the clinician, can establish, or reinforce the notion of cultural mistrust. Further, Phelps, Taylor, and Gerard (2001) explored whether cultural mistrust, ethnic identity, and racial identity schemas of Black college students impacted self-esteem. Results demonstrated that cultural mistrust, ethnic identity, and racial identity accounted for .37 of the variance in self-esteem for Black students. The results of this study suggest that high cultural mistrust, and Pro-Black/Anti-White racial and ethnic identity attitudes are positively related to self-esteem.

Given the barriers discussed above (e.g., cultural mistrust, racial identity schemas, help-seeking attitudes, and preference for same-race clinician) that may impede on

Blacks' help-seeking behaviors, and the therapeutic process when counseling Blacks, it appears necessary to explore these constructs in association with a client's willingness to seek counseling from Whites, as a means of increasing positive attitudes and behaviors of prospective Black clients. Additionally, the lack of current research surrounding this specific area underscores the need for this study.

Statement of the Problem

A number of studies have used data from Black college students, particularly at predominantly White universities, which makes it impractical for researchers and practitioners to generalize the findings to the Black population in general, due to the age range of traditional college students, educational levels, availability of resources, etc. It is the researcher's contention that using a non-college educated sample, in addition to a college-educated sample, may result in alternate findings related to Black clients' willingness to seek counseling from a White clinician. If the two samples are compared, specific factors, such as cultural mistrust, racial identity schemas, and help-seeking attitudes, may have a different impact on each sample's willingness to seek counseling from a White clinician. Also, recent literature does not collectively examine the relationship between cultural mistrust, racial identity schemas, and attitudes toward counseling as a significant influence on prospective Black clients' willingness to seek counseling from a White clinician. Further, the empirical studies that have been conducted discuss preferential attitudes of Black clients for a White or Black clinician which may not be useful since Black clients may not have a choice in which clinician will render counseling services based upon their preference.

Significance of the Problem

Simultaneously examining racial identity schemas, cultural mistrust, and help-seeking attitudes on the willingness of prospective Black clients to seek counseling from a White clinician, rather than exploring these factors as paired or individual constructs, can reveal which construct has a stronger or weaker relationship to client willingness when controlling for other factors. This is important because mental health providers can use this information to assist Black individuals in seeking appropriate mental health services and to help build healthy cross-cultural counseling relationships between Black clients and White clinicians. In addition, examining all three constructs together can uniquely predict prospective Black clients' willingness to seek counseling from a White clinician.

Further, it is important to focus research on a non-college educated sample because their experiences may differ from those individuals who are currently attending, or previously attended, a college or university. For example, the reason(s) for a non-college educated individual to seek counseling services (e.g., the inability to provide for their household, job stress, etc.) may differ from a college-educated sample (e.g., final exam pressures, difficulty with an instructor, trouble selecting a major, graduate school admission testing, etc.). Similarly, college students may also have easier access to counseling services, which is typically provided via the institution, whereas the general, non-college educated sample may not readily have access to counseling services. Also, while relying on a social support network (e.g., family, friends, community leaders, etc.) has worked for many Blacks in addressing mental health concerns, some mental health

issues are beyond the scope of knowledge and expertise in which individuals from these social networks hold. Thus, it is critical that a trained mental health professional is sought and utilized. Likewise, some individuals are not privy to, or do not have access to, such a rich source of social support. For example, those college students attending institutions at a considerable distance from their support network (e.g., out-of-state colleges or universities) may be forced to seek traditional counseling services made available by the institution, such as the counseling center, due to proximity.

Moreover, Black clinicians are represented in the mental health field at a rate of 12.5 percent (ACA Online, 2010), with Blacks comprising of 12.6 percent of the U.S. population (U.S. Census Bureau, 2010). While the percentage of Black counseling professionals reflects the Black population in the U.S., what remains unknown is the percentage of practicing counseling professionals. What is also unknown is the percentage of Black clinicians practicing in areas where there is a high concentration of Blacks with a high need of mental health services. Because research suggests that Black clients generally prefer Black clinicians (Atkinson, 1983; Coleman, Wampold, Casali, 1995; Speight & Vera, 1997; Thompson, Bazile, & Akbar; 2004) it creates a problem when Black individuals are underrepresented in the mental health profession and overrepresented among populations that have a high need for mental health services. Black men and women are more likely to receive treatment in emergency circumstances (Hu et al., 1991), and under coerced or mandated conditions (Takeuchi & Cheung, 1998), by providers they may not have selected had they been given an opportunity to choose a mental health professional. Thus, it is likely that a Black client, who makes the decision

to seek counseling or who is mandated by the courts, school, etc., will be paired with a White clinician, or seeks services from a facility that is primarily staffed by White clinicians because of the shortage of Black mental health clinicians.

Additionally, based on the research surrounding Blacks and the mental health profession, there is little known of how to adequately assist Black individuals who are in need of mental health services. First, we know more about treating mental illness than how to prevent it (Parham, 2002). Second, the mental health field is plagued by disparities in access to treatment (Parham). Lastly, fairly little is known about treating Blacks in a culturally specific context (Parham, 2002).

Finally, research has not adequately addressed the factors that prospective Black clients consider, or do not consider, prior to seeking psychological counseling, specifically seeking psychological counseling from a White clinician. For instance, there is a dearth of existing research that addresses which of these factors serves as the most salient when a Black individual makes the decision to seek counseling from a White clinician. Further, existing research has not adequately examined which of these factors serve as a barrier, and which barriers are most salient, for a Black individual who is not willing to seek counseling from a White clinician, or which factors are least significant when a Black individual decides to seek counseling from a White clinician. Moreover, it is unknown whether cultural mistrust, help-seeking attitudes, and racial identity schemas collectively impact prospective Black clients' willingness to seek counseling from a White clinician. Nickerson, Helms, and Terrell (1994) assert that what remains unclear is the notion of cultural mistrust possibly serving as a barrier between White therapists and

Black clients even before the first contact is made between client and therapist. In addition, racial identity schemas and attitudes toward counseling have not been sufficiently considered as a factor in determining whether or not race is an important issue for the willingness to seek counseling for their mental health concerns.

This study could help the mental health profession develop better outreach to those communities of color, specifically Black communities, so that individuals may consider seeking professional mental health services as a preventive approach, rather than a reactive measure. Better outreach might include educating the Black community on the benefits of counseling services, in attempt to minimize, or eliminate, the stigma surrounding mental health. Additionally, if a Black individual decides to seek counseling, this study could potentially provide White clinicians with a better understanding of the apprehension and resistance that may surface while trying to build the counseling relationship. Moreover, this study could not only highlight the need to train culturally competent clinicians, but also encourage clinicians to always be aware of the biases that may impact the counseling relationship. Research suggests that despite the well-meaning intentions and efforts of White clinicians who think they would never deliberately act in a racist manner toward Black clients (Helms & Cook, 1999; Sue et al., 2007), and who also receive extensive multicultural training (Gushue, 2004), racism often is manifested unconsciously in the counseling process (D'Andrea, 2005; Neville, Worthington, & Spanierman, 2001). Therefore, it is important for clinicians, in general, and White clinicians, specifically, to confront the biases that may manifest during the counseling process, and display a genuineness that cultivates and nurtures the client-clinician

contact. For example, a White clinician who may never have worked with a Black client can authentically reveal his or her lack of experience with this particular group, and attempt to build a relationship from that point forward. Lastly, there is a need to increase the number of licensed Black clinicians, psychologists, and other mental health professionals for those who may feel more comfortable speaking with a clinician that reflects his or her own racial and ethnic background.

Purpose of the Study

The purpose of this study was to examine the potential impact of cultural mistrust, racial identity schemas, and help-seeking attitudes on the willingness of prospective Black clients to seek professional mental health services from a White clinician or a clinic primarily staffed by Whites. A conceptual model of these relationships has been depicted in *Figure 1*. This investigation sought to clarify what relationships may exist between racial identity schemas, cultural mistrust, and Blacks' help-seeking attitudes, in particular. Past studies have identified links between help-seeking attitudes and cultural mistrust (Nickerson, Helms, & Terrell, 1994), help-seeking and racial identity (Austin, Carter, & Vaux, 1990) and cultural mistrust and racial identity (Phelps, Taylor, & Gerard, 2001), yet these studies are limited and dated. This study investigated the collective role of cultural mistrust, racial identity schemas, and help-seeking attitudes on the willingness of prospective Black clients to seek counseling from a White clinician. Further, examination of these constructs will expand the current literature surrounding cultural mistrust, racial identity schemas, and help-seeking attitudes, and develop a greater understanding of how race and culture interact within the field of mental health.

A national sample of self-identified African Americans/Blacks were recruited to participate in this study to determine whether racial identity schemas as measured by the Racial Identity Attitude Scale – Short Form B, level of cultural mistrust as measured by the Cultural Mistrust Inventory, and help-seeking attitudes as measured by the Attitudes Toward Seeking Professional Psychological Help Scale – Short Form predict the willingness of prospective Black clients to seek mental health services from a White clinician or a clinic primarily staffed by Whites, as measured by the Client Willingness Scale.

Theoretical Framework

In an attempt to explore which factors (e.g., cultural mistrust, racial identity schemas, and help-seeking attitudes) impact prospective Black clients' willingness to seek counseling from a White clinician, the researcher provides a theoretical lens in which this study will be viewed and analyzed.

Cultural mistrust can help researchers develop a better understanding of the cultural-related factors that inhibit clients from seeking mental health services, disclosure of personal information, etc. Racial identity schemas can assist researchers in gaining a better understanding of a client's attitude towards their racial reference group, how an individual views himself or herself as part of that specific racial reference group, and how he or she views others that are outside of that racial reference group. Further, racial identity schemas can impact how an individual responds to his or her psychological experiences, and may be linked to behavioral, effective, and cultural predispositions (Coard, Breland, & Raskin, 2001). Finally, help-seeking attitudes provide researchers

with a general sense of a client's perception of the mental health system that includes the potential outcome of the counseling relationship, the effectiveness of counseling, etc.

Definition of Terms

African American or Black. People of African descent who are born in the United States and maintained U.S. citizenship. African Americans represent one of many terms used to categorize as Black Americans. Given that, the terms African Americans and Black Americans or Black people will be used interchangeably.

Attitudes toward seeking professional psychological help/help-seeking attitudes. A tendency to either seek or resist professional psychological aid during crises or after prolonged psychological discomfort.

Clinician/counselor. A person trained to give guidance on personal, social, or psychological problems.

Cultural mistrust. The extent of Blacks to be suspicious of Whites and White-related organizations.

Cultural paranoia. A healthy paranoia that allows Black people to develop and maintain a high degree of suspicion in order to protect themselves from the psychological effects of racial discrimination and persecution from White people.

Historically Black College and Universities (HBCUs). The colleges and/or universities that were traditionally established to facilitate educational and occupational training for Black Americans.

Predominantly White Institutions (PWIs). The colleges and/or universities that were traditionally established to facilitate educational and occupational training for Black Americans.

Racial identity. The degree to which individuals racially perceive themselves and share a common racial heritage with their racial group.

White. People of the Caucasoid race and who descended from people found in Europe and some Middle Eastern nation-states.

Research Question

Do racial identity schemas, cultural mistrust, and help-seeking attitudes predict the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites?

Sub-questions:

- a. How do different levels of mistrust of Whites, racial identity schemas, and attitudes of seeking professional psychological help relate to the willingness of prospective Black clients to seek counseling from a White clinician?
- b. How do different levels of mistrust of Whites, racial identity schemas, and attitudes of seeking professional psychological help relate to the willingness of prospective Black clients to seek counseling from counseling facilities perceived to be primarily staffed by White clinicians?

- c. What is the unique contribution of each independent variable on the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites?
- d. Are the scores on the Cultural Mistrust Inventory, the Racial Identity Attitude Scale, the Attitudes Toward Seeking Professional Psychological Help Seeking Scale, and the Counseling Willingness Scale reliable for this particular sample?
- e. Are the scores on the Cultural Mistrust Inventory, the Racial Identity Attitudes Scale, the Attitudes Toward Seeking Professional Psychological Help Scale, and the Counselor Willingness Scale valid in measuring the targeted constructs of cultural mistrust, racial identity schemas, attitudes toward seeking professional help, and prospective Black clients' willingness to seek counseling from and disclose to a White clinician/clinic primarily staffed by Whites for this particular sample?
- f. What are the similarities and/or differences between participants who attend or have attended college, and participants who have received little to no college education in their willingness to seek counseling from a White clinician/clinic primarily staffed by Whites?

Research Hypotheses

The above research question was explained using the following research hypotheses:

- **Hypothesis 1a:** High levels of Pre-Encounter racial identity schemas will be positively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites.
- **Hypothesis 1b:** High levels of Encounter racial identity schemas will be negatively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites.
- **Hypothesis 1c:** High levels of Immersion-Emersion racial identity schemas will be negatively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites.
- **Hypothesis 1d:** High levels of Internalization racial identity schemas will be positively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites.
- **Hypothesis 2a:** Positive attitudes toward seeking professional psychological help will be positively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites.
- **Hypothesis 2b:** Negative attitudes toward seeking professional psychological help will be positively related to the unwillingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites.

- **Hypothesis 3a:** High levels of cultural mistrust will be negatively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites.
- **Hypothesis 3b:** Low levels of cultural mistrust will be positively related to the unwillingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites.
- **Hypothesis 4:** The college-educated sample will be more willing to seek counseling from a White clinician than the non-college educated sample.

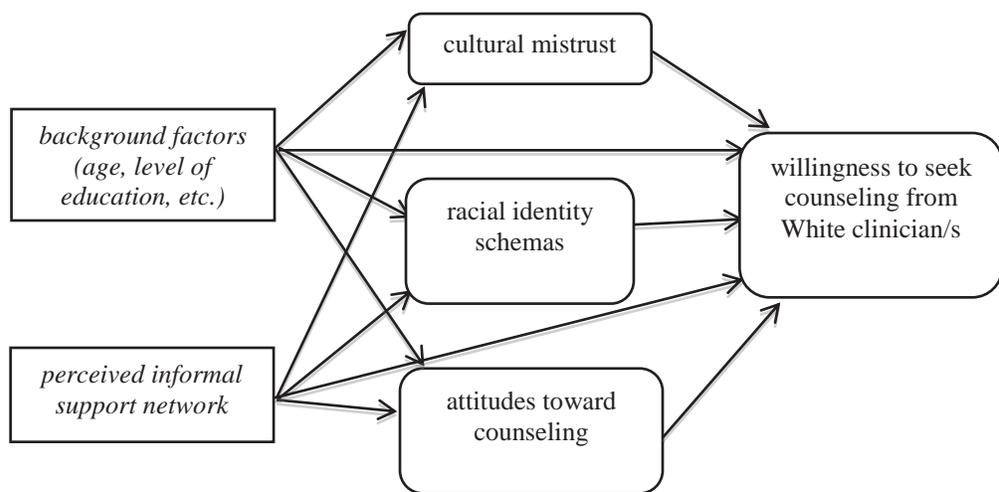


Figure 1. Conceptual model.

The "Racial Identity Schemas" variable is compacted with four schemas: Pre-Encounter, Encounter, Immersion-Emersion, and Internalization. Each schema receives a score indicating the racial identity schema that is most salient.

CHAPTER TWO

Review of the Literature

Historically, Blacks tend to underutilize, prematurely terminate, or make inconsistent use of traditional mental health services (Burkard & Knox, 2004; Kearney Draper, & Baron, 2005; Smedley & Smedley, 2005; Snowden, 2001; Sue, 1988), despite reports of higher prevalence rates of mental disorders among Blacks than in Whites (Regier et al., 1993). Researchers have found that issues such as Black people's mistrust of White people and White-dominated systems (Whaley, 2001), racial identity schemas (Franklin-Jackson & Carter, 2007; Phelps, Taylor, & Gerard, 2001; Pieterse & Carter, 2010), negative attitudes toward counseling (Obasi & Leong, 2009), attitudes toward the stigmas associated with mental illness (Sussman, Robbins, & Earls, 1987), treatment disparities (Parham, 2002), reliance on informal networks of support (Harley & Dillard, 2005; Parham, 2002), and the troubling history of racism entrenched in medical research, diagnosis, and clinical management (Adebimpe, 1981; Bell & Mehta, 1980; Bell et al., 1985; Bhugra & Bhui, 1999; Corbie-Smith, Thomas, & George, 2002; Sashidharan, 1999; Sue, 1999;) may be linked to Black's underutilization of traditional mental health services.

In addition, Black individuals who do seek mental health services may prematurely discontinue therapy (Acosta, 1980; Sue, 1981) given their potential

preference for Black clinicians and the limited number of Black counseling professionals working in the counseling field (Whaley, 1998a, 2001). This literature review will provide a historical perspective on the effect race, racism, discrimination, and prejudice has had on Black people's views on health systems over the past century.

Conceptualization and research on racial identity, cultural mistrust, counselor preference, and help seeking attitudes of Black clients will also be reviewed.

Blacks and Healthcare Systems: A Historical Perspective

Hollar (2004) believes that the history of the slave experience dating from the early sixteenth century and the pervasive devaluation and subjugation of Blacks have left indelible social, biological, and psychological marks on the descendants of all participants in the slavery industry. A potential consequence of being Black in the United States and a descendant of a historical slavery system can have a profound, negative impact in all areas of a Black person's health (Poussaint & Alexander, 2000).

The tumultuous history regarding racism and the health systems date back to the slave era with the medical experimentation of Blacks during slavery as a central foundation (Gamble, 1997). During that time, Harris and colleagues (1996) note that Black bodies were considered to be valuable for experimentation by the medical establishment during the antebellum South, forming the "legacy of mistrust" by Blacks.

They assert:

Southern blacks, helpless and in a lower position in society, became a prime source of medical school dissection experiments and autopsy specimens... This practice continued in the post-bellum South in the form of "night-doctors" who stole and dissected the bodies of blacks (Harris et al., 1996, p. 631).

As a result of these “medical experimentations” and “research”, many scholarly opinions concluded that Blacks were subhuman because they were untrustworthy, sexually promiscuous (Poussaint & Alexander, 2000), innately inclined to submit to authority (Thomas, 1972), and were mentally ill equipped to handle work that was intellectually rigorous (Genovese, 1976). These beliefs deeply impacted the culture of Blacks, eventually instilling a sense of fear and mistrust. There have been many instances of medical abuse towards people of color, specifically Blacks, but no other ethical treatment of Blacks has contributed to the mistrust of the healthcare system and legitimizes the distrust that Blacks have toward the helping profession (Jones, 1997) more than the “Tuskegee Study of Untreated Syphilis in the Negro Male” experiments.

The “Tuskegee Experiment” was conducted between the years of 1932 and 1972 (Jones, 1993). During that time, many Black men participated in this study while under the impression that they would receive treatment for syphilis when, in fact, they did not receive any treatment. As part of its study of the long-term effects of syphilis, the United States Public Health Services denied treatment to 399 poor Black men suffering from the tertiary effects of the disease. Researchers and physicians involved in the “Tuskegee Experiment” also chose not to educate the men regarding treatment or prevention of this social illness. When penicillin drastically altered the treatment of syphilis in the 1940's, the Public Health Services withheld it from the infected participants. They argued that never again would they find such a group of untreated individuals (Jones). Consequently, the United States government willfully agreed to withhold the antidote to the disease. As Blacks are mistrustful of the healthcare system, evidence indicates that same mistrust also

hinder Blacks from participating in research studies. Despite the valiant efforts of the federal government to mandate the inclusion of women and minorities in all federally funded research (National Institutes of Health, 2001), Blacks participation in research continues to be more infrequent than Whites (Scharff et al., 2010).

Due to the history of medical mistrust, Blacks have developed a general mistrust for systems that not only include the mental health system, but also academic and research institutions. Within psychological research, the term cultural mistrust has been used to explain “the belief that African Americans, due to past and ongoing mistreatment related to being a member of that ethnic group, that Whites cannot be trusted” (Terrell et al., 2009, p. 299). Mistrust of academic and research institutions, and investigators, is the most significant attitudinal barrier to research participation reported by Blacks (Calderon et al., 2006; Connell et al., 2001; Corbie-Smith et al., 1999; Corbie-Smith, Moody-Ayers, & Thrasher, 2004; Corbie-Smith, Thomas, & St. George, 2002; Farmer et al., 2007; Freimuth et al., 2001; Hoyo et al., 2003; Sengupta et al., 2000; Shavers, Lynch, & Burmeister, 2001). Its etiology stems from historic events, but is also exacerbated by more current actions (Bates & Harris, 2004; Gamble, 1993; Gamble, 1997; Shavers, Lynch, & Burmeister, 2002), including socioeconomic and healthcare system inequities (Branson, Davis, & Butler, 2007).

From a historical perspective, the “Tuskegee Study of Untreated Syphilis in the Negro Male” is widely recognized as a reason for mistrust because of the extent and duration of deception and mistreatment, and the study’s impact on human subject review and approval (Centers for Disease Control & Prevention, 2009; Department of Health,

Education, & Welfare, 1979; National Institutes of Health, 2004). As recently as the 1990s, unethical medical research involving Blacks has been conducted by highly esteemed academic institutions (Scharff et al., 2010). Washington (2007) describes the history of medical experimentation and abuse by demonstrating that mistrust of medical research and the healthcare infrastructure is extensive and persistent among Blacks, and illustrating that more than four centuries of a biomedical enterprise designed to exploit Blacks is a principal contributor to current mistrust experienced by Blacks. The potential lack of trust also extends to Blacks' views on the mental health systems in the United States.

Cultural Mistrust and Blacks

Some theorists (Grier & Cobbs, 1968; Newhill, 1990; Sue, 1981; White, 1980) assert that Blacks mistrust of Whites, also referred to as cultural mistrust, is a healthy and adaptive characteristic in that it makes an individual aware of negative elements of the Black experience (e.g., racism, discrimination, prejudice). The majority of studies that examine cultural mistrust have used college populations to study the link between cultural mistrust and attitudes toward counseling among Blacks, especially in a cross-racial counseling relationship between a Black client and White clinician. These studies suggest that high cultural mistrust of Whites by Blacks lead to more negative views and expectations of White clinicians (Nickerson, Helms, & Terrell, 1994; Terrell & Terrell, 1984; Thompson, Worthington, & Atkinson, 1994; Watkins & Terrell, 1988; Watkins and Terrell, 1988; Jacobs et al., 2006; Smith et al., 2007).

Cultural Paranoia

Cultural paranoia is another term that has been used in the literature to explain the experiences of Blacks and their relationship to Whites based on the historical experiences of Blacks in the United States (Grier & Cobbs, 1968). Grier and Cobbs (1968) coined the term “cultural paranoia” to describe the healthy, functional high degree of suspicion that Black people needed to develop and to maintain in order to protect themselves from the racial discrimination and persecution of White people. Cultural paranoia allowed Black people “to be suspicious of the motives of every White man and at the same time never allow this suspicion to impair his grasp of reality” (Grier & Cobbs, 1968, p. 161). Such paranoia can cause problems in cross-racial and racially similar counseling relationships. For example, White clinicians may subconsciously and inadvertently be removed from empathizing with a Black client because the historical legacy of Whites mistreatment of Blacks may be too painful, leaving the client to suffer because an intimate knowledge of the client’s experience is vital to effective treatment (Grier & Cobbs, 1968). Also, Grier & Cobb (1968) proposed that Black clinicians may face challenges when working with Black clients because the Black clinician has received mental health training in a primarily White environment and may be experiencing difficulties with his or her own racial identity to provide adequate counseling to a Black client.

Combs et al. (2006) examined the relationship between perceived racism and paranoia across the continuum in a sample of Black college students. In this study, the paranoia continuum included measures of cultural, nonclinical, and clinical paranoia. Respondents were 128 Black college students recruited from three university settings:

private (29%), historically Black (39%), and state-funded (32%) institutions of higher learning. The Perceived Racism Scale (Neilly et al., 1995), The Cultural Mistrust Inventory – Revised (Terrell & Terrell, 1981), The Paranoia Scale (Fenigstein & Venable, 1992), The Personality Assessment Inventory (Morey, 2007), The Self-Consciousness Scale (Fenigstein, Scheier, & Buss, 1975), The Aggression Questionnaire (Buss, & Perry, 1992), The Zung Self-Rating Depression Scale (Zung, 1965), and The Ambiguous Intentions Hostility Questionnaire (Combs et al., 2007) were distributed and completed by each participant. Multiple regression methods were used to determine if perceived racism was predictive of cultural, nonclinical, and clinical levels of paranoia even after controlling for other relevant variables. Results from this study indicated that a clear relationship exists between perceived racism and measures reflecting the lower end of the paranoia continuum (cultural mistrust and nonclinical paranoia). Further, perceived racism was associated with greater levels of anger and hostility and a tendency to blame others for negative outcomes in ambiguous situations. A significant correlation between perceived racism and both cultural mistrust and nonclinical paranoia, indicates the importance of these perceptions for Blacks. In contrast, perceived racism was not predictive of clinical levels of paranoia. The researchers concluded that paranoia among Blacks seem to be largely made up of constructs (perceived racism, hostility) that are based on the subjective perceptions of others' behaviors and motives. These findings suggest that the paranoia experienced by Blacks may not be due to pathological factors, but rather they may be indicative of the traumatic historical experiences of Blacks.

Further, these results suggest that exploring Blacks' perceptions toward Whites may provide some insight into the counseling relationship between Whites and Blacks.

Origin and Development of the Cultural Mistrust Inventory

As previously mentioned, Terrell and Terrell (1981) developed the construct of "cultural mistrust" to describe the theoretical level of suspiciousness and distrust of Blacks toward White educational systems, politicians and political activities, business interactions, and interpersonal and social contexts. The Cultural Mistrust Inventory (CMI) (Terrell & Terrell, 1981) was designed to measure "the tendency of Blacks to be suspicious of Whites and White-related organizations" (Terrell & Terrell, 1981, p. 180). The inventory assessed attitudes and beliefs that impact the way in which Blacks trusted and viewed Whites. Terrell and Terrell determined that these views were assessed in four areas: politics and law, education and training, business and work, and interpersonal relations. Levels of cultural mistrust have been examined in many research studies in conjunction with intelligence, academic and professional expectations, premature termination of counseling services, cross-racial counseling relationships, self-disclosure, and attitudes toward counseling.

Empirical Studies of Cultural Mistrust

Within the past two decades, several empirical studies have examined the relationships between cultural mistrust and academic and psychological variables. For example, Terrell, Terrell, and Taylor (1981) sampled 100 Black male college students to explore the effect race of an examiner and cultural mistrust had on the Wechsler Adult Intelligence Scale (1955) performance of Black college students. The Cultural Mistrust

Inventory was administered and the sample was then randomly assigned to one of six IQ examiners (three Black and three White). A 2 X 2 (High vs. Low Mistrust Level X White vs. Black Examiner) analysis of variance design did not reveal any main effects, except that the examiner's race and the participant's mistrust level interacted to produce significant differences in the IQ scores of the participants. The IQ scores of participants with high cultural mistrust levels whose IQ tests were given by White examiners were significantly lower than those of participants with high cultural mistrust whose IQ tests were given by Black examiners. Black participants with low cultural mistrust who were paired with White examiners scored significantly higher than Black participants with high cultural mistrust who were paired with White examiners.

Terrell and Terrell (1984) also explored whether cultural mistrust and a counselor's race were linked to Black clients' premature termination from counseling. The participants were seeking counseling for a variety of issues, such as marital problems, sexual dysfunctions, anxiety attacks, or mild depression. The participants were separated by male and female, and randomly assigned to one of six different counselors. The counselors were comprised of three White male counselors and three Black male counselors. The clients completed the Cultural Mistrust Inventory and the clinic's standard paperwork during the initial intake session. The counselors were able to assess the client's problem and to create a tentative treatment plan from the intake. Forty-three percent of the Black clients who were seen by White counselors did not return for subsequent counseling sessions. Seventeen percent of Black clients did not return after being counseled by a Black counselor. Terrell and Terrell concluded that there is a

significant relationship between the counselor's race and termination rates of Black clients.

Watkins and Terrell (1988) also examined the effects of cultural mistrust on counseling expectations in Black client – White counselor relationships. Unlike other studies that have used a sample of Black students at predominantly White institutions, this study used Black students attending a predominantly Black college. The researchers sampled 95 Black male and 94 Black female college students at a predominantly Black college in a southwestern city. Participants filled out the Cultural Mistrust Inventory (Terrell & Terrell, 1981), Expectations About Counseling: Brief Form (Tinsley, 1982), and a background information questionnaire. Participants were then assigned to experimental groups based on their level of mistrust. The Expectation About Counseling form was modified to include the word “Black” or “White” next to describe the counselor in the two experimental groups. The researchers used a two (client sex) X two (mistrust level) X two (counselor race) factorial. The trust level was found to significantly affect the Black subjects’ expectations about counseling (Watkins & Terrell, 1988). Highly mistrustful participants viewed the White counselor less favorably than they viewed the Black counselor with regard to the expectations. Watkins and Terrell (1988) concluded that counseling a highly mistrustful Black client may impede on the ability of a White counselor to be therapeutically effective. The researchers concluded that it might be necessary to attend to the needs of the mistrustful Black client in Black client – White counselor relationships.

Watkins et al., (1989) conducted a study to extend the earlier findings of the Watkins and Terrell (1988) research study by examining the effects of cultural mistrust on different variables in Black – White counseling relationships. Watkins et al. investigated the following additional variables: subjects' perceived confidence in the counselor to help them solve various problem areas, perceptions of counselor credibility, and subjects' perceived willingness to return for a follow-up visit to the counselor. 60 Black male and 60 Black female college students who attended a predominantly Black college were given the Cultural Mistrust Inventory (Terrell & Terrell, 1981), the Counselor Effectiveness Rating Scale (CERS) (Atkinson & Wampold, 1982), a Personal Problem Inventory (Cash, Begley, McCown, & Weise, 1975), a Willingness to See the Counselor item, and a background information questionnaire. Participants received identical descriptions of an experienced doctoral level psychologist, with one half seeing a Black psychologist and the other half a White psychologist. Then, participants were assigned to experimental groups based on their level of cultural mistrust, either high vs. low levels. Participants' sex, counselor race, and level of mistrust created a 2 X 2 X 2 design. A multivariate analysis found a significant interaction effect between the participants' level of mistrust and the race of the counselor. These findings revealed that Black students with high levels of mistrust viewed White counselors as less credible (Watkins et al.). The researchers also concluded that regardless of the counselor's race, highly mistrustful Blacks perceived counselors as less able to help them with sexual functioning problems. Further, highly mistrustful students had the most difficulty

discussing problems of self-definition/self-presentation and relationship issues (Watkins et al.).

Poston, Craine, and Atkinson (1991) also expanded upon the Watkins and Terrell (1988) study. Poston, Craine, and Atkinson investigated the relationship between cultural mistrust, counselor dissimilarity confrontation, and Black clients' willingness to self-disclose. Counselor dissimilarity confrontation was described, as "White counselors need to confront openly the racial difference between them and their Black clients rather than project an image of color blindness" (Poston, Craine, & Atkinson, 1991, p. 66). Twenty-two Black male and 31 Black female consumers from a community center program in southern California were sampled. The Cultural Mistrust Inventory (Terrell & Terrell, 1981), the Counselor Effectiveness Rating Scale (Atkinson & Wampold, 1982), and the Self-Disclosure Scale (Poston, Craine, Atkinson, 1991) were given to the participants (Plasky & Lorion, 1984). Gender, race, and counselor confrontation variables for each counselor were manipulated through the use of false resumes and application letters. The researchers used a correlational design with two criterion variables (client willingness to self-disclose and perceived counselor credibility) and six predictor variables (client sex, counselor sex, income, education, cultural mistrust, counselor confrontation philosophy). The researchers found an inverse relationship between counselor effectiveness and credibility, and cultural mistrust, such that Blacks general mistrust of Whites negatively impact their perception of a White counselor as a credible source of help. Moreover, evidence was found that a Black client's willingness to self-disclose to a White counselor increases with more income and decreases with more education.

Ahluwalia (1991) explored the cultural mistrust levels of African Americans, Native Americans, Hispanics, and Asian Americans in relation to their attitudes toward mental health services for their children. A strong positive correlation between cultural mistrust and dissatisfaction with and unwillingness to seek mental health services was evident for Black and Native American parents but not for Hispanic and Asian American parents (Ahluwalia, 1991). Thus, “trust” factors may be more relevant to Black and Native American clients versus clients from other racial and ethnic groups.

Thompson, Worthington, and Atkinson (1994) studied the effects of cultural mistrust and participant self-disclosures to determine if counselor-content orientation was related to the depth of disclosures. The study used a sample of 100 Black undergraduate females. The participants were given the Cultural Mistrust Inventory (Terrell & Terrell, 1981) and the Counselor Expertness Rating Scale (Atkinson & Carskaddon, 1975). Subjects participated in a 35 – 45 minute counseling session with a doctoral student in counseling psychology. Presenting problems of the participants could be either real or contrived. Counselors were trained to use a client-centered (Rogerian) intervention. A two (cultural/universal content) by two (counselor race) by two (high/low mistrust) factorial design was used. Results showed that participants with high cultural mistrust disclosed the least amount of information to White counselors.

Nickerson, Helms, and Terrell (1994) investigated the relationship among Black students’ levels of mistrust of Whites, their opinions about mental illness, and their attitudes toward seeking professional psychological help from mental health clinics perceived to be staffed by primarily White counselors. Participants received the Cultural

Mistrust Inventory (Terrell & Terrell, 1981), Help-Seeking Attitude Scale (Plotkin, 1983), the Reid-Gundlach Social Satisfaction Scale (Reid & Gundlach, 1983), and the Opinions About Mental Illness Scale (Cohen & Struening, 1962). Results of the study showed higher levels of cultural mistrust were related to more negative attitudes toward seeking psychological help from White counselors. “Cultural mistrust was found to be the most consistent and powerful predictor of help-seeking attitudes of Black students” (Nickerson, Helms, & Terrell, 1994, p. 382). However, the study did not reveal consistent relationships between opinions about attitudes regarding mental illness. Similar to previous studies, Blacks who exhibited a high level of mistrust of Whites harbored negative attitudes about seeking mental health from a clinic staffed by mainly White counselors. This study provides further evidence of the relationship between cultural mistrust and Blacks’ attitudes toward seeking psychological help.

In a more recent study, Phelps, Taylor, and Gerard (2001) examined the within-group differences among Black college students. Black (African, African American, and West Indian/Caribbean) university students’ racial identity, cultural mistrust, ethnic identity, and self-esteem were explored. The study sampled 160 undergraduate and graduate students who attended a large, public, predominantly White, southeastern university. The African group consisted of 26 students (10 women, 16 men), the African American group comprised of 110 students (81 women, 29 men), and the West Indian/Caribbean group was made up of 24 students (19 women, 5 men). Students were given the Cultural Mistrust Inventory (Terrell & Terrell, 1981), the Multigroup Ethnic Identity Measure (MEIM) (Phinney, 1992), the Racial Identity Attitude Scale, Long Form

(Helms, 1990), the Rosenberg Self-Esteem Scale (RSE) (Rosenberg, 1979), and a background questionnaire. For the purposes of the study, only the Education and Training, and Interpersonal subscales of the Cultural Mistrust Inventory were used. Results indicated that African American students' scores were statistically different on ethnic identity, cultural mistrust, and racial identity than African and West Indian/Caribbean students. African American students scored higher than both groups on mistrust of Whites in the areas of education and training and interpersonal relations, and Internalization racial identity schemas. Also, African American students scored lower than both groups on the Other-Group Orientation scale. Using multiple regression analysis, cultural mistrust, ethnic identity, and racial identity accounted for 37 percent of the variance in self-esteem of African American students, whereas those same factors did not significantly impact the self-esteem of the African and West Indian/Caribbean participants. These results suggest that the concept of cultural mistrust and racial identity may be more relevant for Blacks born and raised in the United States given the historical experiences of Blacks in the United States. No significant differences were found between the groups on self-esteem.

Whaley (2001) examined the association between cultural mistrust and beliefs about white mental health clinicians among African Americans recently admitted to a psychiatric hospital. The Cultural Mistrust Inventory (Terrell & Terrell, 1981), the Fenigstein Paranoia Scale (Fenigstein & Venable, 1992), and the Need for Approval and False Beliefs and Perceptions subscales of the Psychiatric Epidemiology Research Interview (Dohrenwend et al., 1980) were used as independent measures. As dependent

measures, three true/false questions were asked of participants regarding their beliefs about white clinicians. The instructions to the participant were as follows: “Indicate whether you believe the following statements about clinicians (i.e., doctors, therapists, or counselors) are ‘true’ or ‘false’ – a) ‘Black clinicians and white clinicians are equally good in diagnosing my mental health problems.’” The vagueness of the questions was intentional to safeguard against any discomfort felt on behalf of the patient. Results from a univariate regression analysis of the data concluded participants with high levels of cultural mistrust tended to agree that people prefer ethnically and racially similar clinicians and that white clinicians receive better mental health training. Specifically, the Black patients with severe mental illness are more comfortable with Black clinicians, even though they believe that white clinicians are better trained.

Benkert et al., (2009) examined the relationships between cultural mistrust, medical mistrust, and racial identity, and predicted patient satisfaction among African American adults who are cared for by primary-care nurse practitioners. The Cultural Mistrust Inventory (Terrell & Terrell, 1996), the Trust in Provider Scale (Anderson & Dedrick, 1990), the Black Racial Identity Attitude Scale (Helms, 1990), the Group Based Medical Mistrust Scale (Thompson et al., 2004), and the Michigan Academic Consortium patient-satisfaction questionnaire (Benkert et al., 2002) were used as measures in this study. The sample of 100 patients were predominantly female (69%) with a mean age of 56 ($SD = 14.5$). Seventy-one percent of the patients self-identified as African American, 27 percent as Black, one percent as Afro-American, and one percent as American. The nurse practitioners ($n = 100$) were all female, whereby most nurse practitioners self-

identified as African American (47%). The other nurse practitioners self-identified as Caucasian (50%) and White (3%). Results from a stepwise linear regression analysis of the data concluded that the patients were highly satisfied and moderately trustful of their nurse practitioners, despite having moderate levels of mistrust of the healthcare system (medical mistrust) and mistrust of European Americans (cultural mistrust). Female gender, trust in nurse practitioners, race concordance, transcendent racial identity attitudes, and receipt of care in nurse-managed center were associated with high satisfaction.

Whaley (2012) examined the effects of psychiatric symptoms and demographic variables on memory deficits, as measured by Digit Span Testing (DST) performance, in African American patients with schizophrenia, with levels of cultural mistrust serving as a moderating effects. The researchers hypothesized that the level of cultural mistrust will moderate the effects of psychiatric symptoms and demographic background on DST performance with a sample of Black patients with schizophrenia. The researchers conducted a secondary analysis of data from the Culturally-Sensitive Diagnostic Interview Research Project, a study at the New York State Psychiatric Institute. The sample included consecutive inpatient admissions of African Americans ($N = 349$) to an upstate New York public psychiatric hospital between June 1998 and April 1999. Potential participants were considered eligible if they met the following criteria: (1) they fell between the ages 18 and 59; (2) they self-identified as African descent and were U. S. citizens or immigrated before the age of 14; (3) they were not experiencing a severe psychotic episode at the time of the interview; and (4) they did not require the permission

of a legal guardian to participate. Ultimately, 128 (82%) patients with no missing data were sampled. The sample consisted of 51 percent of patients who were diagnosed with schizophrenia and 49 percent who were diagnosed with other psychotic disorders (72% males; 28% females), with an average age of 38.85 ($SD = 9.18$). The following measures used in this study were: Digit Span Testing, Cultural Mistrust Inventory (Terrell & Terrell, 1981), Total SCID Symptoms, False Beliefs and Perceptions from the Psychiatric Epidemiology Research Interview, Total Chart Symptoms, and the Fenigstein Paranoia Scale (Fenigstein & Venable, 1992). Each participant was thoroughly screened to assess their current mental status and then interviewed. A structural equation modeling (SEM) analysis revealed that psychiatric symptoms had a significant negative impact on working memory with those patients in the low cultural mistrust group; however, psychiatric symptoms had no significant effect among those patients in the high cultural mistrust group. These findings support the view that cultural mistrust plays a significant role in test performance among African American.

All of the studies highlighted above describe how cultural mistrust can impact Blacks' perceptions and attitudes toward counseling relationships and the health system, including the mental health system. That is, though self-disclosure is a critical element of counseling and psychotherapy, the history of systemic oppression has socialized Blacks to hide their true feelings, particularly when relating to Whites (Laughton-Brown, 2010; Ridley, 1984; Whaley, 2001). Levels of cultural mistrust, race/ethnicity, and gender have important implications for Blacks' attitudes toward counseling with racially dissimilar counselors. These attitudinal barriers can present challenges for Blacks who are

considering counseling from a White clinician. Understanding the significant value that many Black people attach to their historical experience, race, and culture may help to minimize any social tension and distance that may exist between a Black client and a White clinician. Moreover, exploring how Blacks identify with their racial group membership may provide additional insight into their attitudes toward Whites and the counseling relationship.

Racial Identity and Blacks

Racial identity is defined as the active fluid process of identifying one's own racial group as a viable self-reference group (Smith, 1989), and has also been linked to Blacks' attitudes toward seeking psychological help. Racial identity has been one of the most widely studied constructs among Blacks (Cross, 1991; Helms, 1990). Several theories of Black racial identity development were modeled during the early 1970s to assist researchers in understanding the interpersonal dynamics between Blacks and Whites. Theorists endeavored to present a framework by which practitioners could be sensitive to racial issues that were hypothesized to influence the counseling process (Helms, 1990). The aim of developing this framework was to define the direction of healthy Black identity development. As a result, knowledge of racial identity development can provide researchers and practitioners with possible explanations of Blacks' help-seeking attitudes and behaviors, levels of cultural mistrust, and their willingness to seek counseling from a White clinician. Cross' nigrescence model has been widely used over the past thirty years. Helms' operationalization of the nigrescence model helped to further advance research in racial identity development. Helms' racial

identity model is characterized by schemas in which one may identify with one or more racial identity schemas, moving from an anti-Black/pro-White view of oneself towards a more healthy, inclusive sense of oneself. While Cross' and Helms' models are the most recognized in the literature, other models of Black identity development do exist.

Black Identity Development Models

Jackson (1975) developed a four-stage model of Black identity development. Stage one of *Passive Acceptance*, involved the acceptance of White culture and standards. The rejection of White culture and standards occur during the second stage, *Active Resistance*, as Black people try to eliminate any influences deriving from the White frame of reference. The goal of the third stage, *Redirection*, was to neither accept nor reject White culture, but rather White culture was considered irrelevant to Black culture. Finally, during the last stage, *Internalization*, Black culture is appreciated and the Black person can both accept and reject different parts of White culture on his or her own merits.

Cross' Nigrescence

Cross (1971) first introduced "nigrescence" in his pioneering article, "The Negro-to-Black Conversion Experience." Nigrescence is defined as the transformation of a preexisting non-Afrocentric identity into one that is Afrocentric (Cross, 1971). The first stage, *Pre-Encounter*, was characterized by a devaluating sense of Black culture versus a valued sense of White culture. For instance, individuals downplay the importance of race in their lives, they deny racism, and focus more on their membership in other groups (for example, religion, social class, and sexual orientation). In the *Encounter* stage, some

event causes one to challenge their old frames of references. For instance, an individual has an actual racist experience, and as a result, begins to reconsider the ideas, thoughts, feelings, and emotions that she or he held to be valid prior to the racist experience. Yet, it is important to note that there are other times when the experience is more positive, such as the individual being exposed to positive historical realities that he or she may have not been cognizant of in the past (e.g., discovering the contributions of African and Black people made to civilization). Those challenges lead to the third stage, the *Immersion-Emersion*, which was depicted by a denigration of White people and White culture and glorifying Black people and Black culture. For example, the individual becomes immersed in the Afrocentric worldview. This stage is representative of the transition from the old to the new frame of reference. This period of transition characterizes a struggle to alleviate all vestiges of Pre-Encounter orientation, and intensely embrace personal implications of the newfound Black identity. The fourth and final stage, *Internalization*, was characterized by secure feelings toward Black culture and Black people and a decline in global anti-White attitudes. For instance, the person is characterized as embracing his or her Black identity, and no longer harbors a strong disdain for White society.

The above Black racial identity development models have provided researchers an understanding of the trajectory in which Blacks achieve a healthy sense of identity in reference to one's own racial group. These frameworks have also contributed to the development of Helms' racial development model, which defines black identity development as being more fluid states, or schemas, rather than successive stages.

Origin and Development of Helms' Racial Identity Attitude Scale

Helms (1990) describes racial identity as a sense of group or collective identity based on the perception that one shares a common racial heritage with a particular group. Helms' (1995) developed the Black racial identity model based on the work of Cross (1971). The Black racial identity model involves schemas in which one moves from a self-denigrating view of oneself as a racial being to a view with a solid and healthy sense of oneself as a racial being. Helms (1995) noted that the model should be viewed in terms of continuous schemas, rather than fixed stages. This change was made because studies revealed that individuals could exhibit characteristics of more than one stage. Helms (1995) encourages researchers and practitioners to examine the entire profile of schemas to get a clearer picture of overall racial identity.

Parham and Helms (1990) developed and validated three versions of the Racial Identity Attitude Scale (RIAS): RIAS-A (Short Form A), RIAS-B (Short Form B), and RIAS (Long Form). All of the scales were developed from the stages in Cross' (1971) Nigrescence model. Empirical studies using the RIAS-B have examined racial identity schemas in relation to numerous personality and counseling-related variables, including psychological well-being (Pyant & Yanico, 1991), self-actualization and affective states (Parham & Helms, 1985), preference for counselor race (Helms & Carter, 1991; Parham & Helms, 1981), perceived sensitivity of counselor (Pomales et al., 1986), and career aspirations (Evans & Herr, 1994). The RIAS was a five-point scale, ranging from strongly disagree to strongly agree. Four subscales measured the four racial identities as theorized by Cross (1971). The Counselor Preference Scale (Parham & Helms, 1981), a

5-point scale ranging from strongly disagree to strongly agree, was also developed and validated for the study. Two multiple regression analyses found that Black college students with Pre-Encounter schemas that devaluated Black culture but valued White culture, were inversely related with respect to their preference for a Black counselor and positively correlated to their preference for a White counselor. Encounter schemas were found to be positively correlated with a preference for a Black counselor. However, some limitations of the RIAS were the psychometric properties. Further, Helms (1990) reported that the Cronbach's alphas for the RIAS were: Pre-Encounter, .67-.76; Encounter, .51-.72; Immersion-Emersion, .66-.69; Internalization, .71-.80. Since the development of the RIAS-B, a high number of studies examining racial identity of Blacks have used the RIAS-B to assess racial identity schemas of Blacks (Helms & Carter, 1991; Nghe & Mahalik, 2001; Phelps et al., 2001; Pomales et al., 1986; Richardson & Helms, 1994). Racial identity has been shown to be related to a variety of other variables, such as Blacks' psychological health, attitudes toward counseling, and counselor preference (Helms & Carter, 1991; Parham & Helms, 1981; Want et al., 2004).

Empirical Studies of Racial Identity

Seminal studies, such as Clark and Clark doll studies (1939), where the majority of Black children displayed a racial preference for the White doll and a negative attitude toward the Black doll, have prompted researchers to explore some aspect of racial identity with Black adults and children. These studies contend that Blacks are more likely than Whites to encounter barriers to healthy racial identity development (Helms, 1989; Parham & Helms, 1985; Smith, 1989). Smith (1989) asserts that a healthy regard for

one's racial schema is psychologically important for racially diverse groups. Thus, for minority students, an important variable worthy of investigation is racial identity.

Parham and Helms (1985) examined the impact of racial identity on the self-actualization and affective states of Black students. The researchers sought to determine if racial identity stages were associated with feelings of inferiority, anxiety, anger, or self-acceptance. 166 Black college students were sampled from four predominantly white universities. 65 of the participants were male and 101 were female. Participants completed the Racial Identity Attitude Scale (Parham & Helms, 1985), the Personal Orientation Inventory (Shostrom, 1963), the Symptom-90 Checklist (Derogatis, Rickels, & Rock, 1976), and a personal data sheet. Multiple regression analysis was used to analyze the data and results found that Pre-Encounter and Immersion schemas were associated with feelings of inferiority, personal inadequacy, and hypersensitivity. Encounter schemas were inversely related to feelings of anxiety and inferiority.

Ponterotto, Alexander, and Hinkston (1988) replicated and extended Atkinson, Furlong, and Poston's (1986) study for relevant counselor characteristics with 101 Black college students who attended a predominantly White public university in the Midwest. The study used a sample of 53 Black male and 48 Black female students. Students were surveyed using Atkinson, Furlong, & Poston's (1986) forced-choice, paired-comparison questionnaire, and the Racial Identity Attitude Scale (Parham & Helms, 1985). Questions related to previous counseling experience and commitment to Black culture were also asked. The researchers used a disconfirmatory hypothesis-testing strategy that allowed alternative hypotheses to be tested (Hayden, 1987; Mahoney, 1976; Platt, 1964; Weimer,

1979). They found that Black clients most preferred counselors with similar schemas and ethnicity, but who were more educated. Results showed that when Black clients were forced to choose between similar schemas and similar ethnicity, similar schemas were selected 57.4 percent of the time. The Encounter (45%) and Internalization (53%) stages ranked similar ethnicity second and third, respectively, and both ranked dissimilar ethnicity 15th. Due to methodological problems with the RIAS, slightly higher internalization scores over encounter scores substantially underscored the limitations of this finding. The Cross Racial Identity Scale (Vandiver et al., 2000) corrected the limitations inherent in the RIAS and improved the psychometric properties of racial identity measurement.

Austin, Carter, and Vaux (1990) investigated the influence of racial identity on Black students' attitudes toward counseling and counseling centers. The researchers' aim was to determine if Black students' preferences for their counselor's race, racial identity schemas, and other cultural and affective variables could explain utilization and underutilization of university counseling centers. 166 Black college students (91 females and 75 males) participated in the study and represented various parts of the United States. The participants completed the Racial Identity Attitude Scale (Parham & Helms, 1985), the University Counseling Center and Testing Center Attitudes Survey (Snyder, Hill, & Derksen, 1972), and a demographic questionnaire. The researchers found an inverse relationship between Internalization racial identity schemas and effectiveness of counseling. An inverse relationship was also found between Internalization schemas and information about the counseling process subscales. Pre-Encounter schemas were

significantly associated with effectiveness of counseling and stigma of counseling subscales.

Helms and Carter (1991) conducted a study that focused on the relationship of White and Black racial identity schemas, and demographic similarity to counselor preference. This study explored two perspectives: the phenomenological-demographic perspective that individuals prefer counselors with similar membership and group characteristics because they believe that similar appearances mean similar schemas (Atkinson, 1983; Simons, Berkowitz, & Moyer, 1970), and the racial identity perspective, which proposes that the racial identity schemas of the client influence their counselor preference. Helms and Carter hypothesized that the factors of race, social class, and gender would predict the preference of a counselor. Results indicated partial support for both perspectives. In Black respondents, demographic variables (i.e., Black men with lower social class) predicted the preference for White male counselors. Also, gender differences resulted in the preference for counselors in both racial groups. For instance, White female respondents had a significant preference for female counselors, Black and White. In addition, Black men had stronger White male counselor preference than did Black females. Results show the relevance of examining gender preferences along with racial preferences.

Delphin and Rollock (1995) examined whether racial identity schemas and university alienation of Black students predict attitudes toward seeking help, knowledge about, and likelihood of using psychological services. This study sampled 180 Black college students (88 males and 92 females) attending a large mid-western university.

Participants completed the Racial Identity Attitude Scale (Parham & Helms, 1985), Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970), the University Counseling Center Attitudes Survey (Snyder, Hill, & Derksen, 1972), the University Alienation Scale (Burbach, 1972), and a demographics questionnaire. Vignettes related to the student's likelihood of seeking help were also assessed. A hierarchical multiple regression equation found that Immersion-Emersion schemas were highly associated with less favorable help-seeking attitudes, which means that Black students who identified strongly with their Black racial group membership were less likely to seek help.

Want et al. (2004) explored Black college students' ratings of White and Black counselors who vary in racial consciousness. Further, the study examined the influence of the client's racial identity schemas on the favorability of the counselor. Findings from this study build on previous research that revealed Blacks' racial identity schemas are related to their preference for counselors. Results indicated that the students' favorability ratings were positively correlated with a counselor's race and racial consciousness. It is important to note that racial consciousness of the counselor was also significant. Want et al. found that Pre-Encounter schemas were associated with low favorability ratings for Black counselors with high racial consciousness. This suggests that Blacks who identified with anti-Black schemas did not prefer Black counselors who openly spoke about racial matters. Thus, it appears that students' racial identity schemas were related to racial preference for a counselor and racial consciousness.

Pillay (2005) investigated racial identity schemas, acculturation, and gender as predictors of psychological health in a sample of African American college students. One hundred and thirty-six African American undergraduate students (54 men and 82 women) attending a predominantly White, state-assisted university located in the Midwest region of the United States were sampled. The participants' ages ranged from 18 to 24 years ($M = 20.4$, $SD = 1.82$). The participants completed a demographic questionnaire developed for this study, the Racial Identity Attitudes Scale (Parham & Helms, 1985), the Mental Health Inventory (Veit & Ware, 1983), and the African American Acculturation Scale – Short Form (Landrine & Klonoff, 1994). A hierarchical ordered regression method found that Pre-Encounter, Encounter, Immersion-Emersion, and Internalization subscales, as a block, were significant predictors of African American psychological health. However, individually, Pre-Encounter and Encounter schemas were identified as significant predictors. This study concluded that the earlier stages of racial identity development are negatively related to psychological health (Munford, 1994; Pyant & Yanico, 1991; Wilcots, 2001), meaning an individual who endorses a pro-White/anti-Black identity is more likely to have reduced psychological functioning (e.g., anxiety, etc.) than the latter schemas.

Sanchez and Carter (2005) examined how African Americans experience, express, and use religiosity to construct their identities, relying upon psychological models that take into account the complexity of these aspects of identity. Of the 317 students recruited to participate in this research study, 270 self-identified African American students returned the completed surveys. The survey packet included the Black

Racial Identity Attitudes Scale – Long Form (Parham & Helms, 1985a), The Three Dimensional Measure of Religious Orientation – Simplified Procedure (Batson & Ventis, 1982), and a Personal Data Sheet. As a result of MANOVA, the study found a significant relationship between racial identity schemas & religious orientation, such that Immersion-Emersion racial identity schemas were predictive of lower levels of Intrinsic religious orientation for African American men and higher levels of Intrinsic religious orientation for African American women. The gender differences identified across racial identity schemas and religious orientation suggest that African American men and women have varied experiences when it comes to race and religion.

Johnson and Arbona (2006) investigated the extent to which ethnic identity and racial identity are related constructs to race-related stress among African American students. Researchers sampled 140 African American college students at a diverse university ($n = 73$) and at a predominantly Black university ($n = 67$). Participants completed a demographic questionnaire, the Black Racial Identity Attitudes Scale – B (Parham & Helms, 1981), the Multigroup Ethnic Identity Measure (Phinney, 1992), and the Index of Race-Related Stress – Brief Version (Utsey, 1999). The findings revealed that an endorsement of Encounter, Immersion-Emersion, and Internalization racial identity schemas are associated with an increase in race-related stress, and ethnic identity was not related to race-related stress. These results are consistent with Helms and Talleyrand's (1997) assertion that racial and ethnic identity may vary in psychological implications for members of visible racial and ethnic minority groups. As such, the results indicate that African Americans who most identify with the Encounter,

Immersion-Emersion, and Internalization racial identity schemas may be sensitive to, and bothered by, experiences of racial discrimination at the cultural and the individual level.

Townes, Chavez-Korell, & Cunningham (2009) examined the extent to which Black racial identity schemas, cultural mistrust, and help-seeking attitudes predicted preference for a Black counselor. 128 Black college students (71 women, 57 men) and 76 Black non-student adults (39 women, 37 men), totaling 204 participants, were sampled. The researchers were particularly interested in prospective Black clients, so those participants who had not had any counseling experience. Respondents were recruited in an urban area in the southern region of the United States and the mean age was 26.85 ($SD = 11.73$). The college sample comprised of students attending a White public university and non-student participants were recruited from community programs and churches. Participants responded to a demographic questionnaire, the Cross Racial Identity Scale (Vandiver et al., 2000), the Cultural Mistrust Inventory (Terrell & Terrell, 1981), the Attitudes Toward Seeking Professional Psychological Help Scale – Short Form (Fischer & Farina, 1995), and a modified version of the Counselor Preference Scale (Parham & Helms, 1981). The Counselor Preference Scale was modified by removing the choices of age, sex, and socioeconomic status, and respondents reported their preference for a Black counselor or preference for a White counselor in 10 different situations using race as the only preference assessed. Townes et al. (2009) found that high levels of cultural mistrust, low assimilation schemas, and high Afrocentric schemas significantly predicted preference for a Black counselor.

Forsythe and Carter (2012) explored the relationships between racial identity schemas and racism-related coping strategies and determined if they were associated with both positive (well-being) and negative (distress) psychological consequences of exposure to racism. 233 Black adults (174 women, 59 men), age 18 or older, were recruited through an online survey to participate in the research study. Many of the respondents identified as African American (57%) and while many reported their origin of birth was in the United States (84%), a fairly large number of participants identified their ethnicity as Caribbean (31%). The mean age of respondents was 33 ($SD = 11.19$). Participants responded to a Personal Demographic Sheet, specific racial incident questions, the Racism-Related Coping Scale (Forsyth & Carter, 2011), the Black Racial Identity Attitudes Scale (Helms & Parham, 1996), the Brief Symptom Inventory (Derogatis, 1983) and the Mental Health Inventory (Veit & Ware, 1983). In a hierarchical cluster analysis, the researchers found that racial identity schemas and coping strategies used by the Internalization-Empowered Resistance cluster group were associated with the least intense psychological symptoms as compared to those used by the Encounter-Bargaining and Immersion-Cultural Hypervigilance cluster groups.

The aforementioned studies demonstrate the importance of assessing the racial identity development of Black individuals who decide to seek traditional counseling services. While racial identity schemas are strongly linked to levels of cultural mistrust, studies on racial identity have also shown that various racial identity stages are associated with Blacks underutilization of counseling services (Bosch & Cimboric, 1994; Campbell-

Flint, 2000; Delphin & Rollock, 1995; Parham & Helms, 1981; Ponterotto, Alexander, & Hinkston, 1988).

Help-Seeking Attitudes and Blacks

Assessing help-seeking attitudes has also been beneficial in assessing Blacks' views and potential outcomes of the counseling relationship. Attitudes toward seeking professional psychological help, or help-seeking attitudes, are defined as the tendency to either seek or resist professional psychological aid during crises or after prolonged psychological discomfort (Fischer & Farina, 1995; Fischer & Turner, 1970). Many Black clients enter into mental health treatment and counseling differently than do White clients, such as under mandated circumstances, rather than voluntary (Hu et al., 1991; Takeuchi & Cheung, 1998). Even more so, once in counseling, some Black clients may view White counselors as a representative of an oppressive society (Sue & Sue, 2003).

Empirical Studies of Help-Seeking Attitudes of Blacks

Wolkon, Moriwaki, and Williams (1973) investigated the relationship between race, social class, self-disclosure, self-reported treatment outcomes, and attitudes toward seeking psychological help. 69 females (44 Black and 25 White) from middle and lower socioeconomic classes, who attended college in Los Angeles, were sampled for the purposes of this study. Participants were given a modified version of Jourard's Self-Disclosure Scale (Jourard & Lasakow, 1958) called the Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970). Respondents completed a demographic questionnaire and answered questions related to counseling experiences and preference for psychological counseling. A chi-square analysis of the data indicated

that self-disclosure scores for middle class Whites were significantly higher than those of middle class Blacks. The results indicated that Blacks preferred Black therapists and are more dissatisfied with treatment than Whites.

Hall and Tucker (1985) examined the relationship between Black and White people's conceptions of mental illness and their attitudes associated with seeking psychological help. A random sample of 321 White and 192 Black schoolteachers participated in this study. Participants received the Fischer and Turner Pro-Con Attitude Scale, which assessed attitudes toward seeking psychological help, by mail. According to the researcher's citation, the Pro-Con Attitude Scale was synonymous with the Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970). Additionally, they received the Nunnally Conception of Mental Health Questionnaire (Nunnally, 1960). Participants were given 10 vignettes that investigated the therapist's versus client's culture, private versus community mental health, therapist's versus client's race and socioeconomic differences, problem types, and the efficacy of seeking treatment. This five-point scale instructed participants to indicate their level of agreement with each vignette. Multiple regression analyses found that although help-seeking attitudes between the Black and the White participants were not significantly different, conceptions of mental health were statistically significant. Moreover, an inverse relationship was found between misconceptions toward mental illness and attitudes toward seeking professional psychological help ($p < .0001$). Blacks indicated more misconceptions related to mental illness on all seven-scale components than Whites. Three of the 10 vignettes concerning therapist-client racial differences were significantly

different. Black participants were less likely to endorse racially dissimilar counselor-client counseling dyads. The researchers contend that Blacks “have a different conceptualization of mental illness and health from Whites and this difference may be a factor in the underutilization of mental health services and professionals by Blacks” (Hall & Tucker, 1985, p. 913).

Ponterotto, Anderson, & Grieger (1986) explored the impact of racial identity schemas and its association with attitudes toward seeking psychological help among 107 Black college students. Participants completed the Racial Identity Attitude Scale (Parham & Helms, 1981), Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970), questions related to counselor race preference, and a demographic inventory. Results indicated that there was no significant relationship between racial identity and the participant’s sex. However, the researchers did find a significant interaction between participants’ sex and racial identity that affected attitudes toward seeking psychological help, such that in the Internalization schema of identity development, women had significantly more positive attitudes toward counseling than did men. However, the same result was not found in the Encounter schema.

Cheatham, Shelton, and Ray (1987) examined the challenges confronting Black and White college students, their origins, and the implications for seeking help. Participants provided demographic data and responded to the Personal Problem Assessment Questionnaire (PPAQ). The PPAQ assesses problem type, frequency, severity, and resolution via help sources. After identifying the problems and rating their intensity, the participants were required to indicate whether or not the problems endorsed

were a function of internal (personality) or external (situational/environmental) forces. Upon the analysis of students' responses, it was discovered that Black students selected more problems but rated them less severely than their White counterparts. Of the problems mentioned, finances and intimate relationships were highly reported amongst both groups. Majority of the students sampled sought informal help sources while only nine percent sought no help at all. The researchers determined that Black and White students are more similar than they are dissimilar in the area of help seeking. However, Black students were more likely to attribute their problems to situational and environmental issues, and they sought professional academic assistance, as opposed to personal counseling, more often than White students did.

Diala et al. (2001) sought to explore the racial differences in attitudes toward seeking professional care and their association with the use of mental health services. A national sample of 13,975, between the ages 15-54, completed the National Comorbidity Survey (NCS). The NCS was developed to study the distribution, correlates, and consequences of psychiatric disorders in the United States. Data was collected by the Institute for Social Research at the University of Michigan between the years 1990 and 1992. The NCS interview was conducted in two parts: Part I ($n = 8,098$), included the core diagnostic interview, a brief risk-factor battery of tests, and an inventory of socio-demographic information, with a response rate of 82.4 percent; Part II ($n = 5,877$) included a more detailed risk-factor test battery, plus secondary diagnoses. A multiple logistic regression was conducted to analyze the data using the Statistical Analysis System (SAS). The researchers concluded that, prior to the use of mental health services,

Blacks expressed more positive attitudes toward seeking professional help than Whites in the general population. Further, they were more likely to seek care if they had serious emotional problems, felt comfortable discussing personal problems with a professional, and less embarrassed about friends knowing that professional services were being sought for emotional problems. Conversely, Blacks were more likely than Whites to report negative attitudes toward seeking professional services after seeking mental health services. Also, they were less likely to return for mental health services, even when their emotional problems persisted. Compared to their White counterparts, Blacks who had utilized mental health services reported less favorable attitudes toward their friends knowing that they had sought mental health services.

Constantine (2002) investigated the degree to which racial and ethnic minority clients' attitudes about counseling, ratings of their counselor's general counseling competence, and ratings of their counselor's multicultural counseling competence would each account for a significant amount of the variance in their counseling satisfaction ratings. The study sampled 112 undergraduate and graduate participants (70% women and 30% men) attending predominantly White colleges' and universities' counseling centers located in the northeast region of the United States who sought and terminated mental health treatment at their campus counseling center. The client participants were asked to complete the Client Demographic Questionnaire, the Attitudes Toward Seeking Professional Psychological Help Scale – Short Form (Fischer & Farina, 1995), the Counselor Rating Form – Short (Corrigan & Schmidt, 1983), the Cross-Cultural Counseling Inventory – Revised (LaFromboise, Coleman, & Hernandez, 1991), and the

Client Satisfaction Questionnaire – 8 (Larsen et al., 1979). The participating counselors were unaware of the nature of the “evaluation forms” completed by the clients. As a result of the multiple regression analysis of the data, Constantine concluded that counselors that were perceived to have a general competence of traditional counseling might also be perceived to be proficient in addressing multicultural counseling issues, or vice versa. Further, racial and ethnic minority college students’ attitudes toward counseling accounted for a significant amount of the variance in their counseling satisfaction ratings. Lastly, prior to utilizing mental health services, Blacks held more positive attitudes about mental health services than Whites, but their attitudes were found to be less positive than those of Whites after using these services.

Duncan (2003) investigated whether age, African self-consciousness, cultural mistrust, and social class predicted Black college males’ attitudes toward seeking psychological help. 131 Black male college students were sampled (121 undergraduates and 10 graduates) and they represented various socioeconomic levels (31% lower class, 67% middle class, and 2% upper class). The sample was drawn from two predominantly White institutions and two Historically Black Colleges and Universities (HBCU). Respondents completed a demographic questionnaire, the Cultural Mistrust Inventory (Terrell & Terrell, 1981), the African Self-Consciousness (Baldwin & Bell, 1982) instrument, the Attitudes Toward Seeking Professional Psychological Help (Fischer & Farina, 1970), and The Four Factor Index of Social Status (Hollingshead, 1971; McAdoo, 1978). Study results suggested that older Black male students, who were of a lower social class, have more positive attitudes toward seeking counseling. However, cultural mistrust

negatively correlated when attitudes toward seeking professional help approached statistical significance ($p = .057$), which suggest that participants with higher cultural mistrust report less positive attitudes regarding seeking professional psychological services.

Obasi and Leong (2009) investigated whether psychological distress and acculturation beyond psychological distress predicted attitudes toward seeking professional psychological services among a sample of 130 Black individuals of varying ethnicities. Each respondent completed the Brief Symptom Inventory (Derogatis & Melisaratos, 1983), the Measurement of Acculturation Strategies for People of African Descent (Obasi, 2005), and the Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970). Results from this study suggested that psychological distress was a significant predictor of psychological help-seeking attitudes. Psychological distress was negatively correlated with attitudes toward seeking professional help.

Most recently, Williams and Justice (2010) conducted a quantitative study, using a basic associational experimental approach, which explored the attitudes that Black males have regarding counseling services at institutions of higher education. Participants were Black male college students and at least 18 years of age. Participants were recruited from four institutions of higher education in Texas: two Predominantly White Institutions (PWIs) and two Historically Black Colleges and Universities (HBCUs). Each participant completed the Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970) and a demographic questionnaire. Findings from this study indicate that

Black male students attending HBCUs did not have a favorable opinion regarding counseling. Black male students attending PWIs reported attitudes toward counseling consistent with those students at a HBCU. Specifically, underclassmen at three out of the four institutions reported negative attitudes of seeking counseling services, though underclassmen students at one HBCU had a more positive attitude than upper level students at the same HBCU. Overall, the participants' attitudes were negative.

Exploring Blacks' help-seeking attitudes and behaviors toward the mental health system are essential to understanding the barriers that interfere with Blacks utilization of mental health services. The above studies emphasize the need for counselors to address a variety of issues (e.g., environmental factors, psychological well-being, gender differences, social class, etc.) experienced on the part of Black individuals prior to, and during, the counseling process.

Although research indicates that Blacks' historical experiences may impact their views toward the counseling process, there are additional cultural factors, such as community support networks, that could also impact whether or not Blacks seek mental health counseling.

Protective Cultural Factors for Blacks

Although treatment disparities have lessened over the years, Blacks are still less likely than Whites to seek mental health services in an outpatient mental health facility (Snowden, 2001). In coping with mental health issues, Blacks have been found to be more likely to rely on community support structures than "traditional" mental health services (Caldwell, 1996; Neighbors et al., 1983; James-Myers et al., 2003). These

networks typically include family and community resources, religious leaders, and indigenous healers (Yeh et al., 2004). Traditional mental health services are usually obtained only via referral from one of these above-described primary support networks, and are treated as a last resort or reactive measure (Jackson et al., 1983). Consequently, Blacks often rely on informal networks of support in lieu of seeking counseling (Harley & Dillard, 2005; Parham, 2002). Where Black people lack the access to professional Black mental health providers, Black ministers are accessible as a source for seeking help. The church and the clergy can also act as gatekeepers to mental health services (Veroff, Douvan, & Kulka, 1981). Black people were found to use the clergy more frequently for serious mental health problems than mental health providers. Treatment expense was cited as the barrier to using the clergy over professional counselors. The researchers also found that 90 percent of the clergy do not refer their clients to professional psychological services. This practice can be problematic since the formal education in counseling and psychology of the clergy varied (Gottlieb & Olfson, 1987) even when postgraduate education was obtained (Friesen, 1988; Weaver, 1995).

Neighbors, Musick, and Williams (1998) found that Black ministers were readily accessible to Black people seeking help for personal challenges. Black people were satisfied with the services they received from Black ministers, and Black ministers act as buffers to professional mental health services. Moreover, the researchers concluded that other social and cultural (e.g., stigma, cost, mistrust, and a philosophy of self-reliance) might exist, preventing Black people from seeking professional psychological help. Also, Taylor, Mattis, and Chatters (1999) found that subjective religiosity served a critical role

in providing comfort and support for Black people. Subjective religiosity is defined as “perceptions and attitudes regarding religion” (Taylor, Mattis, & Chatters, 1999, p. 529). Their study showed that Black people often use religion as a way of coping with life.

Many methods of spirituality are used in the Black church to facilitate health and wellness of its parishioners. One such method is the use of prayer as an active agent to bring physical, mental, emotional spiritual relief (Costen, 1993). Prayer is perceived as a means of relieving pain and suffering often related to daily experiences amongst Black people. In particular, the Black cultural reference to “prayer warrior” epitomizes the importance of ardent prayer during turbulent experiences (Costen).

Taylor et al. (2000), concluded that although the clergy may be the first point of contact for Blacks when mental health challenges are being experienced, many members of the clergy lack the training in identifying mental health problems. Rather than refer their congregants to seek professional counseling services, members of the clergy often consult with other clergy members about mental health issues. Essentially, there is a strong need to build effective partnerships between churches and mental health facilities to reduce the barriers and constraints found in faith communities.

Crosby and Bossley (2012) explored several variables from the religious and psychological help-seeking literature and its relationship to preferences for seeking help from a religious advisor. The participants for this study were 235 college students, ages 18 to 51 years old, from a large university located in southeast Texas. Participants were recruited through an online departmental research recruitment system and given one unit of research credit. Respondents completed the Preferences for Religious Help-Seeking

Scale (Crosby & Bossley), the Attitudes Toward Seeking Professional Psychological Help Scale – Short Form (Fischer & Farina, 1995), the Dimensions of Religiosity Scale (Joseph & DiDuca, 2007), the Religious Involvement Questionnaire (Crosby & Bossley), the Disclosure Expectations Scale (Vogel & Wester, 2003), the Mental Illness Stigma Scale (Day, Edgren, & Eshleman, 2007), the Experiences in Close Relationship Scale – Short Form (Wei et al., 2007), and the Center for Epidemiological Studies-Depression Scale (Radloff, 1977). Crosby and Bossley found that the preferences for religious help-seeking seem to be related to more than internal (or external) aspects of religiosity, as assessed by the cognitive-emotional-oriented Dimensions of Religiosity Scale. Additionally, attitudes toward psychological help seeking were negatively related to preferences for religious help-seeking, and those with a greater preference for seeking help from a religious advisor tended to perceive less benefit in seeking help from a psychological professional. Lastly, participants who had lower expectations for the benefits of self-disclosure (to a psychological professional) were more likely to indicate a preference for religious help-seeking. Mainstream researchers have acknowledged that protective qualities of religious entities are also associated with Black racial identity (Crocker & Major, 1989).

Summary of Literature Review

It appears from a thorough review of the literature that the constructs of cultural mistrust, help-seeking attitudes, and racial identity have been helpful in identifying the significant components that impede on the cross-racial counseling relationship. Central to these issues are anger and distrust toward those who have historically supported

discriminatory practices that block Blacks' access to economic and social resources. Generally, the encounters of Black people with members of the dominant culture (or those representing them) are usually met with ambivalence. Counseling interventions are no exception to this rule. The literature has established that cultural mistrust and negative attitudes toward psychological help-seeking has resulted in Black college students underutilizing counseling services than White students. Racial identity studies have showed that one's racial identity schemas significantly impact the attitudes and experience of the cross-cultural relationship between a Black client and a White counselor. The literature has been criticized because a number of studies have used data from Black college students, particularly at predominantly White universities, which makes it impractical for researchers and practitioners to generalize the findings to the Black population in general. Also, there is a dearth of recent literature that examines the collective influence that cultural mistrust, racial identity schemas, and attitudes toward counseling has on the decision-making process of a Black client who is considering counseling. Further, the empirical studies that have been conducted discuss preferential attitudes of Black clients for a White or Black counselor which may not be useful since Black clients may not have a choice in which counselor will render counseling services based upon their preference. Finally, specific Black cultural factors (e.g., religiosity, extended family support) may serve as additional mediating factors to receiving mental health services for Blacks.

This proposed study will use data from Black college-educated individuals and Black non-college educated individuals from various communities, to examine whether

the relationship of cultural mistrust, racial identity, and attitudes toward counseling has any impact prior to the start of counseling. Further, this study explores the willingness, rather than the preference, of Black clients to seek psychological counseling from a White clinician since Black clients may not have a preference when it comes to choosing the race of their clinician. The aim of this study is to determine whether a relationship exists among racial identity schemas, cultural mistrust, and attitudes toward counseling on the willingness of prospective Black clients to seek counseling from a White clinician.

CHAPTER THREE

Method

Overview

The primary goal of this research study was to examine which factors impact prospective Black clients' willingness to seek counseling from a White clinician. This study explored the relationship between cultural mistrust, racial identity, and help-seeking attitudes, and their potential impact on Black clients' willingness to seek counseling from a White clinician.

Research Question

The research question for this study was as follows:

1. Do racial identity schemas, cultural mistrust, and help-seeking attitudes predict the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites?

The sub-questions were as follows:

- a. How do different levels of mistrust of Whites, racial identity schemas, and attitudes of seeking professional psychological help relate to the willingness of prospective Black clients to seek counseling from a White clinician?

- b. How do different levels of mistrust of Whites, racial identity schemas, and attitudes of seeking professional psychological help relate to the willingness of prospective Black clients to seek counseling from counseling facilities perceived to be primarily staffed by White clinicians?
- c. What is the unique contribution of each independent variable on the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites?
- d. Are the scores on the Cultural Mistrust Inventory, the Racial Identity Attitude Scale, the Attitudes Toward Seeking Professional Psychological Help Seeking Scale, and the Counseling Willingness Scale reliable for this particular sample?
- e. Are the scores on the Cultural Mistrust Inventory, the Racial Identity Attitudes Scale, the Attitudes Toward Seeking Professional Psychological Help Scale, and the Counselor Willingness Scale valid in measuring the targeted constructs of cultural mistrust, racial identity schemas, attitudes toward seeking professional help, and prospective Black clients' willingness to seek counseling from and disclose to a White clinician/clinic primarily staffed by Whites for this particular sample?
- f. What are the similarities and/or differences between participants who attend or have attended college, and participants who have received little to no college education in their willingness to seek counseling from a White clinician/clinic primarily staffed by Whites?

Research Hypotheses

The above research question was explained using the following research hypotheses:

- **Hypothesis 1a:** High levels of Pre-Encounter racial identity schemas will be positively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites.
- **Hypothesis 1b:** High levels of Encounter racial identity schemas will be negatively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites.
- **Hypothesis 1c:** High levels of Immersion-Emersion racial identity schemas will be negatively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites.
- **Hypothesis 1d:** High levels of Internalization racial identity schemas will be positively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites.
- **Hypothesis 2a:** Positive attitudes toward seeking professional psychological help will be positively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites.
- **Hypothesis 2b:** Negative attitudes toward seeking professional psychological help will be positively related to the unwillingness of

prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites.

- **Hypothesis 3a:** High levels of cultural mistrust will be negatively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites.
- **Hypothesis 3b:** Low levels of cultural mistrust will be positively related to the unwillingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites.

Hypothesis 4: The college-educated sample will be more willing to seek counseling from a White clinician than the non-college educated sample.

Participants

A nationwide sample of self-identified African American/Black men and women, who were at least 18 years of age, were solicited to participate in this study. It is estimated that a statistically large sample is adequate for the number of variables involved in the model (Cohen, 1992). Participants who were at least 18 years of age were solicited from two- and four-year institutions, and community environments (e.g., businesses, etc.). A college-educated and non-college educated sample was used for this particular study because past studies assessing cultural mistrust, racial identity, and help-seeking attitudes primarily used samples of college students. Therefore, in order to obtain information regarding help seeking attitudes of a broader population base, a non-college educated sample was also included in this study. The college-educated sample consisted of women and men who were recruited from predominantly White institutions

(PWIs) and Historically Black Colleges and Universities (HBCUs) nationwide via electronic sources. A nationwide sample of non-college educated participants was also recruited from the community, such as barbershops, beauty salons, and churches in the mid-Atlantic region. Permission was asked of local community business proprietors, church officials, etc., to solicit participants at their sites. Inclusion criteria for participating in this study was that participants must self-identify as Black or African American, and were primarily reared in the United States, since this study explored the experiences of Blacks who have primarily lived in the United States. An electronic recruitment tool using email and Facebook was used to recruit participants nationally.

Procedure

This study followed standard consent procedures in online and face-to-face research. The online survey was developed on a secure survey developer database called Qualtrics. For the online survey, participants were first shown the Informed Consent/Welcome Letter detailing the purpose of the study, eligibility requirements, risks, benefits, confidentiality, and the researcher's contact information if participants had any questions or needed assistance. Participants were asked to select "Agree" or "Disagree" at the bottom of the informed consent letter confirming that they met the inclusion criteria, they read the informed consent letter, and that they understood that their participation was voluntary. No incentives were offered to the participants.

For the paper survey, participants were given the Informed Consent/Welcome Letter detailing the same information aforementioned. The participants read the informed consent letter and informed the researcher of whether or not he or she consented to

participate prior to completing the surveys. If a participant decided to participate, he or she was given a copy of the informed consent letter for his or her records after completion of the survey.

Once consent was provided for both online and paper surveys, participants were provided with the remainder of the questions on the survey, including a demographic questionnaire (e.g., age, gender, race/ethnicity, country of origin, country where primarily raised, community where reared, marital status, employment status, student status, highest educational level, annual income, typical means of coping, and counseling experiences), and scales assessing cultural mistrust levels, racial identity schemas, attitudes toward seeking psychological help, and willingness to seek counseling from a White clinician. The questionnaire took approximately 10 to 12 minutes to complete. As part of the informed consent letter, participants were informed that he or she could withdraw from the research study at any point. No identifying information was requested; thus, each participant remained anonymous. A random number was assigned to participants by the researcher for organizational purposes only. Once the responses were collected, the researcher entered all data and analyzed the results.

Measures

This study explored the relationships between three variables – racial identity schemas, as measured by the Racial Identity Attitude Scale – Short Form B (Helms & Parham, 1985); levels of cultural mistrust, as measured by the Cultural Mistrust Inventory (Terrell & Terrell, 1981); help-seeking attitudes as measured by the Attitudes Toward Seeking Professional Psychological Help – Short Form; and the criterion variable of a

Black client's willingness to seek counseling from a White clinician as measured by the Client Willingness Scale (Woodard, 2013).

Background information questionnaire. Participants self-reported their age range, sex, race/ethnicity, country of birth and primary rearing, primary community of rearing, marital status, employment status, student status, educational attainment level, income level, and participants' typical means of coping. Participants were also asked to indicate whether they have had prior experience with counseling as a client. For the purpose of this study, the following question was added to the Background information questionnaire (BIQ) (Woodard, 2013; See Appendix A): "Have you ever considered or are considering going to counseling?" This question was added because it is the researcher's contention that a client's consideration to seek counseling will help to inform his or her willingness to seek counseling from a White clinician. Also, the question (yes/no response): "Have you ever been a client in counseling/psychotherapy with a mental health professional (psychologist, psychiatrist, clinical social worker, psychiatric nurse, alcohol or drug counselor, or licensed professional counselor)?" was included since prior counseling experience, whether positive or negative, may be influential on prospective Black clients' willingness to seek counseling from a White clinician (Townes, Chavez-Korell, & Cunningham, 2009).

Attitudes toward seeking professional psychological help scale – short form.

The Attitudes Toward Seeking Professional Psychological Help Scale – Short Form (ATSPPHS-S) (Fischer & Farina, 1995; see Appendix B) is a 10-item inventory that was developed to identify factors that influence an individual's decision to seek professional

counseling or mental health services (White, 2002). The scale was based on the original 29-item ATSPPH (Fischer & Turner, 1970). The ATSPPHS-S was developed to result in a single score measuring help-seeking attitudes. 14 items were selected from the original ATSPPH-S that exhibited the highest item to total score correlation coefficient. Items that represented a variety of social issues were added to the ATSPPHS-S and randomly distributed among the existing items. The items were distributed to 389 college students in an introductory psychology course. Respondents were required to rate each of the statements in a Likert-type response format consisting of the alternatives *agree*, *partly agree*, *partly disagree*, and *disagree*. A factor analysis was conducted on the 14 key items with two, three, and four factor solutions and Varimax rotation. The ten items that loaded on Factor I (Need) contained all the necessary elements to describe the help-seeking construct and had an internal consistency coefficient of .84. The remaining four items loaded on Factor 2 and formed an interpersonal openness subscale, were eliminated due to low internal consistency ($\alpha = .64$), reducing the items to 10. A four-week test-retest reliability resulted in .80 for the short form. The short form included items, such as “I might want to have psychological counseling in the future” and “I would want to get psychological help if I were worried or upset for a long period of time.”

Scoring. Using a 4-point Likert scale, participants indicate their level of agreement for each item by choosing a range from “disagree” to “agree.” Five items are scored according to the scale, while the other five items are reversed scored. Each item score is totaled to produce a single score. Higher scores indicate more favorable attitudes toward seeking mental health treatment. Participants who scored low on this scale saw

little need for mental health services, and according to DeVries and Valdez (2006) these individuals believed that they could resolve psychological issues on their own.

Validation. Recent studies have demonstrated the validity of the Attitudes Toward Seeking Professional Psychological Help – Short Form in measuring the construct of psychological help-seeking in Black students and clients (Constantine, 2002; Komiya, Good, & Sherrod, 2000; Mendoza & Cummings, 2001; Rochlen, Mohr, & Hargrove, 1999). For example, Constantine (2002) examined whether minority clients' attitudes toward counseling and ratings of their counselors' counseling competence could predict their satisfaction with counseling. The results of a hierarchical regression analysis found that ATSPPH-S scores and ratings of a counselor's general competence accounted for a significant amount of the variance of ethnic minority client's counseling satisfaction ratings. The Cronbach's alpha for internal consistency for the Attitudes Toward Seeking Professional Psychological Help – Short Form calculated by Constantine was .83. The ATSPPHS-S was reported to have good construct validity in that significant point biserial correlations were displayed between individuals' scores on this measure and their psychological help-seeking behavior (Constantine, 2002). For this study, the Cronbach's alpha was .82.

Cultural mistrust inventory. The Cultural Mistrust Inventory (CMI) (Terrell & Terrell, 1981; see Appendix C) assesses the extent to which Blacks mistrust Whites and was used for that purpose in this study. This inventory was based on Grier and Cobbs' (1968) concept of cultural paranoia, which is defined as “a healthy paranoia that allows Black people to develop and maintain a high degree of suspicion in order to protect

themselves from racial discrimination and persecution from White people” (Townes, Chavez-Korell, & Cunningham, 2009, p. 333). The CMI is divided into four subscales: Education and Training, Interpersonal Relations, Business and Work, and Politics and Law.

Terrell and Terrell (1981) assert that the educational and training settings are likely environments in which Blacks are often viewed as being mistrustful. Brazziel (1974) contends that no matter the effort a Black child puts toward their education, white teachers will fail the child. Further, Russell (1974) believes that Black children are misguided into a training that leads to low-wage jobs and occupations. Black people’s suspiciousness of White people in a social context was a basis for developing the Interpersonal Relations subscale. Black people preferred to live in areas where other Black people resided as to avoid interacting with White people as a result of mistrust (Kitano, 1974). The Business and Work subscale was developed to assess Black people’s expectations of unequal, unfair treatment in the workplace (Rutledge & Glass, 1967), and feelings of job security (Baughman, 1970). The Politics and Law subscale was designed to measure Black people’s feelings of alienation from law enforcement, political, and legal systems (Kitano, 1974).

Four Black psychologists independently rated each item for clarity and appropriateness. This procedure was repeated until all judges reached agreement. A total of 81 items were agreed upon and composed the initial CMI. The original CMI was distributed to 172 Black college males. In addition to the CMI, each of the 172 participants was given the Social Desirability Scale (Jackson, 1970) and the Racial

Discrimination Index (Terrell & Miller, 1980). The Racial Discrimination Index is a 24-item Likert scale using a 10-point response format, describing a racially significant incident, and instructs the participant to indicate how often they have been victims of the same or similar racial incident. An item-discrimination analysis was conducted to eliminate those items most participants endorsed. The Cronbach's alpha for internal consistency using a sample of Black clients reported by Nickerson, Helms, and Terrell (1994) was .89. Test-retest reliability within a two-week interval was .86. The final CMI composed of a 48-item Likert scale using a 7-point response format ranging from "strongly disagree" to "strongly agree." The CMI includes items, such as "White teachers teach subjects so that they favor Whites", "White policemen will slant a story to make Blacks appear guilty", and "Blacks should be cautious about what they say in the presence of Whites since Whites will try to use it against them."

For the purposes of this study, only two subscales of the CMI were used: Education and Training, and Interpersonal Relations because of its relevance to the study, such that ability to interact and engage with others are integral in building the counseling relationship. Also, an individual's knowledge regarding counseling, their educational level, and prior educational experiences may impact how the client perceives the counselor and the counseling relationship (Austin, 2009; Harris et. al., 1996; So, Gilbert, & Romero, 2006; Townes, Chavez-Korell, & Cunningham, 2009). Using only the Education and Training, and the Interpersonal Relations subscales reduced the item count from 48 to 21. Ponterotto and Casas (1991) suggest that each scale can be used independently because of low inter-correlations. Thompson, Worthington, and Atkinson

(1994) estimated the coefficient alpha of the Education and Training subscale, and the Interpersonal Relations subscale as .54 and .67, respectively. The coefficient alpha for the combined two subscales was calculated at .73. A Pearson product-moment correlation procedure was computed using the two subscales and found that they correlated significantly ($r = .49, p < .001$). Terrell and Terrell (1981) also found that of the four subscales of the CMI, only the Interpersonal Relation and Education and Training subscales correlated significantly ($r = .23, p < .05$).

Scoring. High scores on the CMI (both sub-scores and total score) suggest a tendency to be more mistrustful of Whites. Low scores indicated a tendency to be more trustful of Whites. The current study used the total scores derived from the 21 items of the Education and Training subscale, and the Interpersonal Relation subscale. Total scores are obtained by adding points for each item; negatively keyed items are reversed scored.

Validation. Numerous studies have demonstrated the validity of the Cultural Mistrust Inventory (Bianchi et al., 2002; Klonoff & Lantrine, 1997; Nickerson, Helms & Terrell, 1994; Phelps, Taylor & Gerard, 2001; Thompson, Worthington, & Atkinson, 1994; Whaley, 2002a; 2001a; 2001d; 1998b). Bianchi and colleagues (2002) explored the relationship among racial identity, cultural mistrust and self-esteem in a population of 100 Black Brazilian male students from two trade schools. The results of hierarchical regression analysis showed that higher internalization attitudes as measured by the People of Color Racial Identity Attitudes Scale (Helms, 1990) were related to lower cultural mistrust scores on the Cultural Mistrust Inventory. The coefficient alpha reported for the

Cultural Mistrust Inventory was .74. For this study, the internal consistency estimate (Cronbach's alpha) was found to be .84.

Client willingness scale. The Client Willingness Scale (CWS) (Woodard, 2013; see Appendix D) is a 10-item inventory that questions Black clients on their willingness to seek counseling from a White clinician. The CWS is based on the Counselor Preference Scale (CPS) developed by Parham and Helms (1981), which is a 40-item inventory assessing Black students' preference for various counselor identities, such as sex, socioeconomic status, and race (i.e. Black or White). Parham and Helms utilized 10 problems, identified by Webster, Sedlacek, and Miyares (1978), in which Black students might decide to seek counseling. Participants for this study were college students and adult non-college students. New items were included on the CWS based on research that examined perceived mental health needs and attitudes toward seeking help in adults (Mohtabai, Olfson, and Mechanic, 2002) taken from the National Comorbidity Survey's 12-month and lifetime prevalence rates of mental disorders (Kessler, et al., 1994; Narrow et al., 2002). Items were representative of various mental health disorders: anxiety, mood, and alcohol and substance use (Mohtabai, Olfson, & Mechanic, 2002). An item related to delusions of persecution (American Psychiatric Association, 1994) and impulse control concerns (American Psychiatric Association, 1994) were included based on the findings associated with the over-diagnosis of paranoid schizophrenia in Black clients (Neighbors et al., 1999; Pavkov, Lewis, & Lyons, 1989; Snowden & Cheung, 1990; Whaley, 2002b; 2001d;), and cultural mistrust (Whaley, 2002a, 2002b, 2002c, 2001a, 2001d, 1998a). New items include:

“1: If I have a problem often feeling depressed:”

“2: If I have a problem with excessive worry and anxiety:”

“3: If I have a problem with drinking too much alcohol or drug use:”

“4: If I have a problem with people harassing or plotting to harm me:”

“5: If I have a problem with controlling my anger:”

The four preferences presented by Parham and Helms (1981) were changed to assess a Black client’s willingness to seek counseling from a White counselor. The modified items include:

“I am willing to see a White counselor”

“I am not willing to see a White counselor”

Scoring. Participants indicated their willingness to seek counseling from a White counselor in each problem scenario. For the purpose of scoring, the selection of whether a Black client is willing to see a White counselor or not willing to see a White counselor was assigned a value: willing to see a White counselor = 1; not willing to see a White counselor = 0. The total score on the CWS reflects the level of willingness of the respondent to seek or not to seek counseling from a White counselor. With the scoring adapted for this scale, a higher total score corresponds to a higher willingness of a Black client to seek counseling from a White clinician. A low total score on the CWS indicates a low desire of a Black client to seek counseling from a White clinician.

Reliability Analysis. For this study, the CWS was used to assess Black participants’ willingness to seek counseling from a White clinician. A pilot study consisting of 10 self-identified Black adult non-students were sampled to determine the

reliability of the CWS. Eight adult women and two adult men completed the survey. The sample consisted of individuals recruited from an inner-city community in the Atlantic region of the United States. Once a participant completed the CWS, he or she was asked questions of clarification, understanding, and sensitivity. Cronbach's alpha for internal consistency was used to determine the reliability coefficient for the instrument.

Cronbach's alpha for the 10 items of the CWS was .83 for the pilot sample ($M = 4.90$, $SD = 3.14$). This measure has not been used in any empirical studies. For this study, the Cronbach's alpha was .93.

Racial identity attitude scale – B. The Racial Identity Attitude Scale (RIAS) (Helms & Parham, 1985; see Appendix E) is a 50-item inventory designed to assess Blacks' racial identity schemas (formerly referred to as attitudes) that reflect the stages of racial identity developed by Cross (1971, 1978) in his model of psychological nigrescence or Black self-actualization under oppressed conditions. The RIAS was developed to assess the schemas (cognitive component) and measure the personality that derives from the Black perspective, so that researchers could theorize and assess the personality characteristics of Blacks. The four racial identity schemas assessed in this measure include Pre-Encounter (an individual operates from a perspective of being non-Black or the opposite of Black), Encounter (an individual begins to question his or her racial identity because of a particular event or circumstance), Immersion-Emersion (an individual chooses to exude Black pride by idealizing everything that is reflective of the Black experience, and disengaging, disowning, and denigrating everything that is White),

and Internalization (an individual who has achieved a sense of security with his or her Blackness, without the denigration of White society).

Three versions of the RIAS were developed. The first version, entitled Racial Identity Attitude Scale – Short Form A (RIAS-A), was designed to modify Cross' (1971) Q-sort items into attitudinal items by requesting that participants use a 30-item, 5-point Likert scale, ranging from “strongly disagree” to “strongly agree”, indicating the participants' level of agreement with the 30-item inventory. Factor analysis was used for the second version of the Racial Identity Attitude Scale – Short Form B (RIAS-B) because of the transitional nature of the Encounter schema, whereby a Black individual begins to transition from a pro-White/anti-Black racial identity schema to a pro-Black/anti-White racial identity schema. Short Form B is also a 30-item, 5-point Likert scale ranging from “strongly disagree” to “strongly agree.” The third version of the RIAS is the long form of the scale, which consists of 50 items with the same range as the short forms. The RIAS-B was used for the purposes of this study because the RIAS-B contains a higher internal consistency than RIAS-A and the long form for the following subscales: Pre-Encounter, Immersion-Emersion, and Internalization (Helms & Parham, 1985).

Reliability studies of the RIAS-B have been: Pre-Encounter, .69; Encounter, .50; Immersion-Emersion, .67; and Internalization, .79. The RIAS has been used in over 50 published research studies (Vandiver et al., 2002). For this study, internal consistency estimates for the four subscales of the RIAS-B were found to be as follows: Pre-Encounter, .66; Encounter, .47; Immersion-Emersion, .67; and Internalization, .64. The

reliability estimates found in this study were consistent with the reliability estimates reported in past studies.

Items on the RIAS-B include:

Pre-Encounter: “I believe that large numbers of Blacks are untrustworthy” and “I believe that White people look and express themselves better than Blacks.”

Encounter: “I feel unable to involve myself in White experiences and am increasing my involvement in Black experiences” and “I am determined to find my Black identity.”

Immersion-Emersion: “I often find myself referring to White people as honkies, devils, pigs, etc.” and “I frequently confront the system and the man.”

Internalization: “I involve myself in causes that will help all oppressed people” and “I feel good about being Black but do not limit myself to Black activities.”

Scoring. Participants respond to each item on a 5-point Likert scale, ranging from “strongly disagree (1)” to “strongly agree (5).” The participants’ score is totaled for each subscale and divided by the number of items in that subscale, producing a mean score for that particular subscale. Consequently, each participant will have four subscale scores that correspond to different stages. Higher scores for each subscale suggest a strong attitude relative to that particular subscale.

Validation. The construct validity of the RIAS-B has been established in a variety of studies. Researchers have found that racial identity schemas (how individuals identify with their socially ascribed racial group) as measured by the RIAS-B, are associated with a number of behavioral, psychological, cultural, and affective variables in a manner

consistent with racial identity theory (Carter, 1995). Ponterotto and Wise (1987) examined the construct validity of the original RIAS. 205 African American participants were recruited from predominantly White universities from two geographically dispersed locations (mid-Atlantic Coast and the Midwest). The age range of participants was 17 to 46 years, with an average age of 21. The following alpha coefficients were calculated for each of the RIAS subscales: Pre-Encounter = .63; Encounter = .37; Immersion-Emersion = .72; and Internalization = .37. Researchers found that the underlying structure of the RIAS supported the theoretical constructs inherent in Cross' original theory as well as Parham and Helms (1981) racial identity schemas works relative to the Pre-Encounter, Encounter, Immersion-Emersion, and Internalization stages. However, there was little support for the Encounter stage as represented in the RIAS. The researchers concluded that Encounter attitudes might be difficult to conceptualize and measure. Further, the authors suggested that the RIAS is limited because it only measures attitudes, which is only one measure of racial identity.

Pre-Encounter attitudes have been associated with high anxiety and greater psychological distress (Carter, 1991), depression and low self-esteem (Pyant & Yanico, 1991). Encounter attitudes have been associated with positive self-esteem (Parham & Helms, 1985), low anxiety (Parham & Helms), and low psychological well-being (Pyant & Yanico, 1991). Immersion-Emersion attitudes have been associated with lower well-being (Carter, 1991; Pyant & Yanico, 1991; Wilson & Constantine, 1999) and higher levels of anxiety, anger, and hostility (Parham & Helms). Internalization attitudes have been associated with greater hope (Jackson & Neville, 1998), an internal locus of control

(Martin & Nagayama-Hall, 1992), and greater psychological well-being (Franklin-Jackson & Carter, 2007).

Additionally, concurrent validity for the RIAS-B has been found through the association of more mature racial identity status attitudes with Afrocentric cultural values (Carter & Helms, 1987), preferences for Black counselors (Helms & Carter, 1991), and participation in Black-oriented activities (Mitchell & Dell, 1992); and the association of less mature racial identity status attitudes with preferences for White counselors (Parham & Helms, 1981), less participation in Black-oriented activities (Mitchell & Dell), and less perception of discrimination in organizations (Watts & Carter, 1991). Positive correlations have also been found between the RIAS-B and measures of ego-identity (Miville et al., 2000), racial socialization (Miller, 1999), and African American acculturation (Pope-Davis et al., 2000).

Helms (1990) summarized the research literature providing validity evidence for the RIAS-B. Racial identity schemas were significantly related to self-esteem, affective states, demographic similarity, and preference for therapists' race in a manner fairly consistent with the racial identity theory (see Helms & Carter, 1991; Ponterotto & Wise, 1987).

In summary, the RIAS has been the most widely used measure of racial identity in the research literature. Internal consistency estimates for the subscales have been variable, particularly for the Encounter scale suggesting that this subscale may not be most consistently measuring the transitional state from pro-White/anti-Black schemas to pro-Black/anti-White schemas in Black people. However, adequate evidence exists to

support the reliability of the Pre-Encounter, Immersion-Emersion, and Internalization scales (Sabnani & Ponterotto, 1992). Regarding validity, there is a growing body of recent work employing the RIAS (especially using the long form) that supports the construct validity of the RIAS (see Carter, 1991; Mitchell & Dell, 1992; Parham & Williams, 1993; Pyant & Yanico, 1991; Taub & McEwen, 1992). Essentially, the Nigrescence model through the development of the RIAS-B by Parham and Helms (1981) has had a catalytic impact on racial identity research. For the purpose of this study, the RIAS-B was used to assess Black participants' racial identity schemas across four stages (Pre-Encounter, Encounter, Immersion-Emersion, and Internalization).

Proposed Data Analysis

The data analyses included preliminary analyses, such as descriptive statistics of the data, chi-square test for association, reliability estimation, and one-way ANOVA. Secondary analyses included, correlation analyses (r), multiple regression analyses, and a special case of structural equation modeling (SEM) called path analysis using Mplus were also used to examine the data. The path analytic approach was utilized to examine the correlation between the variables in five hypothesized models because it is important to determine the direct and indirect effects on Black clients' willingness to seek counseling from a White clinician. The details of the analyses and the statistical techniques utilized to analyze and report the data are described in the following sections. Statistical Package for the Social Sciences (SPSS) 21.0 was used for descriptive statistics, chi-square tests for association, reliability estimates, one-way ANOVA, correlation

analyses, and multiple regression analyses. Again, Mplus was used to conduct path analysis.

Descriptive statistics. Descriptive statistics included each scales' Cronbach's alpha of internal consistency reliability, the mean, the standard deviation, and the observed and possible range of scores (see Table 3 in Chapter 4).

Chi-square tests for association. According to Dimitrov (2008) the chi-square test for association is used to identify a possible association between two categorical variables. For the purposes of this study, chi-square tests for association were used to compare paper and electronic responses to specific demographic data (e.g., student status, sex, age range, marital status, employment status, educational attainment levels, and annual income). Also, chi-square tests for association were used to compare the sex of the participants' responses to specific demographic data.

Reliability estimates. According to Pedhazur and Schmelkin (1991) reliability is a necessary condition of validity, and reliability is used to check the homogeneity of items measuring a variable or to the extent to which item scores are free from "errors of measurement" (p. 82). According to Pedhazur and Schmelkin (1991), Cronbach's alpha or alpha coefficient is the most often used technique in estimating internal-consistency reliability. In the current study, the reliability of the four scales of measurement for help-seeking attitudes, client willingness to seek counseling from a White clinician, racial identity schemas, and cultural mistrust was estimated using Cronbach's alpha technique (see Table 3 in Chapter 4).

One-way ANOVA. Prior to collapsing the data, a one-way ANOVA was

calculated to explore the differences between participants who completed the survey online and those who completed the paper survey in relation to willingness to seek counseling from a White clinician. Further, a one-way ANOVA was calculated to examine the differences between college-educated participants' willingness to seek counseling from a White clinician, and non-college educated participants' willingness to seek counseling from a White clinician.

Correlation (*r*) analyses. In this study the researcher used the correlation coefficient (*r*) to determine if there were positive or negative associations between the variables under study. A correlation analysis is utilized to examine if there is an association between two variables and/or whether there is an observed covariance between the two variables of interest (Kachigan, 1991). According to Kachigan (1991), “the correlation coefficient, finds application in the widest range of data analysis problems” (p. 125). The range of the correlation coefficient or *r* can be from -1 to + 1. While correlation coefficient or *r* of +1 suggests a perfect positive correlation, *r* of -1 suggests a perfect negative correlation, and *r* of 0 suggests that there is no relationship between the two variables of interest. The direct correlations between ATSPPHS-S and Pre-Encounter, ATSPPHS-S and Encounter, ATSPPHS-S and Immersion-Emersion, ATSPPHS-S and Internalization, ATSPPHS-S and CMI, Pre-Encounter and Encounter, Pre-Encounter and Immersion-Emersion, Pre-Encounter and Internalization, Pre-Encounter and CMI, Encounter and Immersion-Emersion, Encounter and Internalization, Encounter and CMI, Immersion-Emersion and Internalization, Immersion-Emersion and CMI, and Internalization and CMI were examined (see Table 4 in Chapter 4). All

relationships were bi-directional, hence they are defined as two-tailed. The critical values for r (for a two-tailed test) based on the study's sample were .088 at $p < .05$ significance level and 0.115 at $p < 0.01$ significance level (Price, 2000).

Regression analyses. Multiple regression analyses were used in the current study to examine if the independent variables predicted the dependent variables (see Table 5 in Chapter 4). According to Kachigan (1991), a regression analysis equation “describes the nature of the relationship between two variables” and “regression analysis supplies variance measures which allow us to assess the accuracy with which the regression equation can predict values on the criterion variable...” (p. 160). Regression analysis could also be termed prediction analysis because it measures the degree of the relationship between the predictor variable and the criterion variable. In this study, the researcher has hypothesized that help-seeking attitudes, racial identity schemas, and cultural mistrust (predictor variables) will predict client willingness (criterion variable). Forced entry regression method (see Table 6 in Chapter 4) and stepwise entry regression method (see Table 7 in Chapter 4) were also used. A p-value of .05 or less was used as the criterion to decide if the degree of prediction was significant.

Path analyses. A path analytic approach was used to depict the correlation matrices hypothesized in the study and to test the hypothesized causal paths between variables. The Mplus program was used to test the path models because it includes the goodness-of-fit indices. Goodness-of-fit index is discussed later on in this section.

A structural model was used to depict the hypothesized relationships. A structural model is the model that represents the hypotheses of the researcher or that which

represents the causal hypotheses (Kline, 1998). Specification of the structural model is the starting point for a path analysis (p. 51). A reduced model was used to depict the outcome of the analysis (Ingram et al., 2000). The reduced model is also known as the over-identified model. Mplus was used to test goodness-of-fit between the hypothesized model/structural model and the independent model (see Tables 8 – 12 and Figures 2 – 6 in Chapter 4).

The path model for this study was hypothesized based on the results of researchers who suggest a causal relationship among racial identity schemas, cultural mistrust, help-seeking attitudes, and client willingness. According to Ender (1998), a path analysis is conducted under the assumptions that:

1. Relations among models are linear, additive, and causal. Curvilinear, multiplicative, or interaction relations are excluded.
2. Residuals are uncorrelated with all other variables and other residuals.
3. The causal flow is in one-direction (i.e., there is no reverse causation).
4. The variables are measured on an interval scale.
5. The variables used as predictors are measured without error.

Based on path analysis literature (Garson, 2007; Mertler & Vannatta, 2005) help-seeking attitudes, racial identity schemas, and cultural mistrust are categorized as exogenous variables. Exogenous variables exist if the study's variance of a specific variable is not explained by the variance of other variables (Dimitrov, 2008). Exogenous variables are explained as a "variable that is not caused by another variable in the model" (Dimitrov, p. 401). Conversely, a variable is referred to as an endogenous variable "if the

variance of this variable is explained by the variance of other variables in the model” (Dimitrov, p. 402). Therefore, a variable caused by one or more variables is considered an endogenous variable. In this case, client willingness can be termed as an endogenous variable. Help-seeking attitudes, racial identity schemas, and cultural mistrust were examined as independent variables, and client willingness was examined as a dependent variable. Mplus was used to test the hypothesized models.

Comparative fit indices. Four path models were tested for goodness of fit. Goodness-of-fit indices that use a comparative approach, place the model of interest or the estimated model somewhere along a continuum; a continuum in which the independence model (a model with unrelated variables) is at one end and the saturated model or full model (a model where all variables are related with each other) at the other (Tabachnick & Fidell, 2001). Although there are several indices to test goodness of fit, four indices, Tucker-Lewis Index (TLI), Comparative Fit Index (CFI), Standardized Mean Square Residual (SRMR), and Root Mean Square Error of Approximation (RMSEA), were chosen for estimating goodness of fit for the models in this study (see Table 13 in Chapter 4).

Ethical Considerations

Fontana and Frey’s (2003, p. 662) ethical guidelines were followed for this study:

1. The identity of the respondents was not revealed. There is no written mention in any public document of the name or any other indicators that identify the respondents. Only general demographic information was collected.

2. No harm was done to the respondent physically, emotionally or in any other way, shape or form.
3. Institutional Review Board (IRB) approval was obtained before starting data collection.

Summary

In Chapter Three, the population of the study and the details of the sample were discussed. The procedure used for data collection and the different instruments utilized for data collection was also explained. Further, a detailed description of the seven different analyses conducted by the researcher to test the hypotheses of the study was provided. In Chapter Four, the results of the analyses conducted by the researcher will be presented.

CHAPTER FOUR

Results

Overview

The study explored whether prospective Black participants' willingness to seek counseling from a White clinician could be predicted by the variables of cultural mistrust, racial identity schemas, and help-seeking attitudes. In addition, the Client Willingness Scale (CWS) was developed and piloted in this study to measure the willingness of prospective Black clients to seek counseling from a White clinician given specific mental health situations. The researcher collected data as described in Chapter Three.

Research Question

Do racial identity schemas, cultural mistrust, and help-seeking attitudes predict the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites?

Pilot Study Design and Results

A pilot study was conducted to check the reliability of the CWS. Ten self-identified African American/Black participants from a large urban mid-Atlantic city participated in the pilot study. The pilot sample was comprised of two males and eight females. The participants reported that they were at least 18 years of age, and self-identified as African American/Black. No other demographic data was collected. The

participants did not receive compensation for their participation in the pilot study. The participants were volunteers and could refuse to participate or decline to answer questions that they found to be uncomfortable or offensive.

The participants answered each of the 10 questions on the CWS in person. Each option was assigned a value (*Willing to see a White counselor = 1, NOT willing to see a White counselor = 0*) for the purpose of scoring. Adding all 10 values produced a total score. Table 1 shows the number of responses given to each item. Overall, 49 percent of respondents showed a willingness to seek counseling from a White clinician, and 51 percent of participants displayed resistance to seeking counseling from a White clinician.

Table 1

Responses to Client Willingness in the Pilot Study (N = 10)

Items	<u>Willing to See White Counselor</u>		<u>Not Willing to See White Counselor</u>	
	<i>n</i>	%	<i>n</i>	%
If I have a problem often feeling depressed.	5	50.0	5	50.0
If I have a problem with excessive worry and anxiety.	7	70.0	3	30.0
If I have a problem with drinking too much alcohol or drug use.	7	70.0	3	30.0
If I have a problem in my personal relationship.	3	30.0	7	70.0
If I have a problem with people harassing or plotting to harm me.	4	40.0	6	60.0
If I have a problem meeting new people.	3	30.0	7	70.0
If I have a problem concerning sexual issues.	4	40.0	6	60.0
If I have a problem concerning racial issues.	4	40.0	6	60.0
If I have a problem overcoming loneliness.	5	50.0	5	50.0
If I have a problem controlling my anger.	7	70.0	3	30.0
Total	49	49.0	51	51.0

For the pilot study, participants were asked to qualitatively report whether the items on the CWS were understandable, readable, and/or offensive in any manner. All participants qualitatively reported that the items on the CWS were understandable, readable, and no items were offensive. Some participants suggested specifying the item that read, “If I have a problem concerning racial issues” to include a statement in which a person may experience racial issues with a specific person and/or situation. However, that suggestion was rejected because specifying that particular item did not work psychometrically because none of the other items on the CWS specified an issue with a specific person and/or situation. Thus, to maintain continuity amongst the items, the “racial issues” item remained as is.

Cronbach’s alpha for internal consistency was used to determine the reliability coefficient for the instrument. The minimal accepted coefficient was set at .60. Cronbach’s alpha for the 10 items of the CWS was .83 for the pilot sample ($M = 4.90$, $SD = 3.14$). The CWS demonstrated high internal consistency without need for revisions and was determined reliable for use in the study. No validity studies were performed at that time.

Results of the Study

Design Overview

The relationship between the predictor variables of cultural mistrust, racial identity schemas, and attitudes toward professional help seeking, and the dependent variable of prospective Black clients’ willingness to seek counseling from a White clinician were examined through descriptive statistics, chi-square tests for association,

reliability estimates, correlational analyses, and multiple regression analyses using the Statistical Package for the Social Sciences (SPSS) 21.0. Mplus was used to conduct a special case of structural equation modeling (SEM) called path analysis in order to investigate the direct and indirect effects of the predictor variables (e.g., background variables, cultural mistrust, racial identity, and help-seeking attitudes) on the outcome variable (client willingness to seek counseling from a White clinician).

Demographic Data

A nationwide sample of 775 participants, 352 males (48%) and 423 females (52%) who self-identified as African American or Black participated in this study by completing electronic and paper surveys. Those participants who completed the electronic surveys submitted their responses via a survey developer database called Qualtrics, and those who completed the paper surveys placed their completed surveys in a secured “Completed Surveys” box that was monitored by the researcher. Of the 789 surveys attempted, 775 participants fully completed and returned the surveys for a 95 percent response rate. Thirty five participants’ responses were eliminated because they did not meet the qualifying criteria: African American/Black and primarily reared in the United States; thus, reducing the total amount of responses analyzed for this study to 740 responses, 335 male (45%) and 405 female (55%).

Participants completed each of the surveys and responded to all of the items as suggested. Of the 740 participants included in this study, one percent were found to be between the ages of 18-22, 14 percent between the ages of 23-27, 32 percent between the ages of 28-32, 18 percent between the ages of 33-37, 12 percent between the ages of 38-

42, and 23 percent were found to be 43 years of age or older. College-educated participants made up 86 percent of the sample. Fourteen percent of the sample were considered non-college educated, as they reported little (less than two years of college) to no college experience. Eighty six percent of the sample was employed, with 68 percent working 40 or more hours per week and 18 percent working 1-39 hours per week. Fourteen percent of the sample reported being unemployed (5% not employed and looking for work, 4% not employed and not looking for work, 4% were retired, and 1% was not able to work due to an unknown disability). Sixty two percent of the sample reported an annual income of \$60,000 and below. Thirty eight percent of the sample reported an annual income above \$60,000. Twenty eight percent of the sample primarily uses prayer and church as a means of coping with emotional or mental health issues, followed by 22 percent of the participants using friends and family as their primary means of coping. Of the 740 participants, 77 percent reported that they considered or are considering going to counseling, and finally, 53 percent of the sample reported that they have had prior experience as a client with a mental health professional. Table 2 depicts the demographic data for participants in this study.

Table 2

Demographic Characteristics of Participants (N=740)

Characteristic	N	%
<u>Sex</u>		
Male	335	45.2
Female	405	54.7
<u>Age Range</u>		
18 – 22	11	1.0
23 – 27	102	14.0
28 – 32	235	32.0
33 – 37	135	18.0
38 – 42	90	12.0
43 or older	167	23.0
<u>Community Where Raised</u>		
Rural Areas	35	5.0
Suburbs	166	22.0
Metro/Urban	458	62.0
Small Town	68	9.0
Other	14	2.0
<u>Marital Status</u>		
Single	415	56.0
Married	219	30.0
Separated	10	1.0
Divorced	47	6.0
Living with Partner	48	6.0
Civil Union	1	0.0

Characteristic	<i>N</i>	%
<u>Employment Status</u>		
Employed (40 hours or more)	502	68.0
Employed (1 – 39 hours)	134	18.0
Not Employed, looking for work	38	5.0
Not Employed, not looking for work	29	4.0
Retired	29	4.0
Disabled, unable to work	8	1.0
<u>Student Status</u>		
Current Student	237	32.0
Not a Student	503	68.0
<u>Highest Education Completed</u>		
Some High School	2	0.0
High School Diploma	25	3.0
Some College	77	10.0
2-Year College Degree or Technical	56	8.0
4-Year College Degree	152	21.0
Some Graduate School	65	9.0
Master's Degree	250	34.0
Doctorate or Professional Degree	113	15.0
<u>Annual Income</u>		
Below \$20,001	89	12.0
\$20,001 – \$40,000	196	26.0
\$40,001 – \$60,000	173	23.0
\$60,001 – \$80,000	128	17.0
\$80,001 – \$100,000	67	9.0
Above \$100,000	87	12.0

Characteristic	<i>N</i>	%
<u>Coping Mechanism</u>		
Counseling/Psychotherapy	32	4.0
Exercise/Physical Activity	141	19.0
Overeating/Less Eating	59	8.0
Work/Job Activities	37	5.0
Prayer/Church	205	28.0
Family/Friends	162	22.0
Substance Use	39	5.0
Other	65	9.0
<u>Consideration of Counseling</u>		
Yes	568	77.0
No	172	23.0
<u>Prior Counseling Experience</u>		
Yes	390	53.0
No	350	47.0

Preliminary Analyses

Descriptive statistics. The overall mean score for the Client Willingness Scale was 6.65 and the standard deviation was 3.54, where scores can range from 0-10. The mean scores demonstrated an overall slight willingness to seek counseling from a White clinician. Seventy-six percent ($n = 561$), 76 percent ($n = 563$), and 76 percent ($n = 568$) of participants reported that they were “willing” to seek counseling from a White clinician for issues concerning depression, worry and anxiety, and alcohol and drug use, respectively. In contrast, 69 percent ($n = 513$) and 38 percent ($n = 283$) of respondents

were unwilling to seek counseling from a White clinician for concerns surrounding racial and harassment issues, respectively. These results indicate that the participants in this study are comfortable with disclosing information to a White clinician for personal issues except for issues surrounding race and harassment, suggesting that race is a topic in which Black participants in this study did not feel as open to discussing with Whites in a mental health setting. Because the CWS has not been used in any other empirical studies, the researcher was unable to compare the mean of the CWS for this research study to past studies.

The Cultural Mistrust Inventory (CMI) had a range of scores from 35-129, indicating average levels of cultural mistrust. For the purposes of this study, only the following CMI subscales were used to measure participants' levels of cultural mistrust: Education and Training and Interpersonal Relations. However, the two subscales yield a total score; thus, producing a total mean. The mean and standard deviation for the CMI in this study was 66.63 and 5.23, respectively, whereby Phelps, Taylor, and Gerard (2001) reported the following CMI subscale means for their study that explored the cultural mistrust, ethnic identity, racial identity, and self-esteem of Black students: Education and Training ($M = 22.31$, $SD = 9.94$); Interpersonal Relations ($M = 52.07$; $SD = 15.65$).

The Attitudes Toward Seeking Professional Psychological Help Scale – Short Form (ATSPPHS-S) had score ranges from 3-30, indicating average, positive attitudes toward seeking help (Fisher & Farina, 1995). For the whole sample, the mean and standard deviation were 19.22, 4.88, respectively, which demonstrated an average positive attitude toward seeking professional psychological help. While other studies with

mixed ethnicity participants report slightly higher means indicative of more positive attitudes toward seeking help (Hatchett, 2007), it is important to note that the present sample included only those participants who self-identified as African American or Black, a group that has been historically characterized as holding more negative attitudes toward seeking psychological help.

The means of the four subscales of Racial Identity Attitudes Scale - B (RIAS-B): Pre-Encounter ($M = 15.79$, $SD = 4.29$), Encounter ($M = 10.66$, $SD = 2.82$), Immersion-Emersion ($M = 19.11$, $SD = 4.68$), and Internalization ($M = 36.32$, $SD = 4.31$), indicated moderate levels of racial identity schemas. The means for the four RIAS-B subscales were higher in comparison to the mean score reported by Whatley, Allen, and Dana (2003) who used the RIAS-B to examine the relation of the Minnesota Multiphasic Personality Inventory (MMPI) to racial identity: Pre-Encounter ($M = 2.10$, $SD = .50$); Encounter ($M = 3.65$, $SD = .48$); Immersion-Emersion ($M = 3.40$, $SD = .54$); Internalization ($M = 3.75$, $SD = .53$).

Total scores and Cronbach's alpha coefficients were calculated for the ATSPPHS-S, CWS, RIAS-B (Pre-Encounter, Encounter, Immersion-Emersion, and Internalization subscales), and CMI. According to Pedhazur and Schmelkin (1991), a score of .80 or higher meant that 80% of the variance is systematic or reliable variance. Alpha coefficients for the scales indicated good internal consistency with the exception of the RIAS-B subscales. Although the internal consistency estimates for the RIAS-B subscales in this study were lower than .80, they were either similar or higher than estimates in other published studies using this measure (Halgunseth et al., 2005; Helms, 1990; Helms

& Parham, 1985; Pieterse & Carter, 2010; Ponterotto & Wise, 1987; Sanchez & Carter, 2005; Want et al., 2004; Watt, 2006; Pillay, 2005). See Table 3 for reliability estimates for all measures used in this study.

Table 3

Internal Consistency Reliabilities

Measure/Scale	N	Mean	SD	α	Range	
					Possible Range	Actual
ATSPPHS-S (10 items)	740	19.22	4.88	.82	0 – 30	3 – 30
CWS (10 items)	740	6.65	3.54	.93	0 – 10	0 – 10
RIAS-B Pre-Encounter subscale (9 items)	740	15.79	4.29	.66	9 – 45	9 – 32
RIAS-B Encounter subscale (4 items)	740	10.66	2.82	.47	4 – 20	4 – 20
RIAS-B Immersion-Emersion subscale (8 items)	740	19.11	4.68	.67	8 – 40	8 – 36
RIAS-B Internalization subscale (9 items)	740	36.32	4.31	.64	9 – 45	14 – 45
CMI (21 items)	740	66.43	15.23	.84	21 – 147	35 – 129

Chi-square tests for association. Chi-square tests for association were conducted to examine whether there were differences between the sex of participants across demographic variables, such as age range, educational attainment, employment status, annual income, marital status, coping mechanisms, consideration of counseling, and prior counseling experience. The differences between response formats across demographic variables (e.g., student status, sex, age range, marital status, employment status, educational attainment, and annual income) were also examined.

A chi-square analysis was used to examine whether there were differences between the sex of the participants across the demographic variables. The chi-square results revealed that there were no significant differences between the sex of the participants on the variable of educational attainment ($p > .05$). However, there were significant differences on the remaining demographic variables. Specifically, the results from the chi-square test show that there was a statistically significant association between sex and coping mechanisms, $X^2(7, 740) = 60.68, p < .001$. Thus, the representation of males and females within each coping mechanism group departed from random variation. That is, more females reported that they utilize prayer/church as their primary means of coping with mental and emotional concerns ($n = 133$) than the male participants ($n = 72$). Also, there was a statistically significant association between sex and participants' consideration of counseling, $X^2(1, 740) = 42.16, p < .001$. Thus, the representation of males and females within each consideration of counseling group departed from random variation, such that each consideration of counseling group had substantially and significantly more of one sex than the other: female participants considered counseling or

were considering counseling ($n = 348$) more so than the male participants ($n = 220$). Lastly, there was a statistically significant association between sex and the participants' prior counseling experience with a mental health professional, $X^2(1, 740) = 46.64, p < .05$. Thus, the representation of males and females within each prior counseling experience group departed from random variation, meaning no prior counseling group had substantially and significantly more of one sex than the other: both female ($n = 228$) and male ($n = 162$) participants in this study have had prior counseling experience with a mental health professional. Participants' primary coping mechanism, consideration of counseling, and prior counseling experience is important because all three variables can impact whether prospective Black clients will seek counseling from a White clinician. For instance, if a participant reports that he or she primarily relies on informal networks of support, has never considered counseling, and has no prior counseling experience, the participant may not be willing to seek counseling from a White clinician.

A chi-square analysis was used to examine whether there were statistically significant differences between the response formats of the participants across the demographic variables. The chi-square results revealed that there were no statistically significant differences between the response format of the participants on the variables of sex, age range, marital status, employment status, and annual income ($p > .05$). However, there were statistically significant differences on the remaining demographic variables of student status and educational attainment. Specifically, the results from the chi-square test reveal that there was a statistically significant association between the response formats and student status, $X^2(1, 739) = 8.05, p < .01$. Thus, the representation

of electronic responses and paper responses within each student status group departed from random variation, such that participants who completed the study's survey electronically reported that they were current students (either secondary or post-secondary school) ($n = 233$) as compared to participants who completed the survey by paper ($n = 4$). Further, there was a statistically significant association between the response formats and participants' educational attainment, $X^2(7, 739) = 156.73, p < .001$. Thus, the representation of electronic responses and paper responses within each educational attainment group departed from random variation. This means that the majority of participants who completed the electronic survey earned a master's degree ($n = 248$) as compared to those participants who completed the survey by paper ($n = 2$).

One-way ANOVA. A one-way ANOVA was used to test for differences in participants' general attitude toward counseling between those who completed the survey electronically versus participants who completed the survey on paper. Participants who completed the survey electronically versus paper differed significantly across general attitudes toward counseling, $F(1, 739) = 5.10, p < .05$, such that participants who completed the survey electronically had more positive attitudes toward seeking professional psychological help.

A one-way ANOVA was used to test for differences in participants' RIAS-B Encounter racial identity schema between those who completed the survey electronically versus participants who completed the survey on paper. Participants who completed the survey electronically versus paper differed significantly across the RIAS-B Encounter racial identity schema subscale, $F(1, 739) = 6.56, p < .05$. Thus, participants who

completed the survey by paper endorsed an Encounter racial identity schema slightly more than those participants who completed the survey electronically.

A one-way ANOVA was used to test for differences in participants' RIAS-B Immersion-Emersion racial identity schema between those who completed the survey electronically versus participants who completed the survey on paper. Participants who completed the survey electronically versus paper differed significantly across the RIAS-B Immersion-Emersion racial identity schema subscale, $F(1, 739) = 6.40, p < .05$. Thus, participants who completed the survey by paper endorsed an Immersion-Emersion racial identity schema slightly more than those participants who completed the survey electronically

A one-way ANOVA was used to test for differences in participants' general attitude toward counseling between those participants that were college educated (earned two-year degree or more) versus participants who were non-college educated (less than two years). Participants who were college educated versus non-college educated differed significantly across general attitudes toward counseling, $F(1, 739) = 12.83, p < .001$, such that college-educated participants had more positive attitudes toward seeking professional psychological help.

A one-way ANOVA was used to test for differences in participants' RIAS-B Pre-Encounter racial identity schema between those participants that were college educated (earned two-year degree or more) versus participants who were non-college educated (less than two years). Participants who were college educated versus non-college educated differed significantly across the RIAS-B Pre-Encounter racial identity schema

subscale, $F(1, 739) = 5.08, p < .05$. These results indicate that non-college educated participants endorsed a Pre-Encounter racial identity schema slightly more than those participants who were college-educated.

Hedge's G. Participants who completed the ATSPPHS-S on paper were moderately less inclined to seek professional psychological help ($M = 17.46, SD = 5.09, n = 37$) than those who completed the ATSPPHS-S electronically ($M = 19.31, SD = 4.86, n = 703$), $p < .05, g = 0.38$. Participants who completed the RIAS-B on paper endorsed Encounter racial identity schemas slightly more ($M = 11.81, SD = 3.16, n = 37$) than those who completed the RIAS-B electronically ($M = 10.60, SD = 2.79, n = 703$), $p < .05, g = -0.431$. Participants who completed the RIAS-B on paper endorsed Immersion-Emersion racial identity schemas slightly more ($M = 21.00, SD = 5.84, n = 37$) than those who completed the RIAS-B electronically ($M = 19.01, SD = 4.59, n = 703$), $p < .05, g = -0.427$. College-educated participants were slightly more inclined to seek professional psychological help ($M = 19.48, SD = 4.82, n = 636$) than those non-college educated participants ($M = 17.64, SD = 5.05, n = 104$), $p < .001, g = -0.38$. Non-college educated participants endorsed Pre-Encounter racial identity schemas slightly more ($M = 16.66, SD = 4.80, n = 104$) than those college-educated participants ($M = 15.64, SD = 4.19, n = 636$), $p < .05, g = 0.24$.

Participants who completed the paper survey were significantly less likely to be current higher education students & had significantly less levels of education than the participants who completed the survey electronically. There was a statistically significant difference between participants who completed the survey electronically and those who

completed the survey on paper on three scales: ATSPPHS, RIAS-B Encounter subscale, and RIAS-B Immersion-Emersion subscale. The reason for this difference could potentially be because participants who completed the survey on paper were less likely to be current students and completed less education than those that completed the survey electronically. Therefore, current student status and education attainment levels may potentially make a difference in prospective Black clients' willingness to seek counseling from a White clinician.

The effect size was also calculated to determine the practical significance between those groups so the researchers further examined the data to determine the demographic factors that may have been related to those differences. Chi-square tests for association determined significant differences on only the following variables: student status, educational attainment, response format, sex, coping mechanisms, consideration of counseling, and prior counseling experience. The participants who completed the survey electronically were more likely to be current students, $X^2(1, N = 739) = 8.05, p < .05$, and more likely to have earned a two-year degree or higher, $X^2(7, N = 739) = 156.73, p < .001$.

Secondary Analyses

Multiple analyses were conducted in order to address the hypotheses that cultural mistrust, racial identity schemas, and help-seeking attitudes would predict prospective Black clients' willingness to seek counseling from a White clinician. First, zero-order correlations were conducted to examine the relationship between predictor and outcome variables. Second, predictors that were significantly related to prospective Black clients'

willingness to seek counseling from a White clinician were entered into a multiple regression, a forced entry regression, and a stepwise regression analyses to examine the amount of variance each predictor explained in prospective Black clients' willingness to seek counseling from a White clinician. Lastly, path analysis was conducted to determine the direct and indirect effects on Black clients' willingness to seek counseling from a White clinician.

Results of correlation (*r*) analyses. Multiple R is the coefficient used to describe the degree of relationship between the criterion and the combined group of predictor variables (Hinkle, Wiersma, & Jurs, 1994). The correlation matrix shows the extent to which the predictor variables are correlated with the criterion variable and with other predictor variables. Table 4 shows the correlation matrix for the study's sample. Preferably, predictor variables should show high correlations with the criterion variable and low inter-correlations with other predictor variables. High inter-correlations among predictor variables (multi-collinearity) will confound the importance of any given predictor variable and will severely limit the size of multiple R, which is the absolute value of the correlation coefficient between the predicted scores and the actual scores (Stevens, 1996).

Help-seeking attitudes. In the overall sample, the scores on the ATSPPHS-S correlated with scores on the CWS, resulting in a statistically significant positive correlation, $r(740) = .21, p < .01$. This suggests a relationship between Black participants' positive attitudes toward counseling and willingness to seek counseling from a White clinician. Correlational analyses also revealed statistically significant

relationships between ATSPPHS-S and RIAS-B Pre-Encounter, $r(740) = -.20, p < .01$, and RIAS-B Internalization, $r(740) = .08, p < .05$; however, using Davis (1971) criteria of descriptors, the Pre-Encounter association was negligible since the correlation coefficients were less than 0.0 – 0.2. These results indicate that those participants who endorsed Pre-Encounter racial identity schemas (Pro-White/anti-Black attitudes) hold unfavorable help seeking attitudes. Internalization racial identity schema (strong Black racial group identity and a decline in global anti-White attitudes) were more likely to hold favorable help-seeking attitudes. The scores on the ATSPPHS-S did not correlate with the scores on the RIAS-B Encounter, the RIAS-B Immersion-Emersion, and the CMI.

Racial identity schemas. Correlational analyses were conducted between the scores on the racial identity subscales (Pre-Encounter, Encounter, Immersion-Emersion, and Internalization) and the CWS. A statistically significant negative correlation was found between scores on the CWS and scores on the RIAS-B Encounter, $r(740) = -.25, p < .01$, suggesting a negative relationship between participants who endorsed Encounter racial identity schemas and likeliness to seek counseling from a White clinician. A statistically significant negative correlation was also found between scores on the CWS and the RIAS-B Immersion-Emersion, $r(740) = -.33, p < .01$, suggesting a negative relationship between those participants who endorsed Immersion-Emersion racial identity schemas and likeliness to seek counseling from a White clinician. Lastly, a statistically significant negative correlation was found between scores on the CWS and the RIAS-B Internalization, $r(740) = -.11, p < .05$, implying a negative relationship between those participants who endorsed Internalization racial identity schemas and likeliness to seek

counseling from a White clinician. No relationship was found between the scores on the CWS and scores on the RIAS-B Pre-Encounter, $r(740) = -.03, p > .05$. There was also a high correlation between the scores on the RIAS-B Encounter and the scores on the RIAS-B Immersion-Emersion, $r(740) = .70, p < .01$, implying that a positive relationship between those participants who endorsed Encounter racial identity schemas and participants who endorsed Immersion-Emersion racial identity schemas. The Encounter and Immersion-Emersion racial identity schemas also indicate multi-collinearity, such that the correlations amongst these two independent variables are strong. This is an undesirable situation because multi-collinearity increases the standard errors of the coefficients for some independent variables, resulting in the possibility of some coefficients not being significant.

Cultural mistrust. The results indicated that a statistically significant negative correlation was found between scores on the CWS and scores on the CMI, $r(740) = -.40, p < .01$, suggesting that those participants who had higher levels of cultural mistrust were less likely to seek counseling from a White clinician. Significant correlations were also found between the CMI and the other predictor variables. Statistically significant positive correlations were found between scores on the CMI and scores on the following subscales: RIAS-B Immersion-Emersion, $r(740) = .53, p < .01$, RIAS-B Encounter, $r(740) = .39, p < .01$, and the RIAS-B Internalization, $r(740) = .14, p < .01$. The results suggest a positive relationship between those participants who endorsed an anti-White/pro-Black racial identity schema (Immersion-Emersion) and expressed a mistrust of Whites. Participants who were more likely to begin questioning his or her racial

identity because of a particular event or circumstance (Encounter racial identity schema) also reported high levels of cultural mistrust. Similarly, the results imply that those who have achieved a sense of security with his or her Blackness, without the denigration of White society (Internalization racial identity schema) also had a slight mistrust of Whites.

Table 4

Correlations for the Client Willingness Scale and the Predictor Variables

Variable	1	2	3	4	5	6	7	<i>M</i>	<i>SD</i>
1. CWS	—	.21**	-.03	-.25**	-.33**	-.11*	-.40**	6.65	3.54
2. ATSPPHS-S		—	-.20**	.04	-.01	.08	-.06	19.22	4.88
3. Pre-Encounter			—	.16**	.05	-.28**	.01	15.79	4.29
4. Encounter				—	.70**	.43**	.39**	10.66	2.82
5. Immersion-Emersion					—	.39**	.53**	19.11	4.68
6. Internalization						—	.14**	36.32	4.31
7. CMI							—	66.43	15.23

Note. CWS = Client Willingness Scale; ATSPPHS-S = Attitudes Toward Seek Professional Psychological Help Scales – Short Form; Pre-Encounter = RIAS-B Pre-Encounter; Encounter = RIAS-B Encounter; Immersion-Emersion = RIAS-B Immersion-Emersion; Internalization = RIAS Internalization; CMI = Cultural Mistrust Inventory

N = 740 **p* < .05 ***p* < .01 (2-tailed)

Results of regression analyses. Multiple regression analyses were conducted to examine the predictability of the independent variable or the predictor variable on the criterion variable (Kachigan, 1991). Help-seeking attitudes, Pre-Encounter racial identity schemas, Encounter racial identity schemas, Immersion-Emersion racial identity schemas, Internalization racial identity schemas, and cultural mistrust variables were examined solely as predictor variables on the criterion variable (Black client willingness to seek counseling from a White clinician). A p-value of .05 or less was used as the criterion to decide if the degree of prediction was significant. The results of the multiple regression analyses are provided in Table 5.

Racial identity schemas and client willingness. Hypothesis 1a postulated that high levels of Pre-Encounter racial identity schemas would be positively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites. The study found that Pre-Encounter racial identity schemas were not a significant predictor of prospective Black clients' willingness to seek counseling from a White clinician; hence, hypothesis 1a was not supported ($\beta = .022, t = .601, p > .05$). Hypothesis 1b theorized that high levels of Encounter racial identity schemas would be negatively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites. Results showed that Encounter racial identity schemas were not found to be a significant predictor of prospective Black clients' willingness to seek counseling from a White clinician; hence, hypothesis 1b was not supported ($\beta = -.039, t = -.780, p > .05$). Hypothesis 1c postulated that high levels of Immersion-Emersion racial identity schemas

would be negatively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites. The study found that Immersion-Emersion racial identity schemas were a significant, negative predictor of prospective Black clients' willingness to seek counseling from a White clinician ($\beta = -.151, t = -2.975, p < .01$), such that participants who endorsed Immersion-Emersion racial identity schemas were not willing to seek counseling from a White clinician. Hence, hypothesis 1c was supported. Finally, Hypothesis 1d posited that high levels of Internalization racial identity schemas would be positively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites. The study found that Internalization racial identity schemas were not a significant predictor of prospective Black clients' willingness to seek counseling from a White clinician; hence, hypothesis 1d was not supported ($\beta = -.001, t = .033, p > .05$).

Help-seeking attitudes and client willingness. Hypothesis 2a posited that positive attitudes toward seeking professional psychological help would be positively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites, and Hypothesis 2b theorized that negative attitudes toward seeking professional psychological help would be positively related to the unwillingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites. The study found that positive and negative help-seeking attitudes were a significant, positive predictor of prospective Black clients' willingness to seek counseling from a White clinician, such that participants who exhibited favorable help-seeking attitudes would be willing to seek counseling from a

White clinician, and participants who exhibited unfavorable help-seeking attitudes would be unwilling to seek a White clinician. Hence, Hypotheses 2a and 2b were supported, respectively ($\beta = .199, t = 5.907, p < .001$).

Cultural mistrust and client willingness. Hypothesis 3a postulated that high levels of cultural mistrust would be negatively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites, and Hypothesis 3b posited low levels of cultural mistrust would be negatively related to the willingness of prospective Black clients to seek counseling from a White clinician/clinic primarily staffed by Whites. The study found that high and low levels of cultural mistrust were significant, negative predictors of prospective Black clients' willingness to seek counseling from a White clinician, such that participants who endorsed high levels of cultural mistrust were significantly less likely to seek counseling from a White clinician, while participants who endorsed low levels of cultural mistrust were significantly more likely to seek counseling from a White clinician; therefore, Hypotheses 3a and 3b were supported, respectively ($\beta = -.288, t = -7.393, p < .001$).

Forced entry regression method. In the forced entry method, predictor variables are entered simultaneously according to some pre-specified order, which is dictated in advance by the purpose and logic of the researcher. Using this method, the analysis revealed a statistically significant model when six variables were entered as predictors (e.g., help-seeking attitudes, Pre-Encounter, Encounter, Immersion-Emersion, Internalization, and cultural mistrust). Yet, the model that included only help-seeking attitudes, Immersion-Emersion, and cultural mistrust as predictors explained the most

variance, 21 percent (Adjusted $R^2 = .211$). When a fourth variable of Pre-Encounter was entered, less variance was explained of client willingness (Adjusted $R^2 = .210$). Thus, the ideal model included three predictor variables $F(3, 736) = 56.13, p < .01$, with all three variables (e.g., help-seeking attitudes, Immersion-Emersion, and cultural mistrust) being statistically significant predictors of client willingness to seek counseling from a White clinician, when all three variables were entered as predictors. The fact that only 21 percent of the variance was accounted for using these three variables could be due to additional factors not examined in this study (e.g., coping strategies, counseling expectations), which may be contributing to the willingness of prospective Black clients to seek counseling from a White clinician. The results of the forced entry regression method are provided in Table 6.

Stepwise entry regression method. In the stepwise entry method, variables are entered into a model based on mathematical criteria. The five variables that were significantly correlated with prospective Black clients' willingness to seek counseling from a White clinician (e.g., cultural mistrust, consideration of counseling, Immersion-Emersion, help-seeking attitudes, and educational attainment) were entered as predictor variables. With a stepwise regression method, the analysis revealed a significant model ($F(5, 734) = 45.45, p < .001$), with all listed variables accounting for 24 percent of the variance (Adjusted $R^2 = .23$). Consideration of counseling ($\beta = -.13, t = -3.717, p < .001$) and educational attainment ($\beta = -.08, t = 2.492, p < .05$) were included in this model as statistically significant predictor variables. The results suggests that cultural mistrust, consideration of counseling, the Immersion-Emersion racial identity schemas, attitudes

toward seeking professional psychological help, and highest level of educational attainment are statistically significant predictors of prospective Black clients' willingness to seek counseling from a White clinician. Of the regression analyses conducted in this study, the stepwise regression method appears to be a better fit in determining the predictive nature of the independent variables and outcome variables, since it explained more variance. The results of the stepwise entry regression method are provided in Table 7.

In summary, prospective Black clients with positive help-seeking attitudes on the Attitudes Toward Seeking Professional Psychological Help Scale – Short Form, lower scores on the RIAS Immersion-Emersion racial identity schema subscale, and lower scores on the Cultural Mistrust Inventory showed a willingness to seek counseling from a White clinician. Conversely, participants who reported negative help-seeking attitudes, endorsed high levels of Immersion-Emersion racial identity schemas, and high levels of cultural mistrust exhibited an unwillingness to seek counseling from a White clinician. Moreover, participants' consideration of counseling, as measured on the Background Information Questionnaire (BIQ), negatively predicted their willingness to seek counseling from a White clinician, whereas educational attainment, along with other predictors (e.g., cultural mistrust, Immersion-Emersion, help-seeking attitudes, and consideration of counseling), positively predicted their willingness to seek counseling from a White clinician; thus Hypothesis 4 was supported. Pre-Encounter racial identity schemas, Encounter racial identity schemas, and Internalization racial identity schemas

were not significant predictors of prospective Black clients' willingness to seek counseling from a White clinician.

Table 5

Summary of Multiple Regression Analysis for Variables Predicting Willingness to Seek Counseling from a White Clinician (N = 740)

Variable	B	SE(B)	β	<i>t</i>	Sig. (<i>p</i>)
Help-Seeking Attitudes ¹	.144	.024	.199	5.907	.000
Pre-Encounter ²	.018	.030	.022	.601	.548
Encounter ²	-.048	.062	-.039	-.780	.436
Immersion-Emersion ²	-.114	.038	-.151	-2.975	.003
Internalization ²	-.001	.033	-.001	-.033	.973
Cultural Mistrust ³	-.067	.009	-.288	-7.393	.000

Note. ¹ As measured by the Attitudes Toward Seeking Professional Psychological Help Scale – Short Form, ² As measured by the Racial Identity Attitudes Scale - B, ³ As measured by the Cultural Mistrust Inventory. $R^2 = .21$

* $p < .05$ ** $p < .01$ *** $p < .001$

Table 6

Summary of Forced Entry Regression Method for Variables Predicting Willingness to Seek Counseling from a White Clinician (N = 740)

Variable	B	SE B	β	R	R ²	Adj R ²
Step 1				.21	.05	.04
Help-Seeking Attitudes ¹	.14	.02	.20***			
Step 2				.39	.15	.15
Help-Seeking Attitudes	.15	.03	.21***			
Immersion-Emersion ²	-.25	.03	-.33***			
Step 3				.46	.21	.21
Help-Seeking Attitudes	.14	.02	.19***			
Immersion-Emersion	-.13	.03	-.18***			
Cultural Mistrust ³	-.07	.01	-.29***			

Note. ¹ As measured by the Attitudes Toward Seeking Professional Psychological Help Scale – Short Form, ² As measured by the Racial Identity Attitudes Scale - B, ³ As measured by the Cultural Mistrust Inventory. R²= .21

p* < .05 *p* < .01 ****p* < .001

Table 7

Summary of Stepwise Entry Regression Method for Variables Predicting Willingness to Seek Counseling from a White Clinician (N = 740)

Variable	B	SE B	β	R	R ²	Adj R ²
Step 1				.40	.16	.16
Cultural Mistrust ³	-.09	.01	-.40***			
Step 2				.44	.19	.19
Cultural Mistrust	-.09	.01	-.40***			
Consideration ⁴	-1.6	.28	-.20***			
Step 3				.46	.22	.21
Cultural Mistrust	-.07	.01	-.31***			
Consideration	-1.6	.27	-.20***			
Immersion-Emersion ²	-.13	.03	-.17***			
Step 4				.48	.23	.23
Cultural Mistrust	-.70	.01	-.30***			
Consideration	-1.2	.30	-.14***			

Immersion-Emersion	-.13	.03	-.18***			
Help-Seeking Attitudes ¹	.10	.03	.13***			
Step 5				.49	.24	.23
Cultural Mistrust	-.07	.01	-.30***			
Consideration	-1.1	.30	-.13***			
Immersion-Emersion	-.14	.03	-.18***			
Help-Seeking Attitudes	.09	.03	.12**			
Educational Attainment ⁴	.17	.07	.08*			

Note. ¹ As measured by the Attitudes Toward Seeking Professional Psychological Help Scale – Short Form, ² As measured by the Racial Identity Attitudes Scale - B, ³ As measured by the Cultural Mistrust Inventory, ⁴ As measured by the Background Information Questionnaire. $R^2 = .24$
 * $p < .05$ ** $p < .01$ *** $p < .001$

Results of path analyses. Path analysis is a variant of structural equation modeling (SEM), which takes a confirmatory (i.e., hypothesis testing) approach to the multivariate analysis of a structural theory bearing on some phenomenon (Byrne, 1998). Using this method, structural (i.e., regression) equations represent the causal direct and indirect associations that are examined in this study, and these structural equations can be modeled pictorially to allow for a clear conceptualization of the theory under study (Byrne, 1998). However, causality cannot be determined in this study. Researchers have not reached a consensus as to the “appropriate” sample size for path analysis, though some have proposed a guideline that defines a small sample size as $N < 100$ (Kline, 1998). Nonetheless, the model’s complexity must be considered when determining the sample size. The literature suggests that complex models with more parameters require larger sample sizes (Kline, 1998). Due to the large number of indicator variables (items per measure) and a relatively large sample size in this study, path analysis (a variant of SEM) was used to incorporate the effects of measurement error on path estimates (Schumacker & Lomax, 1996), such that direct and indirect effects among variables were determined in a hypothesized path model.

Full model. The path analysis started with an initial (full) model using five background variables, also referred to exogenous variables (e.g., sex, education, age, consideration of counseling, and prior counseling experiences). Dimitrov (2008) explains exogenous variables as those variables that are not explained by the variance of other variables in the model. Other background variables, such as marital status, employment, community where primarily reared, and perceived informal support network were not

used because preliminary analyses indicated that they do not make a difference on the mediating and outcome variables and/or result in data misfit. Thus, five background variables, three mediating variables (e.g., cultural mistrust [CM], racial identity schemas [RIS], and attitudes toward counseling [ATC]), and the outcome variable (e.g., client willingness to seek counseling from White clinician [CW]), were used in this path analysis. The mediating variables and the outcome variable are known as the endogenous variables. Endogenous variables are explained by the variance of one or more variables in the model. The full model is depicted in *Figure 2*.

In the initial (full) model, there is a direct effect (one-way arrow) (a) from each background variable to each mediating variable (CM, RIS, ATC) and the outcome variable (CWS), and (b) from each mediating variable to the outcome variable. This is a just-identified model (with theoretically perfect data fit). The estimates of direct effect (DE), indirect effect (IE), and total effect (TE) under the full model are provided in Table 8. The full model was run four times, with the mediating variable RIAS being successive: subscales PreEnc (Pre-Encounter), Enc (Encounter), Imm (Immersion-Emersion), and Int (Internalization). These four variables were used to represent RIS separately for both conceptual and model identification purposes.

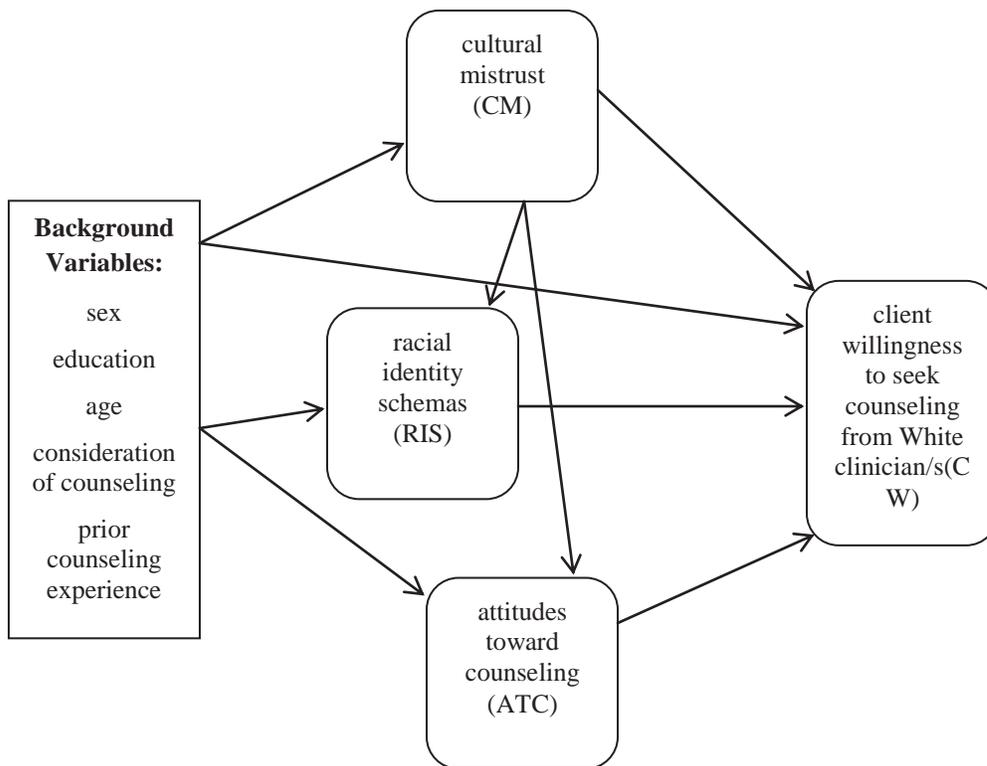


Figure 2. Initial (full) model.

A justified model that illustrates a direct effect from each background variable to each mediating variable (CM, RIS, ATC) and the outcome variable (CWS) and from each mediating variable to the outcome variable.

Table 8 summarized the results from the four estimations under the full model, whereby the effects (direct, indirect, and total effects) for the four RIAS subscales are not presented together. The estimates of the effects of the other variables (which are the same in each run of the model) are averaged over the four computations because (a) they are practically the same, with small variations in the decimals, and (b) statistically non-significant effects are dropped from the model to arrive to a modified (final) model.

In Table 8, the statistically significant effects are given in bold. The statistically non-significant (direct and/or indirect) effects were then dropped from the model to obtain four final models described later. The shaded cell in the first column indicate non-significant direct effects; that is, arrows that were subsequently dropped from the model.

In Table 8, mediating variables (e.g., cultural mistrust and racial identity schemas), and one background variable (e.g., consideration of counseling) were significant predictors on the outcome variable of prospective Black clients' willingness to seek counseling from a White clinician. Specifically, cultural mistrust had a relatively small, statistically significant, negative direct and indirect effect on prospective Black clients' willingness to seek counseling from a White clinician (TE = -0.094), such that prospective Black clients with higher levels of cultural mistrust were less willing to seek counseling from a White clinician. Further, Encounter (DE = -0.170), Immersion-Emersion (DE = -0.138), and Internalization (DE = -0.056) racial identity schemas had a relatively small, statistically significant, negative direct effect on prospective Black clients' willingness to seek counseling from a White clinician, such that prospective Black clients who endorsed Encounter, Immersion-Emersion, or Internalization racial identity schemas were less willing to seek counseling from a White clinician. Finally, participants' consideration of counseling had a moderately large, statistically significant, negative direct and indirect effect on prospective Black clients' willingness to seek counseling from a White clinician (TE = -1.387). This suggests that prospective Black clients who have considered counseling, or are considering counseling, were not willing to seek counseling from a White clinician.

More specific direct and indirect effects between intermediate and background variables were noted. The largest statistically significant total effects amongst these paths were: prior counseling to cultural mistrust (TE = -3.955); consideration of counseling to attitudes toward counseling (TE = -3.861); and age to cultural mistrust (TE = 3.442).

These results indicate that prospective Black clients who have had prior counseling experience as a client with a mental health professional expressed low levels of cultural mistrust, those that have considered or are considering counseling reported negative attitudes toward counseling, and older participants in this study endorsed significantly more cultural mistrust. It is important to note that the items “Have you ever considered or are considering going to counseling?” and “Have you ever been a client in counseling/psychotherapy with a mental health professional (psychologist, psychiatrist, clinical social worker, psychiatric nurse, alcohol or drug counselor, or licensed professional counselor)?” on the Background Information Questionnaire were entered as categorical variables rather than continuous variables ($1 = \text{yes}$; $2 = \text{no}$).

Table 8

Estimation of Direct, Indirect, and Total Effects Under Initial (Full) Path Model

Path	Direct Effect	Indirect Effect	Total Effect
CM → CW	-0.081***	-0.013**	-0.094***
PreEnc → CW	-0.003	-0.018*	-0.021
Enc → CW	-0.176***	0.007	-0.170***
Imm → CW	-0.140***	0.001	-0.138***
Int → CW	-0.056*	0.009*	-0.047
ATC → CW	0.094***	—	0.094***
CM → PreEnc	0.008	—	0.008
CM → Enc	0.073***	—	0.073***
CM → Imm	0.161***	—	0.161***
CM → Int	0.037***	—	0.037***
CM → ATC	-0.036**	0.003	-0.033**
PreEnc → ATC	-0.201***	—	-0.201***
Enc → ATC	0.068	—	0.068
Imm → ATC	0.015	—	0.015
Int → ATC	0.097**	—	0.097**
EDUC → CW	0.327	-0.020	.309
EDUC → CM	0.688	—	0.688
EDUC → PreEnc	-0.714*	0.006	-0.709*
EDUC → Enc	0.238	0.050	0.288
EDUC → Imm	0.391	0.111	0.502
EDUC → Int	0.531	0.025	0.556
EDUC → ATC	0.747*	0.032	0.778*
SEX → CW	0.127	0.192	0.319
SEX → CM	-1.030	—	-1.030
SEX → PreEnc	0.054	-0.008	0.045

SEX → Enc	0.402*	-0.075	0.326
SEX → Imm	0.010	-0.166	-0.156
SEX → Int	-0.720*	-0.038	-0.758*
SEX → ATC	1.114***	0.021	1.136**
AGE → CW	-0.340	-0.133	-0.473
AGE → CM	3.442**	—	3.442**
AGE → PreEnc	-0.889*	0.028	-0.861*
AGE → Enc	-0.515*	0.252*	-0.263
AGE → Imm	-0.488	0.554*	0.067
AGE → Int	-0.050	0.126*	0.077
AGE → ATC	1.554***	-0.082	1.473***
CONSIDER COUNS → CW	-0.998**	-0.389*	-1.387***
CONSIDER COUNS → CM	0.364	—	0.364
CONSIDER COUNS → PreEnc	-0.231	0.003	-0.228
CONSIDER COUNS → Enc	-0.336	0.027	-0.309
CONSIDER COUNS → Imm	0.335	0.059	0.394
CONSIDER COUNS → Int	-0.204	0.013	-0.191
CONSIDER COUNS → ATC	-3.851***	-0.089	-3.861***
PRIOR COUNS → CW	-0.180	0.239	.059
PRIOR COUNS → CM	-3.955**	—	-3.955**
PRIOR COUNS → PreEnc	0.532	-0.032	0.500
PRIOR COUNS → Enc	0.084	-0.289**	-0.205
PRIOR COUNS → Imm	-0.614	-0.637**	-1.251**
PRIOR COUNS → Int	-0.052	-0.145*	-0.197
PRIOR COUNS → ATC	-1.572***	0.102	-1.469***

Note. CM= cultural mistrust; ATC = attitudes toward counseling; PreEnc = Pre-Encounter; Enc = Encounter; Imm= Immersion-Emersion; Int= Internalization; EDUC = educational attainment; CONSIDER COUNS = consideration of counseling; PRIOR COUNS = prior counseling; CW = client willingness. NA (not applicable) indicates that the effect is not included in this model.

* $p < .05$. ** $p < .001$. *** $p < .001$

Models 1-4. The statistically non-significant (direct or indirect) effects in each of the four computations under the full model were dropped and the resulting (final) model was analyzed. There were four final models that differed only by the RIAS-B subscales used in the model. Specifically:

Model 1, with the RIAS subscale Pre-Encounter (PreEnc)

Model 2, with the RIAS subscale Encounter (Enc)

Model 3, with the RIAS subscale Immersion-Emersion (Imm)

Model 4, with the RIAS subscale Internalization (Int)

The path diagram for each of these models are provided with the Figures 3, 4, 5, and 6, respectively, and the results from the estimation of direct, indirect, and total effects under each of these models are provided with Tables 9, 10, 11, and 12, respectively.

Model 1. The reduced model under Model 1 with the RIAS subscale Pre-Encounter used five exogenous variables (sex, education, age, consideration of counseling, and prior counseling experiences). Thus, exogenous variables, three mediating variables (e.g., CM, PreEnc, and ATC) and one outcome variable (CW) (endogenous variables) were used in this path analysis. Model 1 is depicted in *Figure 3*.

In *Figure 3*, there is a direct effect (one-way arrow) (a) from prior counseling experience to CM, ATC, CW, from age to CM, PreEnc, ATC, from education to PreEnc, ATC, from consider counseling to ATC, from sex to ATC and (b) from CM to ATC, CW, from PreEnc to ATC, from ATC to CW. The DE, IE, and TE under Model 1 are provided in Table 9.

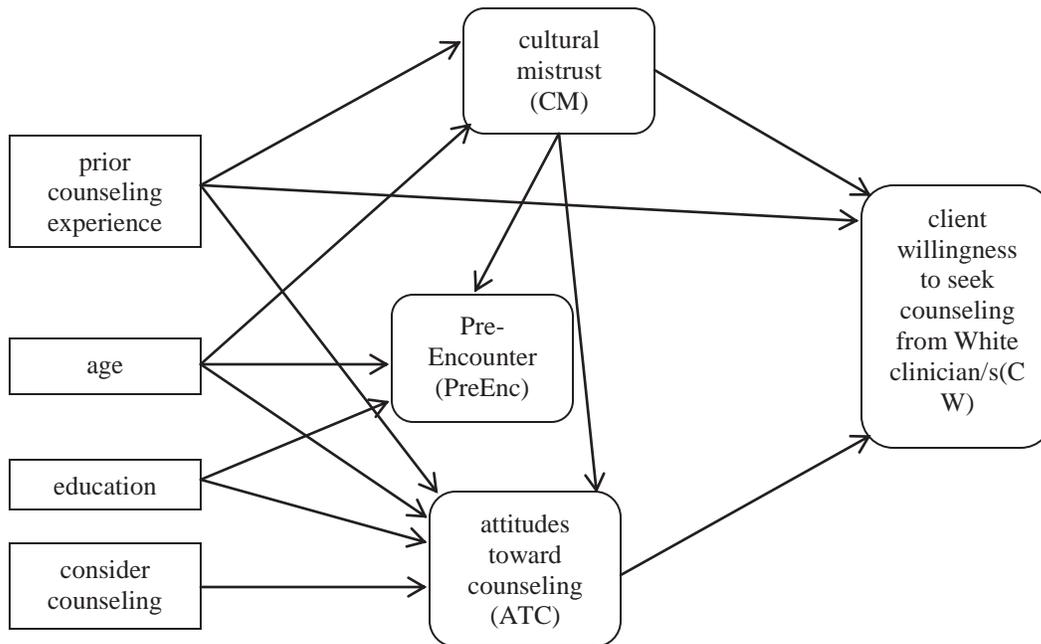


Figure 3. Model 1 (with the RIAS subscale Pre-Encounter)

In Table 9 representing the reduced model under Model 1 had a direct and/or indirect effect on the outcome variable of Blacks' willingness to seek counseling from a White clinician. Cultural mistrust reported a relatively small, statistically significant, negative direct and indirect effect on client willingness (TE = -0.094), in contrast to attitudes toward counseling having a relatively small, statistically significant, positive direct effect on client willingness (DE = 0.094). This suggests that participants with higher levels of cultural mistrust were least likely to seek counseling from a White clinician, also participants with more positive attitudes toward counseling were more willing to seek counseling from a White clinician.

Additionally, Pre-Encounter racial identity schemas had a relatively small, statistically significant, negative indirect effect on client willingness (IE = -0.019). Thus, participants who endorsed Pre-Encounter racial identity schemas were not willing to seek counseling from a White clinician. Educational attainment and the sex of the participant

had a relatively small, statistically significant, positive indirect effect on client willingness ($IE = 0.076$; $IE = 0.104$, respectively). This suggests that the higher the participants' educational attainment the more likely participants would be willing to seek counseling from a White clinician. Consideration of counseling had a moderately large direct and indirect, negative effect on a Black client's willingness to seek counseling from a White clinician ($TE = -1.541$). This finding indicated that if the participant had considered, or is currently considering counseling, the participant was unlikely to be willing to seek counseling from a White clinician.

More specific direct and indirect effects between the intermediate and background variables were highlighted. The largest statistically significant total effects amongst these paths were: consideration of counseling to attitudes toward counseling ($TE = -3.895$); prior counseling experience to cultural mistrust ($TE = -3.777$); and age to cultural mistrust ($TE = 3.589$). These results indicate that prospective Black clients who have considered, or considering, counseling exhibited negative attitudes toward counseling, participants who had prior counseling experience as a client with a mental health professional reported lower levels of cultural mistrust, and older participants endorsed significantly more cultural mistrust.

Table 9

Estimation of Direct, Indirect, and Total Effects Under Model 1

Path	Direct Effect	Indirect Effect	Total Effect
CM → CW	-0.091***	-0.003*	-0.094***
ATC → CW	0.094***	NA	0.094***
CM → ATC	-0.032***	NA	-0.032***
PreEnc → CW	NA	-0.019**	-0.019**
PreEnc → ATC	-0.201***	NA	-0.201***
EDUC → CW	NA	0.076*	0.076*
EDUC → PreEnc	-0.730*	NA	-0.730*
EDUC → ATC	0.658*	0.147*	0.804*
SEX → CW	NA	0.104*	0.104*
SEX → ATC	1.112***	NA	1.112***
AGE → CW	NA	-0.187	-0.187
AGE → CM	3.589***	NA	3.589***
AGE → PreEnc	-0.907*	NA	-0.907*
AGE → ATC	1.409***	.069	1.477***
CONSIDER COUNS → CW	-1.175***	-0.366**	-1.541***
CONSIDER COUNS → ATC	-3.895***	NA	-3.895***
PRIOR COUNS → CW	NA	0.214	0.214
PRIOR COUNS → CM	-3.777**	NA	-3.777***
PRIOR COUNS → ATC	-1.494***	0.119*	-1.374***

Note. CM= cultural mistrust; ATC = attitudes toward counseling; PreEnc = Pre-Encounter; Enc = Encounter; Imm= Immersion-Emersion; Int= Internalization; EDUC = educational attainment; CONSIDER COUNS = consideration of counseling; PRIOR COUNS = prior counseling; CW = client willingness. NA (not applicable) indicates that the effect is not included in this model.

* $p < .05$. ** $p < .001$. *** $p < .001$

Model 2. The reduced model under Model 2 with the RIAS subscale Encounter used five exogenous variables (sex, education, age, consideration of counseling, and prior counseling experiences). Thus, exogenous variables, three mediating variables (e.g., CM, Enc, and ATC) and one outcome variable (CW) (endogenous variables) were used in this path analysis. Model 2 is depicted in *Figure 4*.

In *Figure 4*, there is a direct effect (one-way arrow) (a) from prior counseling experience to CM, ATC, CW, from age to CM, Enc, ATC, from education to ATC, from consider counseling to ATC, from sex to Enc, ATC and (b) from CM to Enc, ATC, CW, from ATC to CW. The DE, IE, and TE under Model 2 are provided in Table 10.

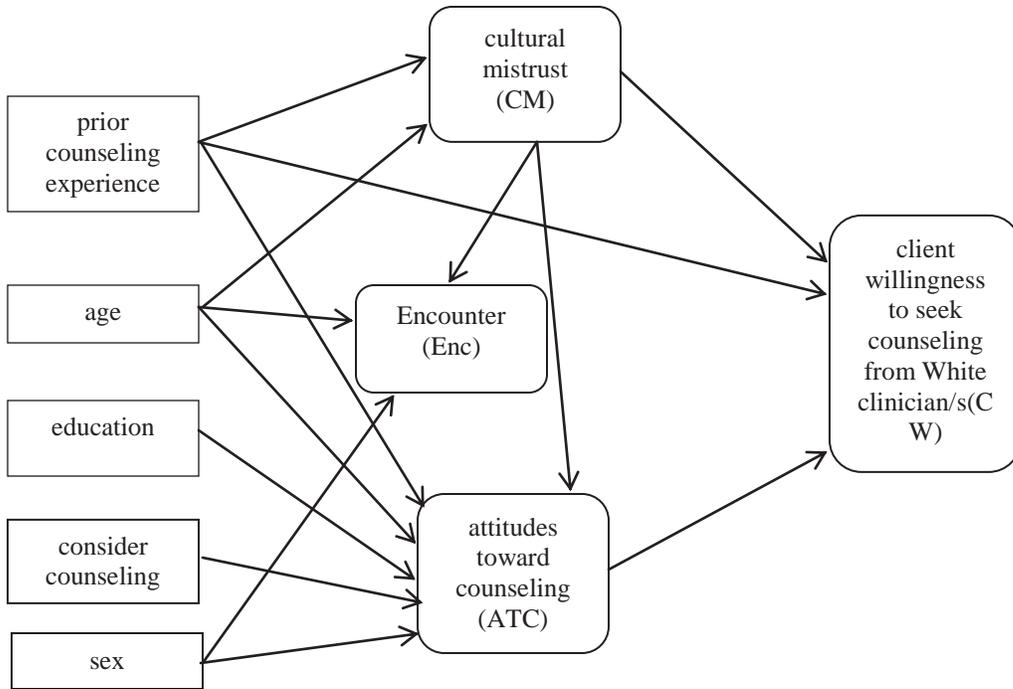


Figure 4. Model 2 (with the RIAS subscale Encounter)

In Table 10 representing the reduced model under Model 2 had a direct and/or indirect effect on the outcome variable of Blacks' willingness to seek counseling from a White clinician. Results indicated that cultural mistrust had a relatively small, statistically significant, negative direct and indirect effect on prospective Black clients' willingness to seek counseling from a White clinician (TE = -0.094), in contrast to attitudes toward counseling having a relatively small, statistically significant, positive direct effect on

client willingness ($DE = 0.098$). These results indicate that participants with higher levels of cultural mistrust were unwilling to seek counseling from a White clinician, and participants with more positive attitudes toward counseling were likely to seek counseling from a White clinician.

Educational attainment ($IE = 0.079$) and the sex of the participant ($IE = 0.108$) had a relatively small, statistically significant, positive indirect effect on prospective Black clients' willingness to seek counseling from a White clinician. This suggests that participants with higher educational attainment are more willing to seek counseling from a White clinician. Similar to Model 1, consideration of counseling had a moderately large, statistically significant direct and indirect negative effect on Black clients' willingness to seek counseling from a White clinician ($TE = -1.582$). This finding indicated that if the participant has considered or is currently considering counseling, the participant was unlikely to be willing to seek counseling from a White clinician. The Encounter racial identity schema variable was not statistically significant (direct and/or indirect); therefore, it was dropped from the model.

Additionally, more specific direct and indirect effects are between intermediate and background variables. The largest statistically significant total effects amongst these paths were: consideration of counseling to attitudes toward counseling ($TE = -3.849$); prior counseling experience to cultural mistrust ($TE = -3.777$); and age to cultural mistrust ($TE = 3.589$). These results indicate that prospective Black clients who have considered, or are considering counseling, reported negative attitudes toward counseling, participants who had prior counseling experience as a client with a mental health

professional endorsed significantly less cultural mistrust, and those older prospective Black clients reported high levels of cultural mistrust.

Table 10

Estimation of Direct, Indirect, and Total Effects Under Model 2

Path	Direct Effect	Indirect Effect	Total Effect
CM → CW	-0.091***	-0.003*	-0.094***
ATC → CW	0.098***	NA	0.098***
CM → Enc	0.074***	NA	0.074***
CM → ATC	-0.033***	NA	-0.033***
EDUC → CW	NA	0.079*	0.079*
EDUC → ATC	0.801*	NA	0.801*
SEX → CW	NA	0.108*	0.108*
SEX → Enc	0.466*	NA	0.466*
SEX → ATC	1.101**	NA	1.101**
AGE → CW	NA	-0.182	-0.182
AGE → CM	3.589***	NA	3.589***
AGE → Enc	-0.604**	0.264**	-0.340
AGE → ATC	1.587***	-0.119*	1.468***
CONSIDER COUNS → CW	-1.203***	-0.378***	-1.582***
CONSIDER COUNS → ATC	-3.849***	NA	-3.849***
PRIOR COUNS → CW	NA	0.198	0.198
PRIOR COUNS → CM	-3.777**	NA	-3.777**
PRIOR COUNS → Enc	NA	-0.278**	-0.278**
PRIOR COUNS → ATC	-1.601***	0.125*	-1.475***

Note. CM= cultural mistrust; ATC = attitudes toward counseling; PreEnc = Pre-Encounter; Enc = Encounter; Imm= Immersion-Emersion; Int = Internalization; EDUC = educational attainment; CONSIDER COUNS = consideration of counseling; PRIOR COUNS = prior counseling; CW = client willingness. NA (not applicable) indicates that the effect is not included in this model.
* $p < .05$. ** $p < .001$. *** $p < .001$

Model 3. The reduced model under Model 3 with the RIAS subscale Immersion-Emersion used five exogenous variables (sex, education, age, consideration of counseling, and prior counseling experiences). Thus, exogenous variables, three mediating variables (e.g., CM, Imm, and ATC) and one outcome variable (CW) (endogenous variables) were used in this path analysis. Model 3 is depicted in *Figure 5*.

In *Figure 5*, there is a direct effect (one-way arrow) (a) from prior counseling experience to CM, ATC, CW; from age to CM, ATC; from education to ATC; from consider counseling to ATC; from sex to ATC and (b) from CM to Imm, ATC, CW; from ATC to CW. The DE, IE, and TE under Model 3 are provided in Table 11.

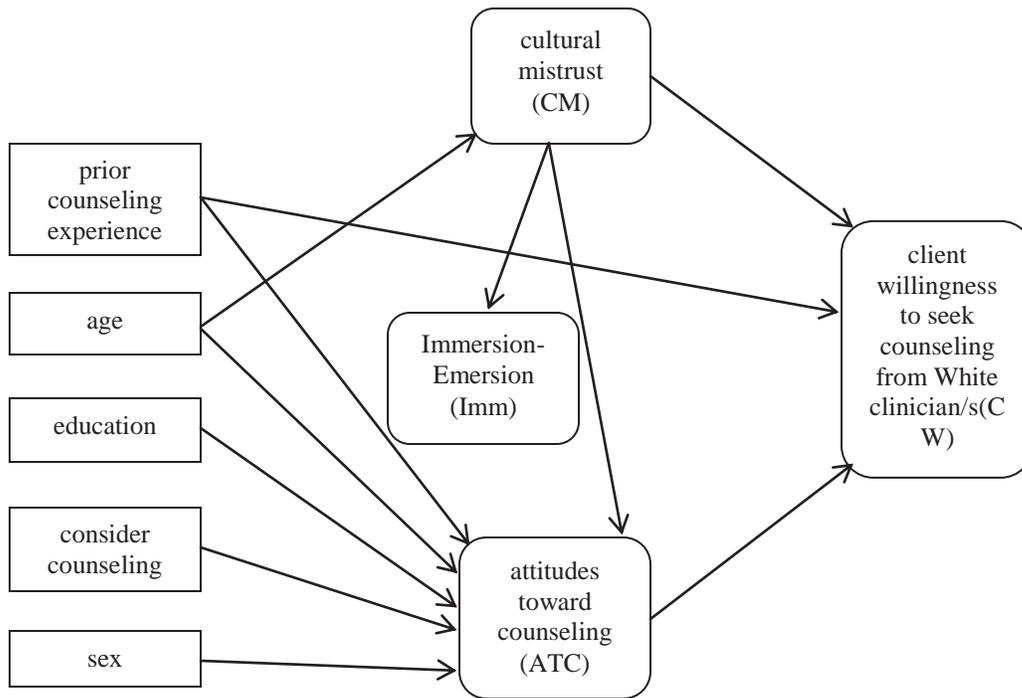


Figure 5. Model 3 (with the RIAS subscale Immersion-Emersion)

In Table 11 representing the reduced model under Model 3 had a direct and/or indirect effect on the outcome variable of Blacks’ willingness to seek counseling from a White clinician. Results indicated that cultural mistrust had a relatively small, statistically significant, negative direct and indirect effect on client willingness (TE = -0.094), in contrast to attitudes toward counseling having a relatively small, statistically significant,

positive direct effect on client willingness ($DE = 0.097$). This suggests that participants with higher levels of cultural mistrust were unwilling to seek counseling from a White clinician, also participants with more negative attitudes toward counseling were unwilling to seek counseling from a White clinician.

Educational attainment ($IE = 0.077$) and the sex of the participant ($IE = 0.106$) had a relatively small, statistically significant, positive indirect effect on client willingness. This suggests that participants with a higher educational attainment were more willing to seek counseling from a White clinician. Similar to Models 1 and 2, consideration of counseling had a direct and indirect, negative effect on Black clients' willingness to seek counseling from a White clinician ($TE = -1.546$). As a result, participants who have considered or is currently considering counseling, were resistant to seeking counseling from a White clinician. The Immersion-Emersion racial identity schema variable was not statistically significant (direct and/or indirect); therefore, it was dropped from the model.

Intermediate and background variables also resulted in direct and indirect effects in Model 3. The largest statistically significant total effects amongst these paths were: consideration of counseling to attitudes toward counseling ($TE = -3.849$); prior counseling experience to cultural mistrust ($TE = -3.777$); and age to cultural mistrust ($TE = 3.589$). These results indicate that the participants who have considered, or were currently considering counseling, expressed negative attitudes toward counseling, participants who had prior counseling experience as a client with a mental health

professional endorsed lower levels of cultural mistrust, and those older prospective Black clients expressed higher levels of cultural mistrust.

Table 11

Estimation of Direct, Indirect, and Total Effects Under Model 3

Path	Direct Effect	Indirect Effect	Total Effect
CM → CW	-0.091***	-0.003*	-0.094***
ATC → CW	0.097***	NA	0.097***
CM → Imm	0.162***	NA	0.162***
CM → ATC	-0.033**	NA	-0.033**
EDUC → CW	NA	0.077*	0.077*
EDUC → ATC	0.801*	NA	0.801*
SEX → CW	NA	0.106*	0.106*
SEX → ATC	1.101**	NA	1.101**
AGE → CW	NA	-0.184	-0.184
AGE → Imm	NA	0.582**	0.582**
AGE → CM	3.589**	NA	3.589**
AGE → ATC	1.587***	-0.119*	1.468***
CONSIDER COUNS → CW	-1.175***	-0.372**	-1.546***
CONSIDER COUNS → ATC	-3.849***	NA	-3.849***
PRIOR COUNS → CW	NA	0.2000	0.2000
PRIOR COUNS → CM	-3.777**	NA	-3.777**
PRIOR COUNS → Imm	NA	-0.613**	-0.613**
PRIOR COUNS → ATC	-1.601***	0.125*	-1.475***

Note. CM= cultural mistrust; ATC = attitudes toward counseling; PreEnc = Pre-Encounter; Enc = Encounter; Imm= Immersion-Emersion; Int= Internalization; EDUC = educational attainment; CONSIDER COUNS = consideration of counseling; PRIOR COUNS = prior counseling; CW = client willingness. NA (not applicable) indicates that the effect is not included in this model.

* $p < .05$. ** $p < .001$. *** $p < .001$

Model 4. The reduced model under Model 4 with the RIAS subscale

Internalization used five exogenous variables (sex, education, age, consideration of counseling, and prior counseling experiences). Thus, exogenous variables, three mediating variables (e.g., CM, Int, and ATC) and one outcome variable (CW) (endogenous variables) were used in this path analysis. Model 4 is depicted in *Figure 6*.

In *Figure 6*, there is a direct effect (one-way arrow) (a) from prior counseling experience to CM, ATC, CW; from age to CM, ATC; from education to ATC; from consider counseling to ATC; from sex to ATC and (b) from CM to Int, ATC, CW; from ATC to CW. The DE, IE, and TE under Model 4 are provided in Table 12.

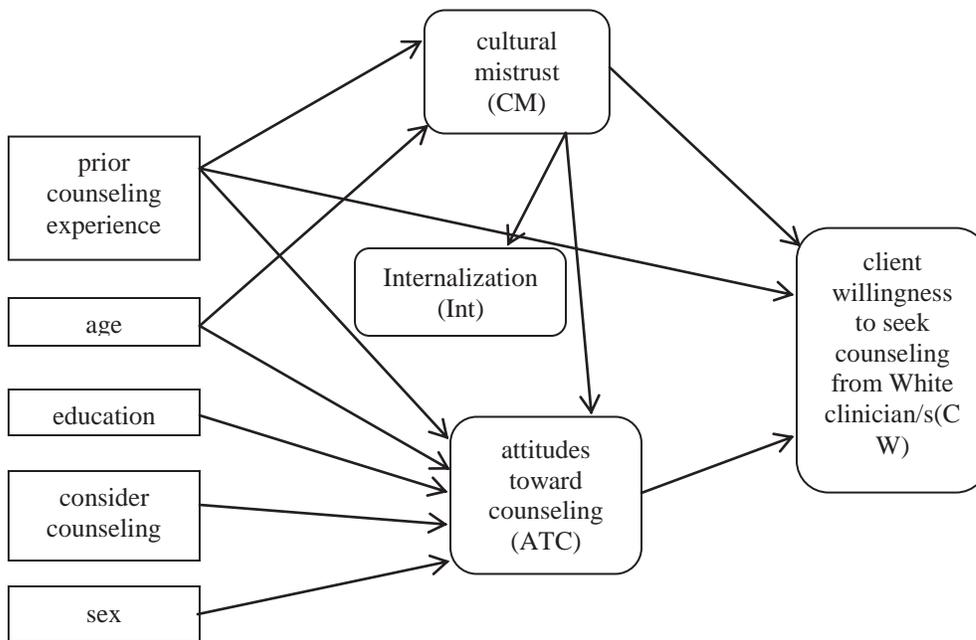


Figure 6. Model 4 (with the RIAS subscale Internalization)

In Table 12 representing the reduced model under Model 4 had a direct and/or indirect effect on the outcome variable of Blacks' willingness to seek counseling from a White clinician. Cultural mistrust reported a relatively small, statistically significant negative direct and indirect effect on client willingness (TE = -0.094), in contrast to attitudes toward counseling having a relatively small statistically significant positive direct effect on client willingness (DE = 0.099). This suggests that participants with higher levels of cultural mistrust were unwilling to seek counseling from a White

clinician, and participants with more positive attitudes toward counseling were willing to seek counseling from a White clinician.

Educational attainment and the sex of the participant had a statistically significant, positive indirect effect on client willingness ($IE = 0.079$; $IE = 0.109$, respectively), such that participants with higher educational attainment were likely to seek counseling from a White clinician. Similar to Models 1, 2, and 3 consideration of counseling had a direct and indirect, negative effect on a Black client's willingness to seek counseling from a White clinician ($TE = -1.536$). This finding suggests that if the participant has considered, or is currently considering, counseling, the participant is unlikely to be willing to seek counseling from a White clinician. The Internalization racial identity schema variable was not statistically significant (direct and/or indirect); therefore, it was dropped from the model.

Further, direct and indirect effects between intermediate and background variables were specified. The largest statistically significant total effects amongst these paths were: consideration of counseling to attitudes toward counseling ($TE = -3.849$); prior counseling experience to cultural mistrust ($TE = -3.777$); and age to cultural mistrust ($TE = 3.589$). These results indicate that prospective Black clients who have considered, or are considering counseling, endorsed negative attitudes toward counseling, participants who had prior counseling experience as a client with a mental health professional expressed significantly less cultural mistrust, and those older prospective Black clients had expressed more cultural mistrust.

Table 12

Estimation of Direct, Indirect, and Total Effects Under Model 4

Path	Direct Effect	Indirect Effect	Total Effect
CM → CW	-0.091***	-0.003*	-0.094***
ATC → CW	0.099***	NA	0.099***
CM → Int	0.038***	NA	0.038***
CM → ATC	-0.033**	NA	-0.033**
EDUC → CW	NA	0.079*	0.079*
EDUC → ATC	0.801*	NA	0.801*
SEX → CW	NA	0.109*	0.109*
SEX → ATC	1.101**	NA	1.101**
AGE → CW	NA	-0.181	-0.181
AGE → CM	3.589**	NA	3.589**
AGE → Int	NA	0.137*	0.137*
AGE → ATC	1.587***	-0.119	1.468***
CONSIDER COUNS → CW	-1.156***	-0.380**	-1.536***
CONSIDER COUNS → ATC	-3.849***	NA	-3.849***
PRIOR COUNS → CW	NA	0.197	0.197
PRIOR COUNS → CM	-3.777**	NA	-3.777**
PRIOR COUNS → Int	NA	-0.145*	-0.145*
PRIOR COUNS → ATC	-1.601**	0.125*	-1.475***

Note. CM= cultural mistrust; ATC = attitudes toward counseling; PreEnc = Pre-Encounter; Enc = Encounter; Imm= Immersion-Emersion; Int = Internalization; EDUC = educational attainment; CONSIDER COUNS = consideration of counseling; PRIOR COUNS = prior counseling; CW = client willingness. NA (not applicable) indicates that the effect is not included in this model.

* $p < .05$. ** $p < .001$. *** $p < .001$ (statistically significant effects)

Comparative fit indices. The Tucker-Lewis Index (TLI), Comparative Fit Index (CFI), Standardized Mean Square Residual (SRMR), and Root Mean Square Error of Approximation (RMSEA) were calculated to estimate the goodness of fit for all four models. The indices are provided in Table 13. The initial (full) model is a just-identified model because all possible effects are included, so there is a theoretically perfect data fit

with this model. Table 13 shows the goodness-of-fit indices for the subsequent four models.

Table 13

Goodness-of-Fit Indices for Data Fit of Four Path Models

Path Model	χ^2	Df	CFI	TLI	SRMR	RMSEA	90% CI for RMSEA*	
							LL	UL
Model 1	7.561	12	1.000	1.000	0.013	.000	.000	.023
Model 2	9.936	11	1.000	1.000	0.015	.000	.000	.036
Model 3	14.100	13	0.998	0.997	0.016	.011	.000	.039
Model 4	20.115	13	0.982	0.965	0.021	.027	.000	.049

Note. CFI=Comparative Fit Index, TLI=Tucker-Lewis Index, SRMR = Standardized Mean Square Residual, and RMSEA =Root Mean Square Error of Approximation. CI=confidence interval; LL = lower limit; UL= upper limit

Summary

The results from the descriptive statistics of the data, chi-square tests for association, reliability estimation, correlation analyses, multiple regression analyses, One-Way ANOVA, and path analyses provide some very useful insights about the relationships among the variables involved in the study. The predictor variables that correlated highest with scores on the Client Willingness Scale were scores on the ATSPPHS-S, the RIAS-B Encounter subscale, the RIAS-B Immersion-Emersion subscale, and the Cultural Mistrust Inventory subscale. Also, results of the multiple regression analyses indicated that attitudes toward seeking professional psychological help, Immersion-Emersion racial identity attitudes, and cultural mistrust significantly predicted the willingness of prospective Black clients to seeking counseling from a White clinician such that participants in this study who reported positive help-seeking attitudes were willing to seek counseling from a White clinician. In contrast, participants in this study that operated from the Immersion-Emersion racial identity schema and had high levels of cultural mistrust were unwilling to seek counseling from a White clinician. Additionally, with a step-wise regression method, results demonstrated that cultural mistrust, consideration of counseling, Immersion-Emersion racial identity schemas, attitudes toward seeking professional psychological help, and high levels of educational attainment accounted for 24 percent of the variance in prospective Black clients' willingness to seek counseling from a White clinician. Lastly, path analysis results revealed that background variables (e.g., consideration of counseling and prior counseling experience) and mediating variables (e.g., cultural mistrust, racial identity

schemas, and attitudes toward counseling) had statistically significant direct and/or indirect effects on the outcome variable (e.g., client willingness to seek counseling from a White clinician). That is, participants in this study who had not considered or were not currently considering counseling, endorsed lower levels of cultural mistrust, identified least with the Encounter, Immersion-Emersion, and Internalization racial identity schemas, and reported positive help-seeking attitudes were willing to seek counseling from a White clinician. A more detailed discussion of the results, the implications for clinician training and practice, and recommendations for future research will be presented in Chapter Five.

CHAPTER FIVE

Discussion

Within the fields of counseling and psychology, the research literature shows that Blacks are less likely than Whites to seek counseling services (Angold et al., 2002; Buser, 2009; Kearney, Draper, & Baron, 2005; Song, Sands, & Wong, 2004; Whaley, 2001) although some research suggests that Blacks are diagnosed with higher rates of mental illness when compared to their White counterparts (Breslau et al., 2005; Buser, 2009; Institute of Medicine, 2003; Robins & Regier, 1991). Although there is much literature that examines a Black client's preference for a counselor's race (Townes, Chavez-Korell, & Cunningham, 2009), there is limited research focused on this topic as it relates to prospective Blacks' willingness to seek counseling from a White clinician to address their mental issues.

The current study examined the relationships between cultural mistrust, racial identity schemas, and help-seeking attitudes on the willingness of prospective Black clients to seek professional mental health services from a White clinician or a clinic primarily staffed by Whites. More specifically, the hypotheses posited that prospective Black clients who endorsed high levels of Pre-Encounter (e.g., pro-White/anti-Black attitudes) or high levels of Internalization (i.e., positive Black racial group identification and full acceptance of all things White) racial identity schemas would be willing to seek

counseling from a White clinician/clinic primarily staffed by Whites. Conversely, prospective Black clients who endorsed high levels of Encounter (i.e., questioning pro-White attitudes and furthering their Black identity) or high levels of Immersion-Emersion (e.g., pro-Black/anti-White) racial identity schemas would be unwilling to seek counseling from a White clinician/clinic primarily staffed by Whites. In regards to help-seeking attitudes and behaviors, it was hypothesized that prospective Black clients with positive attitudes toward seeking professional psychological help, in general, would be willing to seek counseling from a White clinician/clinic primarily staffed by Whites, and prospective Black clients with negative attitudes toward seeking professional psychological help would be unwilling to seek counseling from a White clinician/clinic primarily staffed by Whites. It was also proposed that prospective Black clients who report high levels of cultural mistrust would be unwilling to seek counseling from a White clinician/clinic primarily staffed by Whites, while prospective Black clients who report low cultural mistrust would be willing to seek counseling from a White clinician/clinic primarily staffed by Whites. Lastly, it was hypothesized that the college-educated sample would report more willingness to seek counseling from a White clinician than would the non-college educated sample.

Racial Identity and Willingness to Seek Counseling from White Clinicians

Although it was hypothesized that high levels of Pre-Encounter racial identity schemas and high levels of Internalization racial identity schemas would be significantly, positively related to prospective Black clients' willingness to seek counseling from a White clinician, since individuals operating from these schemas hold favorable views

toward Whites (Sanchez & Carter, 2005), these hypotheses were not supported. While previous research studies have found that Pre-Encounter and Internalization racial identity schemas do positively predict a preference for a White clinician (Cathey-Austin, 2009; Parham & Helms, 1981; Ponterotto, Anderson, & Grieger, 1986; Want et al., 2004), findings from this study suggest that race may not have been the most salient factor in determining willingness to seek counseling for those participants who endorsed the Pre-Encounter and Internalization racial identity schemas (Woodfork, 2012). One explanation for the contradictory findings in this study could be that the participants in this study who endorse Pre-Encounter schemas may not be aware of racism and injustices that are prevalent in society; therefore, they do not consider race to be salient to their identity. This may explain why Pre-Encounter was not a significant predictor on the willingness of prospective Black clients to seek counseling from a White clinician. Also, participants who endorsed Internalization schemas may have a more integrated view of racial identity; that is, they are able to see both the positive and negative elements of being Black or White (Sellers et al., 1998). Therefore, the race of a clinician becomes a less critical variable, and perhaps personal or professional characteristics of the clinician, such as counseling skill level, become more important (Parham & Helms, 1981; Pillay, 2005; Sellers et al., 1998). Also, other important factors may be more salient in prospective Black clients' willingness to seek a White clinician, such as a White clinicians' level of racial consciousness (Want et al., 2004), a White clinician who expresses cultural sensitivity (Thompson & Bazile, 2004), cultural mistrust (Nickerson, Helms, Terrell, 1994; Worrell, 2006), and client characteristics, such as client age, age

cohort, gender, and level of education (Cabral & Smith, 2011). Lastly, seeking counseling from White clinicians may not have been much of a factor at all, but rather the mental health system, as whole, may have been the primary factor in the resistance of counseling. Because the system of counseling has been historically oppressive, no matter the race of the counselor, clinicians may be seen as part of the oppressive system that seeks to disempower Blacks rather than empower.

It was also hypothesized that high levels of Encounter racial identity schemas would be significantly, negatively related to prospective Blacks' willingness to seek counseling from a White clinician; however, Encounter racial identity schemas failed to reach statistical significance in predicting the willingness of prospective Black clients to seek counseling from a White clinician. Thus, this hypothesis was not supported.

Although Encounter racial identity schemas have been found to be related to preference for a clinician's race (Cathey-Austin, 2009; Cross, 1971; Parham & Helms, 1981), in this study these findings were not supported. Conversely, several studies have found that there was no significant relationship between preference for a clinicians' race and Encounter racial identity schemas (Ponterotto, Anderson, & Grieger, 1986; Atkinson, Furlong, & Poston, 1986). One explanation for these findings is that the Encounter racial identity subscale may not be adequately measuring the transitional state from Pre-encounter schemas to Immersion-Emersion schemas (Ponterotto, Anderson, & Grieger, 1986). Additionally, the Encounter schema reported low reliability, suggesting that participants did not respond to items in a predictive, consistent manner (Ponterotto

&Wise, 1987; Yanico, Swanson, & Tokar, 1994), which may be related to the transitional nature of the Encounter schema (Helms, 1990; Want et al., 2004).

Although Pre-Encounter, Encounter, and Internalization racial identity schemas were not found to be significantly related to the willingness of participants to seek counseling from a White clinician, Immersion-Emersion racial identity schemas were found to have a negative statistical significance in predicting prospective Black clients' willingness to seek counseling from a White clinician. This hypothesis was supported. This suggests that participants who endorsed pro-Black/anti-White schemas were not likely to want to seek counseling from a White clinician. These results confirm findings from prior studies that have found that Immersion-Emersion racial identity schemas are significantly associated with less favorable help-seeking attitudes (Delphin & Rollock, 1995; Duncan, 2003; Townes, Chavez-Korell, & Cunningham, 2009; Want et al., 2004). Therefore, it appears that prospective Black clients who express pride in being Black, and reject anything that is associated with Whites and White societal systems, may resist seeking counseling from White clinicians. One could also argue that individuals operating within an Immersion-Emersion racial identity schema may view seeking assistance from White clinicians as betraying their own racial group, given the strong pro-Black/anti-White views they hold.

It is important to note that the Encounter and Immersion-Emersion racial identity schemas were highly correlated (multi-collinearity), which may have confounded the importance of the Pre-Encounter and Internalization racial identity schemas by severely

limiting the size of their predictions on Black clients' willingness and making these predictor variables less of a focus in this study (Dimitrov, 2008).

While past research explored Black clients' preference for a clinician's race (Austin, Carter, & Vaux, 1990; Helms & Carter, 1991; Townes, Chavez-Korell, & Cunningham, 2009), this study sought to examine prospective Black clients' willingness to seek counseling from a White clinician. Preference for a White clinician, or a clinician of a different race, can depend upon myriad of factors specific to the client's needs, desires, and counseling expectations. However, willingness suggests an individual's openness, or consent, to pursue a particular interests, etc. Nonetheless, if an individual is not willing to seek counseling, preference for a counselor's race does not appear to be as relevant from that point forward, such that willingness is a precursor to preference. Also, participants in this study may have interpreted willingness differently when considering whether they would seek counseling from a White clinician. For example, some participants may have interpreted willingness as one's ability to seek counseling from a White clinician, or some participants may believe willingness to mean the same as preference and completed the surveys accordingly. Further research may want to examine the intersection of willingness and preference as an influence on Black individuals' help-seeking attitudes.

Help-Seeking Attitudes and Willingness to Seek Counseling from White Clinicians

It was hypothesized that participants who held positive attitudes toward seeking professional psychological help would be willing to seek counseling from a White clinician. This hypothesis was supported. Conversely, it was hypothesized that those who

held negative attitudes toward seeking professional psychological help would be unwilling to seek counseling from a White clinician. This hypothesis was also supported. These findings, similar to other findings in the literature, could be interpreted to mean that Black individuals who are amenable to seeking assistance for mental health concerns are less concerned about the race of their clinician (Austin, Carter, & Vaux, 1990; Townes, Chavez-Korell, & Cunningham, 2009).

Cultural Mistrust and Willingness to Seek Counseling from a White Clinician

Results from this study revealed that cultural mistrust was significantly related to prospective Black clients' willingness to seek counseling from a White clinician; supporting the hypotheses that high levels of cultural mistrust would be negatively related to the willingness of a Black client to seek counseling from a White clinician, and low levels of cultural mistrust would be positively related to the willingness of a Black client to seek counseling from a White clinician. Cultural mistrust was significantly predictive, and yielded direct and indirect effects, of Black clients' willingness to seek counseling from a White clinician, such that participants who endorsed high levels of cultural mistrust were most likely to resist seeking counseling from a White clinician as compared to participants who endorsed low levels of cultural mistrust. Therefore, as confirmed by previous studies, high levels of cultural mistrust appear to serve as a barrier to seeking mental health treatment for Blacks (Benkert et al., 2009, Nickerson, Helms, & Terrell, 2004; Shaka, 2006; Townes, Chavez-Korell, & Cunningham, 2009). Based on the historical experiences between Blacks and the health systems, it is not surprising that

cultural mistrust continues to serve as a barrier for Blacks to seek counseling, particularly from White clinicians (Corbie-Smith, Thomas, & St. George, 2002).

Educational Attainment and Willingness to Seek Counseling from a White Clinician

Contrary to the initial hypothesis that the college-educated sample would be more willing to seek counseling from a White clinician than the non-college educated sample, prospective Black clients' willingness to seek counseling from a White clinician did not seem to change by educational level; thus, this hypothesis was not supported. Although the majority of participants in this study were highly educated, with most earning a master's degree, their willingness to seek counseling from a White clinician did not differ from those who were not college educated. Duncan (2003) confirmed this finding, asserting that when potential clients were experiencing emotional problems, education was not found to differentiate between those who frequented mental health facilities from those who did not. This finding could also be a result of the considerable size difference between the non-college educated sample and the college-educated sample, whereby significantly more college-educated individuals participated in the study. Having a smaller non-educated sample may have lowered the statistical significance of the educational attainment variable.

Additionally, while educational attainment and willingness to seek counseling were not significantly related, when educational attainment was paired with cultural mistrust, participants' consideration of counseling, Immersion-Emersion racial identity schemas, and help-seeking attitudes, a Black clients' unwillingness to seek counseling from a White clinician was more likely. That is, participants who endorsed high levels of

cultural mistrust, had considered or currently considering counseling, endorsed pro-Black/anti-White racial identity schemas, exhibited negative help-seeking attitudes, and had little to no college education, were resistant to seeking counseling from a White clinician. Although research addressing educational attainment generally indicates that that a higher level of education predicts more positive attitudes toward seeking help (So et al., 2005; Surgenor, 1985), what remains unclear from the results of this study is whether education alone contributes to willingness to seek counseling from a White clinician.

Background Variables and Client Willingness to Seek Counseling from a White Clinician

The results of this study revealed significant relationships among the background variables and prospective Black clients' willingness to seek counseling from a White clinician. A participants' consideration of counseling, paired with cultural mistrust, made the most significant contribution to the prediction of prospective Black clients' willingness to seek counseling from a White clinician. That is, the willingness of the participants in this study to seek counseling from a White clinician was less likely when cultural mistrust was combined with participants' consideration of counseling. Consideration of counseling also had a moderate, significant negative direct and indirect effect on prospective Black clients' willingness to seek counseling from a White clinician; that is, participants in this study who have considered counseling, and/or are currently considering counseling, are unwilling to seek counseling from a White clinician. This finding that cultural mistrust and consideration of counseling was related

to unwillingness to seek counseling from a White clinician could be attributed to the fact that Black individuals who have considered or do actually consider pursuing some form of mental health counseling may more likely trust working with a Black clinician than a White clinician (So et al., 2005; Townes, Chavez-Korell, & Cunningham, 2009; Want et al., 2004).

Moreover, this study revealed that female participants were slightly more inclined to seek counseling from a White clinician. Previous studies have confirmed this finding, asserting that Black women are more inclined to seek help for personal problems than Black men (Berger et al., 2005; Stabb & Cogdal, 1992). Another explanation for this gender difference could be that there were more female participants in this study than male participants.

Relationships Between Background and Predictor Variables

A finding that may have significantly influenced participants' willingness to seek counseling from a White clinician was the relationship between cultural mistrust and Immersion-Emersion racial identity schemas. This correlation indicated that Black participants' cultural mistrust of White people and White culture was significantly related to their hatred and disdain for the White racial group. This finding is significant because past studies have denoted that high cultural mistrust, and pro-Black/anti-White racial identity schemas are positively related; hence, the participants in this study may be resistant to seeking counseling from a White clinician because of their intense feelings of mistrust of Whites, coupled with some degree of hatred for White people (Townes, 2003). As a result, if seen by a White clinician, the client may disclose less to the White

clinician, reject counseling efforts and treatment plans by White clinicians, or prematurely terminate the counseling relationship (Townes, Chavez-Korell, & Cunningham, 2009).

Prior counseling experience as a client with a mental health professional had a relatively large, negative direct effect on prospective Black clients' cultural mistrust levels of Whites such that participants who had less exposure to the counseling process with a professional clinician/clinicians reported higher levels of cultural mistrust. This finding is supported with past studies that suggest prospective Black clients with no psychotherapy experience and little knowledge of the profession reported that although psychotherapy might be beneficial, most clinicians lacked an adequate knowledge of African American life and struggles to accept or understand them (Thompson, Bazille, & Akbar, 2004). Therefore, lack of exposure to prior counseling experiences may serve as another barrier to seeking counseling from a White clinician.

Further, participants in this study who have considered or are currently considering counseling, report strong negative help-seeking attitudes. This finding indicates that prospective Black clients who may have considered counseling, or are currently considering counseling, do not hold favorable attitudes toward counseling, which could be due to Blacks typically seeking counseling under coerced or mandated conditions (Duncan, 2003; Takeuchi & Cheung, 1998; Townes, Chavez-Korell, & Cunningham, 2009). That is, help-seeking attitudes may not be attitudes that are inherently considered a Black cultural norm, so having to do so under coercion could produce some negative attitudes. Further, past studies purport that Black individuals

typically rely on informal networks of support instead of seeking mental health counseling (Harley & Dillard, 2005; Parham, 2002). For example, clients who rely on their religious beliefs/community for support could be considered another African American cultural norm (Crosby & Bossley, 2012; Hall, Everett, & Hamilton-Mason, 2012; Obasi & Leong, 2009; So et al., 2005) and may anticipate a discrepancy between the client's belief system and that of their potential clinician.

Lastly, participants' age had a large, positive direct effect on participants' levels of cultural mistrust such that older participants in this study reported higher levels of cultural mistrust. One potential explanation between the positive association between age and level of cultural mistrust is that as individuals become more exposed to the larger society, this may increase their chances of experiencing discrimination (Greer, 2011; Whaley, 2001). With over half of the sample (53%) reporting their age as 33 or older, this may explain why there are high levels of cultural mistrust expressed by the sample. This finding suggests that since older potential clients may experience higher levels of cultural mistrust, they may benefit from seeking clinicians who are culturally competent.

Overall, cultural mistrust was shown to be the strongest predictor of Black clients' willingness to seek counseling from a White clinician. Cultural mistrust may have been a more significant predictor because cultural mistrust describes an individual's feelings and attitudes toward someone other than the self, and it may be easier for an individual to express those feelings and attitudes toward others, such as "Blacks should not have anything to do with Whites since they cannot be trusted," whereas items on the racial identity measures use more "I" statements, such as "I feel unable to involve myself in

White experiences and am increasing my involvement in Black experiences” forcing one to examine the self in relation to a racial reference group and their place with that group, and that introspection may be more difficult. Also, racial identity may be difficult to conceptualize because though individuals may share the same racial background and make-up (e.g., being Black), there is intra-racial variation amongst individuals in how they racially identify themselves or determine if race is most salient to their identity. Also, because the main aim of this study was to assess prospective Black clients’ willingness to seek counseling from a White clinician and cultural mistrust assesses Blacks’ mistrust of Whites, it appears most appropriate that cultural mistrust would be a strong predictor of prospective Blacks’ willingness to seek counseling from a White clinician because both constructs explore prospective Blacks’ attitude towards Whites.

Despite the assumption that racial identity schemas, alone, would be a significant predictor of prospective Black clients’ willingness to seek counseling from a White clinician, racial identity schemas, particularly the Immersion-Emersion schema, coupled with high levels of cultural mistrust, did seem to significantly predict prospective Black clients’ willingness. Therefore, potential clients who may hold anti-White views and mistrust White systems will be less likely to seek counseling from a White clinician. It appears as though race may not be a salient factor for prospective Black clients unless these prospective Black clients hold a negative view of Whites and/or experience high levels of cultural mistrust. Moreover, individuals who have had minimal exposure to counseling, as well as those who are considering counseling, may prefer working with a Black clinician as opposed to working with a White clinician. Finally, individuals who

expressed negative help-seeking attitudes, and who have little to no college education, will also be less likely to seek counseling from a White clinician.

Limitations of the Study

There were several limitations in this study, including limitations with the chosen sample and instrument use. First, this study used prospective Black clients in order to assess attitudes that may prevent Black people from seeking help from predominantly White mental health institutions. However, this study does not establish a cause and effect relationship between prospective Black clients' attitudes and their willingness to seek counseling from a White clinician, such that the researcher is unable to determine if the predictor variables causes the outcome variable (client willingness to seek a White clinician) to exist, but can only highlight the relationships that exist between the predictor variables and the outcome variable.

Second, the results may not be representative of an actual clinical population because no mental health history was collected from the participants and recruitment was not done at a specific mental health hospital or agency. Third, although the college educated sample was recruited nation-wide, no demographic questions specified the type of college attended (e.g., public, private, Historically Black Colleges and Universities [HBCUs], Predominantly White Institutions [PWIs]), which could have been useful information in examining prospective Black clients' willingness to seek counseling from a White clinician, such that students who attend HBCUs may respond differently to the willingness to seek counseling from a White clinician, than those students who attend PWIs.

Fourth, the non-college educated sample was largely underrepresented in the study when compared to the college-educated sample such that there were six times as many college-educated participants versus non-college educated participant. Specifically, 34 percent of the participants earned a master's degree, followed by 21 percent who earned a bachelor's degree, and 15 percent who earned a doctorate or professional degree. Thus, results may not be generalizable to a non-college educated population. Future research with a larger sample of non-college educated Black participants could be beneficial to our understanding of which factors are related to the willingness of prospective Black clients to seek counseling from a White clinician. Also, the sample used in this study was not representative of a younger population with only one percent of the sample reporting their age between 18 – 22 years. This particular age group is considered “traditional college age” whereby students graduate from high at the age of 18 and complete four years of college, graduating at the age of 22. This particular age group may perceive help-seeking from White clinicians differently than other age groups because they are transitioning from adolescence to early adulthood, and that important transition may impact their willingness to seek counseling from a White clinician.

Fifth, the sampling procedures of the study may have impacted who completed the study's instruments. Participants who completed the online surveys could complete the surveys at their leisure and in the comfort of their preferred environment. Also, participants had the option of completing the surveys alone, without the distraction of others or the influence of others' presence. However, if the participants who completed the online surveys had questions or concerns about any of the items, the researcher could

only be reached by email or telephone, which prevents their questions or concerns from being addressed immediately by the researcher. Also, the researcher visited community sites, such as barbershops, salons, and churches, whereby there was easy access to a group of individuals who could complete the paper surveys. Thus, unless a participant requested to complete the survey alone, all surveys completed at these sites were done so while others were present. The participants who completed the paper survey may have been influenced to answer certain items in a particular manner because of the presence of the researcher. In addition to the presence of the researcher possibly serving as an influence on the participants' responses, the researcher was immediately accessible for any questions or concerns participants may have had.

Finally, given the primary coping strategies (e.g., prayer/church, family/friends, exercise/physical activity, etc.) described by the participants in the demographic questionnaire, a measure of coping might have been useful to include in this study. A more in-depth assessment of Blacks' primary means of coping could provide a better understanding of prospective Black clients' willingness to seek counseling from White clinicians. For example, an examination of racial identity schemas and preferred coping methods could yield significant findings as it relates to client willingness, given that some research purports that racial identity schemas are associated with preferences for particular coping strategies (Forsyth & Carter, 2012).

Instrumentation Limitations

With respect to limitations with the scales used in this study, this was the first time using the Client Willingness Scale. One limitation of the Client Willingness Scale is

that test-takers can respond to items based on social desirability; that is, what the test-taker feels is socially acceptable, as opposed to his or her willingness. Although the instrument demonstrated high reliability with this particular sample, validity studies were not conducted. Validity studies are needed to establish convergent and discriminant validity of the scale.

Implications for Counseling Practice, Training, and Research

Cultural Mistrust in Prospective Black Clients and Counseling Practices

Because it was found in this study that prospective Black clients' willingness to seek counseling from a White clinician was related to their cultural mistrust of White people, Black clients who paired with a White clinician, may find it difficult to establish trust with the clinician in the therapeutic process (Constantine, 2007; Parham, 2004; Sue, 2010; Sue & Sue, 2003; Whaley, 2001). When prospective Black clients express high levels of cultural mistrust, it could become a challenge for White clinicians to establish a therapeutic rapport with the client that is necessary to provide a positive therapeutic experience for clients (Terrell & Terrell, 1984). Therefore, White clinicians should be aware of this potential resistance and work to establish trust and a strong positive rapport with their Black clients at the very beginning of the therapeutic relationship.

White clinicians can assess cultural mistrust, without the use of an instrument, by posing questions that seek to gain insight on the Black client's attitude towards seeking counseling from a White clinician. For example, Sue and Sue (2003) suggests that the White counselor ask, "Sometimes, clients feel uncomfortable seeing counselors of a different race. Would that be a problem for you?" If the client expresses an unfavorable

attitude toward meeting with a White clinician, follow up questions about the origin and cultivation of those attitudes may reveal a certain level of cultural mistrust, for example “I understand that you have some strong feelings or opinions towards meeting with me. If I were given the opportunity, what could I do to help ease some of those feelings?” According to Sue and Sue (2003), because Blacks tend to prefer Black clinicians, one way in which a White clinician can establish trust with a Black client in the initial counseling session, is to acknowledge and discuss the different racial backgrounds between the clinician and client as a way of making the client feel most comfortable and exhibiting cultural competence.

Racial Content and Black Clients’ Self-Disclosure

Black participants in this study who experienced high levels of cultural mistrust might have been unwilling to seek counseling from a White clinician based on the belief that it would be easier to talk about their problems to a clinician who does not identify as White. Thompson, Worthington, and Atkinson (1994) found that Black female clients disclosed less when the clinician failed to address the cultural or racial content of their presenting problems, but only paid more attention to the universal content. Black clients tend to disclose more detailed, intimate information when their presenting problems were discussed from a racial or cultural perspective. Cross, Parham, and Helms (1991) posited that counseling climates that minimize and question the importance of Black clients’ racial experiences could harm counseling alliances. The results of this study suggest that prospective Black clients’ racial identity schemas impact the willingness to seek counseling from a White clinician; thus, if a Black client decides to seek counseling from

a White clinician, it is important for the clinician to assess the client's racial identity status as an important component to building the client-clinician relationship. White clinicians can assess racial identity attitudes, without the use of an instrument, by inquiring about the client's choice in friends, the client's neighborhood, school choice, etc. For example, the counselor may ask questions such as, "What primary race are the individuals in your peer group? School? Neighborhood?" The answer to these questions may potentially provide some insight into the person's racial identity schema.

Black Traditional Coping Strategies and Counseling Practices

As reported in this study, 28 percent of the sample utilized prayer/church as their primary means of coping with mental and emotional concerns. This is consistent with the literature that purports spirituality and religious practices are frequently relied upon by many African Americans as the most fundamental methods of coping with race-related difficulties and general adversities (Greer, 2011; Plummer & Slane, 1996; Utsey, Adams, et al., 2000). Because spirituality and religious beliefs are reported to be utilized more often than any other coping mechanism, it is critical for the White clinician to possibly assess, and include, potential Black clients' current coping mechanisms as part of the therapeutic process and treatment planning. For instance, use of music to provoke a spiritual awakening can assist in setting the proper mood for a therapy session (Parham, 2002). Further discussion of spirituality and extended family support may be additional variables to consider when working with Black clients (Greer, 2011; Adams, et al., 2000).

Culturally Sensitive Counselor Interventions

In order to foster and facilitate a healthy Black client-White clinician relationship, clinicians may want to assess a Black client's potential level of cultural mistrust since it was found that high levels of cultural mistrust might serve as a barrier to the therapeutic relationship. Such assessment could include an examination of external variables (e.g., experiences of racism) that can affect an individual's well-being. White clinicians should consider focusing on creating a safe climate within the counseling relationship that facilitates the exploration of racial and cultural experiences that have fostered cultural mistrust (Townes, 2003) and a client's racial identity development. Creating a safe environment would include an acknowledgment of racial privilege and the racial injustices present in society. For example, if a White clinician finds his or her Black client to experience mistrust, placing more emphasis in the session on Black clients' racial experience and the problems that result from racial issues, such as work-related racism and discrimination, etc., could assist the mistrustful Black client with exploring the reasons behind their cultural mistrust and how that cultural mistrust impacts the counseling relationship. This would give the White clinician an opportunity to help Black clients work through their issues of mistrust of Whites (Watkins & Terrell, 1988). Moreover, clinicians should be non-judgmental about the Black clients' cultural views, and validate their feelings of cultural mistrust when warranted (Constantine, 2007; Parham, 2004; Townes, 2003; Whaley, 2001). Further, clinicians may want to become more visible in the communities where there is a history of mistrust and anti-White attitudes on the part of the residents, and begin to cultivate and foster those relationships

by connecting with supporting agencies, local businesses, and churches that are central to the community. This will allow individuals from these communities to have another viable option in dealing with any personal or mental health challenges.

Finally, Lewis-Cole and Constantine (2006) posited that mental health professionals who are knowledgeable about individual, institutional, and cultural forms of racism-related stress might also encourage the client to use more spiritual or group-based coping resources rather than to rely solely on himself or herself to deal with such stressors.

Practical strategies for White clinicians. With the awareness that specific factors, such as cultural mistrust, age, etc., are strong predictors of Black prospective clients' unwillingness to seek counseling from a White clinician, there are specific counseling strategies that may assist White clinicians in building the counseling relationship with Black clients. The researcher recommends that the racial/ethnic background of the client may not be obvious, so all pre-conceptions about a clients' race/ethnicity should be suspended. White clinicians may want to consider how racial/ethnic differences between clinician and client might impact the counseling relationship, such that White clinicians can ask questions such as, "I am aware that I am White and you are Black. Do you feel our racial differences will impact the work we will be doing together?" Lastly, White clinicians should acknowledge the power, privilege, and racism that may arise within the counseling relationship.

Suggestions for Counselor Training

Cultural competence has been defined as the continual acquisition of the awareness, knowledge, and skills necessary to facilitate the psychological well-being and development of clients from diverse backgrounds (APA, 1993; D.W. Sue, Arredondo, & McDavis, 1992; D. W. Sue & D. Sue, 2008). Multicultural counseling competence mandates that clinicians (a) become aware of their assumptions or formulations about human nature; (b) understand the worldview of culturally different clients; and (c) actively develop and implement relevant, appropriate, and sensitive interventions and skills in working with culturally different clients (Sue & Sue, 2008). In most cases, White students are able to obtain an intellectual understanding of societal racism from didactic teachings and can even identify biased attitudes in others (Sue et al., 1999). Yet, these same students often find significant difficulty in identifying their own personal biases, and once they are made aware of these biases, may find it even more difficult to address it appropriately. Perhaps this is largely due to the dissonance that such acknowledgement creates (Sue et al., 1999). Consequently, they are unaware of the social and therapeutic impact that their own race has upon their racially different clients (Sue & Torino, 2005). Therefore, the results of this study highlighted the importance for training programs to incorporate experiential learning components that encourage clinicians-in-training to (a) explore and acknowledge their own racial and cultural biases, and (b) understand and manage their social impact when working with clients of color. With this knowledge and awareness, clinicians will be better equipped to address potential racial and/or cultural

barriers that may arise during the counseling process, such as cultural mistrust, White privilege, and racial identity.

Suggestions for Future Research

The findings of this study revealed that the participants that endorsed a more pro-Black/anti-White racial identity schema (Immersion-Emersion) were less willing to seek counseling from a White clinician. Given the dearth of research surrounding the willingness of Black clients to seek counseling from White clinicians, the fact that Blacks do experience mental health concerns, and that limited numbers of Black counseling professionals are available (APA, 2010), more research is needed to assess the impact that Black clients' willingness to seek counseling from a White clinician has on the cross-racial/cultural relationship. The lack of availability of Black clinicians in the counseling field (Whaley, 1998a, 2001) could hinder help-seeking behaviors in Blacks who have a preference for Black clinicians (Nickerson, Helms, & Terrell, 1994). Another reason Black clients could prolong their psychological discomfort by not seeking help could be because of their high mistrust of Whites, high Immersion-Emersion racial identity schemas, and their consideration for counseling. Future research is necessary to establish if these specific issues factored into current Black clients' decision to prolong seeking professional psychological help.

Additionally, more research is needed to assess the willingness of prospective Black clients to seek counseling from a White clinician, rather than Black clients' preferential attitudes toward a clinician's race, because preference for a clinician's race does not guarantee that the client will be able to seek counseling from a clinician that he

or she prefers. Further, if a client is remanded to seek counseling and is paired with a White clinician, it is important to assess whether that client would be willing to disclose personal and sensitive information to the clinician.

Another potential area of research is to explore Black clients' willingness to seek counseling from a Black clinician, since prospective Black clients' racial identity schemas may influence their choice of a clinician when it comes to race. That is, although a client and clinician share the same racial background, it does not necessarily mean the client and clinician endorse the same racial identity schemas. Also, future research may want to explore informal networks of support, as well as racial identity development, as an influence on the help-seeking attitudes of Black clients. Finally, since help-seeking attitudes, Immersion-Emersion racial identity schemas, consideration of counseling, educational attainment, and cultural mistrust only accounted for 24 percent of the variance in prospective Black clients' willingness to seek counseling from a White clinician, researchers may want to assess other variables that may explain Black clients' willingness, including coping styles, counseling outcomes, etc.

APPENDICES

Appendix A

Background Information Questionnaire

Sex:

- Male
 Female
 Other (specify): _____

Age Range:

- | | |
|----------------------------------|--------------------------------------|
| <input type="checkbox"/> 18 – 22 | <input type="checkbox"/> 33 – 37 |
| <input type="checkbox"/> 23 – 27 | <input type="checkbox"/> 38 – 42 |
| <input type="checkbox"/> 28 – 32 | <input type="checkbox"/> 43 or older |

Race/Ethnicity (*select all that apply*):

- African American / Black
 African
 Caribbean / West Indian
 Bi-racial / Multi-racial (specify): _____
 Other (specify): _____

Country of Birth: _____

In what country were you primarily raised? _____

Primary Community Where Raised:

- Rural Areas (e.g. farm)
 Suburbs
 Metropolitan / Urban (e.g. city)

- Small Town
- Other (specify): _____

Marital Status:

- Single
- Married
- Separated
- Divorced
- Living with partner
- Civil Union

Which of the following categories best describes your current employment status?

- Employed, working 40 or more hours per week
- Employed, working 1-39 hours per week
- Not employed, looking for work
- Not employed, NOT looking for work
- Retired
- Disabled, not able to work

Are you a student?

- Yes
 - Undergraduate
 - Graduate
- No

Highest Level of Education Completed:

- Some high school
- Earned high school diploma (or equivalent)
- Some college (less than 2 years)
- Earned 2-year college degree or technical school graduate
- Earned 4-year college degree
- Some graduate school beyond undergraduate
- Earned master's degree
- Earned doctorate or professional degree (e.g. Ph.D., Ed.D., Dr.Ph., M.D., J.D., Psy.D.)

Annual Income:

- Below \$20,001
- \$20,001 - \$40,000
- \$40,001 - \$60,000
- \$60,001 - \$80,000
- \$80,001 - \$100,000
- Above \$100,000

Which method of coping do you use most often when experiencing emotional or mental health issues?

- Counseling/psychotherapy
- Exercise/physical activity
- Overeating/under-eating
- Work/job activities
- Prayer/church
- Family/friends
- Substance use (e.g., illegal drugs, prescription drugs, alcohol, etc.)
- Other (specify): _____

Have you ever considered or are considering going to counseling?

- Yes No

Have you ever been a client in counseling/psychotherapy with a mental health professional (psychologist, psychiatrist, clinical social worker, psychiatric nurse, alcohol or drug counselor, or licensed professional counselor)?

- Yes No

Appendix B

Attitudes Toward Seeking Professional Psychological Help Scale – Short Form

Directions: Read each statement carefully and give your honest feelings about the beliefs and attitudes expressed. **There are no “right” or “wrong” answers.** Please circle the number that best expresses your level of agreement. Select only one answer. **Please answer all items.**

	Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
1.	If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	0	1	2	3
2.	The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.	0	1	2	3
3.	If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.	0	1	2	3
4.	There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears <i>without</i> resorting to professional help.	0	1	2	3
5.	I would want to get psychological help if I were worried or upset for a long period of time.	0	1	2	3
6.	I might want to have psychological counseling in the future.	0	1	2	3
7.	A person with an emotional problem is not likely to solve it alone; he or she <i>is</i> likely to solve it with professional help.	0	1	2	3
8.	Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	0	1	2	3

	Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
9.	A person should work out his or her own problems; getting psychological counseling would be a last resort.	0	1	2	3
10.	Personal and emotional troubles, like many things, tend to work out by themselves.	0	1	2	3

Appendix C

Cultural Mistrust Inventory (Education and Training; Interpersonal Relations Subscales)

Directions: Read each statement carefully and give your honest feelings about the beliefs, and attitudes expressed. Indicate the extent to which you agree by using the scale below.

The higher the number you choose for the statement, the more you agree with that statement. **There are no “right” or “wrong” answers, only what is right for you.** If in doubt, circle the number that seems most nearly to express your present feelings about the statement. Select only one answer. **Please answer all items.**

1 = Strongly Disagree	2 = Disagree	3 = Slightly Disagree	4 = Neither Agree nor Disagree	5 = Slightly Agree	6 = Agree	7 = Strongly Agree
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1. White teachers teach subjects so that they favor Whites.

1 2 3 4 5 6 7

2. White teachers are more likely to slant the subject matter to make Blacks look inferior.

1 2 3 4 5 6 7

3. White teachers deliberately ask black students questions, which are difficult so they will fail.

1 2 3 4 5 6 7

4. Black parents should teach their children not to trust White teachers.

1 2 3 4 5 6 7

5. Blacks should be suspicious of a White person who tries to be friendly.

1 2 3 4 5 6 7

6. Whether you should trust a person or not is not based on his or her race.

1 2 3 4 5 6 7

7. There are some Whites who are trustworthy enough to have as close friends.

1 2 3 4 5 6 7

8. Blacks should not have anything to do with Whites since they cannot be trusted.

1 2 3 4 5 6 7

9. It is for Blacks to be on their guard when among Whites.

1 2 3 4 5 6 7

10. Of all ethnic groups, Whites are more likely to give you something then take it back.

1 2 3 4 5 6 7

11. White friends are LEAST likely to break their promise.

1 2 3 4 5 6 7

12. Blacks should be cautious about what they say in the presence of Whites since Whites will try to use it against them.

1 2 3 4 5 6 7

13. Whites can rarely be counted on to do what they say.

1 2 3 4 5 6 7

14. Whites are usually honest with Blacks.

1 2 3 4 5 6 7

15. Whites are as trustworthy as members of any other ethnic group.

1 2 3 4 5 6 7

16. Whites will say one thing and do another.

1 2 3 4 5 6 7

17. When a White teacher asks a Black student a question, it is usually to get information, which can be used against him or her.

1 2 3 4 5 6 7

18. Black students can talk to a White teacher in confidence without fear that the teacher will use it against him or her.

1 2 3 4 5 6 7

19. Whites will usually keep their word.

1 2 3 4 5 6 7

20. Blacks should not confide in Whites because they will use it against you.

1 2 3 4 5 6 7

21. If a Black student tries, he or she will get the grade he or she deserves from a White teacher.

1 2 3 4 5 6 7

Appendix D

Client Willingness Scale

Directions: Here is a list of problems for which adults might seek counseling. If you were to experience these problems, would you be willing to see a White counselor or would you not be willing to see a White counselor?

For each problem listed, please select one of the two choices that reflect your personal willingness. Assume that you can have your choice of counselor sex (male or female). Circle the number that best express your feelings about the corresponding statement. Select only one answer. **Please answer all items.**

	Statement	I am willing to see a White Counselor	I am <u>not</u> willing to see a White counselor
1.	If I have a problem often feeling depressed.	1	0
2.	If I have a problem with excessive worry and anxiety.	1	0
3.	If I have a problem with drinking too much alcohol or drug use.	1	0
4.	If I have a problem in my personal relationship.	1	0
5.	If I have a problem with people harassing or plotting to harm me.	1	0
6.	If I have a problem meeting new people.	1	0
7.	If I have problem concerning sexual issues.	1	0
8.	If I have a problem concerning racial issues.	1	0
9.	If I have problem overcoming loneliness.	1	0
10.	If I had a problem controlling my anger.	1	0

Appendix E

Racial Identity Attitudes Scale – B

Directions: Use the scale below to respond to each statement. **There are no “right” or “wrong” answers.** Please circle the number that best expresses your level of agreement or uncertainty with the corresponding statement. Select only one answer. **Please answer all items.**

	Statement	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
1.	I believe that being Black is a positive experience.	1	2	3	4	5
2.	I know through experience what being Black in America means.	1	2	3	4	5
3.	I feel unable to involve myself in White experiences and am increasing my involvement in Black experiences.	1	2	3	4	5
4.	I believe that large numbers of Blacks are untrustworthy.	1	2	3	4	5
5.	I feel an overwhelming attachment to Black people.	1	2	3	4	5
6.	I involve myself in causes that will help all oppressed people.	1	2	3	4	5
7.	I feel comfortable wherever I am.	1	2	3	4	5
8.	I believe that White people look and express themselves better than Blacks.	1	2	3	4	5
9.	I feel very <u>uncomfortable</u> around Black people.	1	2	3	4	5
10.	I feel good about being Black, but do not limit myself to Black activities.	1	2	3	4	5

	Statement	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
11.	I often find myself referring to White people as “honkies”, “crackers”, “White trash”, “devils”, “Whitey”, etc.	1	2	3	4	5
12.	I believe that to be Black is <u>not</u> necessarily good.	1	2	3	4	5
13.	I believe that certain aspects of the Black experience apply to me, and others do not.	1	2	3	4	5
14.	I frequently confront the system and “the man.”	1	2	3	4	5
15.	I constantly involve myself in Black political and social activities (e.g. art shows, political meetings, Black theater, etc.)	1	2	3	4	5
16.	I involve myself in social action and political groups even if there are no other Blacks involved.	1	2	3	4	5
17.	I believe that Black people should learn to think and experience life in ways which are similar to White people.	1	2	3	4	5
18.	I believe that the world should be interpreted from a Black perspective.	1	2	3	4	5
19.	I have changed my style of life to fit my beliefs about Black people.	1	2	3	4	5
20.	I feel excitement and joy in Black surroundings.	1	2	3	4	5
21.	I believe that Black people came from a strange, dark, and uncivilized continent.	1	2	3	4	5
22.	People, regardless of their race, have strengths and limitations.	1	2	3	4	5

	Statement	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
23.	I find myself reading a lot of Black literature and thinking about being Black.	1	2	3	4	5
24.	I feel guilty and/or anxious about some of the things I believe about Black people.	1	2	3	4	5
25.	I believe that a Black person's most effective weapon for solving problems is to become part of the White person's world.	1	2	3	4	5
26.	I speak my mind regardless of the consequences (e.g., being kicked out of school, being imprisoned, being exposed to danger, etc.).	1	2	3	4	5
27.	I believe that everything Black is good, and consequently, I limit myself to Black activities.	1	2	3	4	5
28.	I am determined to find my Black identity.	1	2	3	4	5
29.	I believe that White people are intellectually superior to Blacks.	1	2	3	4	5
30.	I believe that because I am Black, I have many strengths.	1	2	3	4	5

Appendix F

IRB Approval Letter



Office of Research Integrity and Assurance

Research Hall, 4400 University Drive, MS6D5, Fairfax, Virginia
22030 Phone: 703-993-5445; Fax 703-993-9590

DATE: July 22, 2013
TO: Regine Talleyrand, Ph.D.
FROM: George Mason University IRB
Project Title: [490782-1] The Relationship Between Racial Identity Schemas, Cultural Mistrust, and Help-Seeking Attitudes as Predictors of Prospective Black Clients' Willingness to Seek Counseling from White Clinicians
SUBMISSIONTYPE: New Project
ACTION: DETERMINATION OF EXEMPT STATUS
DECISIONDATE: July 22, 2013
REVIEWCATEGORY: Exemption category #2

Thank you for your submission of New Project materials for this project. The Office of Research Integrity & Assurance (ORIA) has determined this project is EXEMPT FROM IRB REVIEW according to federal regulations.

Please remember that all research must be conducted as described in the submitted materials.

Please note that any revision to previously approved materials must be submitted to the ORIA prior to initiation. Please use the appropriate revision forms for this procedure.

If you have any questions, please contact Karen Motsinger at 703-993-4208 or kmotsing@gmu.edu. Please include your project title and reference number in all correspondence with this committee.

Appendix G

In-Person Informed Consent/Welcome Letter

Principal Investigator:

Dr. Regine Talleyrand, Ph.D.

Researcher:

Nicole L. Woodard, M.A., Ed.M.

Title of Study:

The Relationship Between Racial Identity Schemas, Cultural Mistrust, and Help-Seeking Attitudes as Predictors of Prospective Black Clients' Willingness to Seek Counseling from White Clinicians

July 2013

Dear Participant,

You are being invited to participate in a research study exploring the relationship between Blacks and counseling. Specifically, the purpose of this study is to examine the potential impact of cultural mistrust, racial identity attitudes, and help-seeking attitudes on the willingness of prospective Black clients to seek professional mental health services from a White counselor. In order to take this survey, you must self-identify as African American or Black, and be at least 18 years of age. I am very interested in your responses to the attached survey. Your participation in this research study should take approximately 10-12 minutes. I am hopeful that the findings of this research study will help the field to gain a better understanding of how race and culture interact within the field of mental health.

Your responses to the attached survey will remain completely confidential. Names and other identifiers will not be placed on the survey or other research data. Return of the completed survey will serve as your informed consent to participate in this study. There are no foreseeable risks involved in participating in this research study, and there will be no compensation or reimbursement for your participation. Please understand that your participation is voluntary and you are free to withdraw from this research study at any time and for any reason without penalty.

This research study is being conducted by Nicole Woodard in the Department of Counseling and Development at George Mason University. I may be reached at (703) 764-5057 for questions or to report a research-related problem. In addition, you are welcome to contact Dr. Regine Talleyrand at (703) 993-4419. You may contact the George Mason University Office of Research Integrity and Assurance at (703) 993-4121 if you have questions or comments regarding your rights as a participant in this research study.

This research study has been reviewed according to George Mason University procedures governing your participation in this research study.

Completion of the survey will act as your consent to take part in this research study. You may retain this letter for your records. Thank you in advance for your participation.

Nicole L. Woodard, M.A., Ed.M.

Appendix H

Electronic Informed Consent/Welcome Letter

Principal Investigator:

Dr. Regine Talleyrand, Ph.D.

Researcher:

Nicole L. Woodard, M.A., Ed.M.

Title of Study:

The Relationship Between Racial Identity Schemas, Cultural Mistrust, and Help-Seeking Attitudes as Predictors of Prospective Black Clients' Willingness to Seek Counseling from White Clinicians

July 2013

Dear Participant,

You are being invited to participate in a research study exploring the relationship between Blacks and counseling. Specifically, the purpose of this study is to examine the potential impact of cultural mistrust, racial identity attitudes, and help-seeking attitudes on the willingness of prospective Black clients to seek professional mental health services from a White counselor. In order to take this survey, you must self-identify as African American or Black, and be at least 18 years of age. I am very interested in your responses to the electronic survey. Your participation in this research study should take approximately 10-12 minutes. I am hopeful that the findings of this research study will help the field to gain a better understanding of how race and culture interact within the field of mental health.

Your responses to the electronic survey will remain completely confidential. Names and other identifiers will not be placed on the survey or any other research data. Submission of the electronic survey will serve as your informed consent to participate in this study. The survey is being made available on Qualtrics Survey Software. Qualtrics utilizes Transport Layer Security (TLS) technology that protects the researcher's information using both server authentication and data encryption, ensuring that data is safe, secure, and available only to authorized persons. There are no foreseeable risks involved in participating in this research study, and there will be no compensation or reimbursement for your participation. Please understand that your participation is voluntary and you are free to withdraw from this research study at any time and for any reason without penalty.

This research study is being conducted by Nicole Woodard in the Department of Counseling and Development at George Mason University. I may be reached at (703) 764-5057 for questions or to report a research-related problem. In addition, you are welcome to contact Dr. Regine Talleyrand at (703) 993-4419. You may contact the George Mason University Office of Research Integrity and Assurance at (703) 993-4121

if you have questions or comments regarding your rights as a participant in this research study.

This research study has been reviewed according to George Mason University procedures governing your participation in this research study.

Completion of the survey will act as your consent to take part in this research study. You may print this letter for your records. Thank you in advance for your participation.

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BIOGRAPHY

Nicole L. Woodard was born and raised in Los Angeles, California where she attended King/Drew High School of Medicine and Science. After graduating high school, Ms. Woodard first earned an Associate of Arts degree in Liberal Arts at Santa Monica College in 2003. Thereafter, she attended the University of California, Irvine where she earned a Bachelor of Arts degree in Psychology and Social Behavior in 2006. Immediately following graduation from her undergraduate institution, she began her studies at Teachers College at Columbia University in the Department of Counseling Psychology where, in 2008, she was awarded a Master of Education degree and a Master of Arts degree both in Psychological Counseling.

Ms. Woodard has several years of counseling experience within the college counseling and community mental health settings. She has worked as a psychotherapist in a private practice setting, and she is currently an extern at the MedStar Rehabilitation Hospital in Washington, D.C., in the Clinical Psychology division. She is also currently employed as a counselor at Northern Virginia Community College in Annandale, Virginia. Ms. Woodard has taught student development courses at the undergraduate level, and is currently an adjunct professor of psychology at the University of the District of Columbia. Ms. Woodard will also begin teaching graduate level coursework in the Counseling Department at the University of the District of Columbia in fall 2014.

In addition to clinical and teaching experiences, Ms. Woodard has presented at national and regional conferences, and was recognized in 2012 with an Emerging Leader Award by the American College Counseling Association. She is also a member of several other national and state divisions.