MISTRUST LEVEL AND ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP

THESIS

Presented to the Graduate Council of the University of North Texas in Partial Fulfillment of the Requirements

For the Degree of MASTER OF SCIENCE

By

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Denton, Texas
August, 1989
Nickerson, Kim J., Mistrust Level and Attitudes Toward Seeking Professional Psychological Help. Master of Science (Clinical Psychology), August, 1989, 64 pp., 2 tables, references, 49 titles.

This study explored the relationship between cultural mistrust level and attitudes toward seeking professional psychological help. It was hypothesized that Blacks with high levels of cultural mistrust, when compared to those with low levels, would show less favorable attitudes toward seeking formal help for psychological problems.

Black students were administered the Cultural Mistrust Inventory, Help-Seeking Attitude Scale, Reid-Gundlach Social Service Satisfaction Scale, and Opinions About Mental Illness Scale. Using a 2 (gender) x 2 (mistrust level) MANCOVA, a main effect for the factor of mistrust level was found along with a mistrust level by gender interaction. Students with higher levels of cultural mistrust were found to hold less favorable attitudes toward seeking professional psychological help when compared to students with lower levels of cultural mistrust.
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MISTRUST LEVEL and ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP

One's willingness to seek professional psychological help has been found to be influenced by several factors. These include the ethnicity of professionals offering the services (Atkinson, 1983), and beliefs and expectations the prospective client holds regarding the professionals offering the service (Dixon & Glover, 1984; Rotter, 1978). Several studies have found that Blacks are less willing to visit a mental health clinic than Whites. However, most of these studies have been comparative studies between Blacks and Whites. Few studies have actually explored characteristics of Blacks which seem to be related to the extent to which members of this ethnic group will attend mental health centers. Several studies have attempted retrospectively, to account for these differences between Blacks and Whites.

There is little research linking the beliefs and expectations that Blacks hold towards Whites, who make up the majority of mental health professionals, with the willingness of Blacks to seek psychological help. It is possible that the willingness of Blacks to seek counseling is significantly influenced by the overall ethnic make-up of
the counseling facility. Studies exploring correlates of willingness to visit mental health and counseling centers would seem to be important for both practical and theoretical reasons. From a practical perspective such findings may have implications for increasing the extent to which Blacks are willing to seek help. From a theoretical perspective, these results may have implications for cultural and social variables regarding the behavior of Blacks.

Up until the mid 1960s, most research involving the utilization of mental health centers on college campuses neglected analyses of minority use (Segal, 1966). The research population at that time reflected the fact that most college campuses were populated by middle class Whites. However, with the emergence of Blacks and other racial minorities onto the campuses of predominantly white institutions, researchers began to explore the mental health of the new groups (Gibbs, 1975). In order to get an accurate understanding of the mental health and mental health concerns of individuals attending colleges and universities, it seems important to examine all the factors surrounding the counseling experience as it relates to both majority and minority class members.

The following section will review some variables which have been hypothesized to be related to utilization of mental health services. Finally, the focus of this study
along with the hypotheses to be tested and measurement devices to be used will be explained.

**Help Seeking Behavior**

Much of the research examining cultural factors within the counseling relationship focuses heavily on behavior observed once the relationship has begun. Some authors suggest that expectations held by clients before the initial session are important (Vontress, 1971). However, they fail to address whether these factors prevent the actual initiation of contact. Mistrust and accompanying expectations embedded within interracial counseling relationships may preclude the initiation of contact with counseling facilities by Blacks.

Previous research seems to support the notion that minorities are less likely to seek psychological help than non-minorities (Harrison, 1975; Haviland, Horswill, O'Connell, & Dynneson, 1983; Karno & Edgerton, 1969). Moreover, trends of Blacks to visit counseling centers have been examined by several authors. As early as the mid-sixties, Kysar (1966) noted that black students on a predominantly white college campus in Chicago were underrepresented in the use of professional psychological services. He noted that most of the black students were inner-city youths who because of their cultural differences, might have had a need for services due to the stresses associated with adapting to a predominantly white
Gibbs (1975) archivally studied the use of a university counseling center by Blacks over a three year period. She identified case records of black students in the clinic files from the three previous years and analyzed them to determine utilization rates, demographic characteristics, presenting problems, duration of therapy and reason for termination. These data were then compared to available data on the entire clinic population along with findings of a utilization-termination survey conducted a few years earlier.

Results indicated that for the first year studied, Blacks were overrepresented in the clinic population relative to their ratio in total student population. Blacks were underrepresented over the next two years, but not at a statistically significant level when compared to the first year. However, when the last two years of utilization were compared to the general population of non-black users, significance was attained. Gibbs called for more studies to examine more thoroughly how the other variables affected utilization rates of the black student.

Even outside the domain of university counseling centers, Blacks seem to be underrepresented in client populations (Neighbors & Jackson, 1984; Smead, Smityey-Willis & Smead, 1982). Andrulis (1977) examined a fifty percent random sample of terminated cases from a
comprehensive mental health center. The population groups of Blacks, Mexican-Americans, and Whites were composed of people who had received inpatient, outpatient, and day hospital services. Demographic information, psychiatric history, referral source, diagnosis, discharge, and referral need were obtained from the records. Results indicated that there were significant differences found among referral patterns, diagnoses, discharge, and referral need when ethnicity was considered. Most notably, the minorities were significantly underrepresented when cases from family members, which are a major source of referrals, was considered.

Some have suggested that variables other than race alone should be considered when examining the use of psychological services by Blacks. Johnson (1977) designed a study to examine the predisposition of college students to seek psychological help on a predominantly black campus. In the study, the attitudes of the participants toward the value of counseling were assessed. The results suggested that the predisposition to seek counseling was affected by the type of problem to be discussed. Personal adjustment problems seemed significantly to reduce the frequency of counseling sought.

In an earlier study, Wolkon, Moriwaki, and Williams (1973) examined the relationship of race and social class to attitudes toward help seeking, race of therapist, self-
disclosure and self-reported treatment outcomes. Sixty-nine female college students, which included lower and middle class Blacks and middle class Whites, completed the Fischer and Turner Attitudes Toward Seeking Professional Psychological Help questionnaire. Demographic information was gathered along with accounts of actual experiences with, and preferences for counseling.

The subjects' attitudes toward psychotherapy was assessed by comparing middle-class Blacks to middle-class Whites and middle-class Blacks to lower-class Blacks. Although there was no significant difference found in the attitudes toward seeking help in the former case, the latter case yielded significant results. Since the attitudes toward psychotherapy of the middle-class Blacks were less positive than those of the middle-class Whites (but not significantly), it might be reasonable to suggest that if all black subjects had been collapsed, significance would have been reached. Nevertheless, the findings suggest that attitudes toward therapy were not related to race alone; social class also was seen as an important factor.

Thompson and Cimbolic (1978) examined factors such as counselor preference, sex of client, sex of counselor, race of counselor, and type of problem and their effects on black students' use of university counseling centers. Forty-two black females and 33 black males completed a survey questionnaire presenting them with two hypothetical
situations and accompanying choices for counselors. Demographic data and information regarding previous counseling center experiences were also elicited.

Results suggested that counselor preference was related to counseling center use for both hypothetical situations. The subjects preferred black counselors and their likelihood of taking problems to the counseling center increased as counselor preference increased. The likelihood of a subject taking a problem to a counseling center was significantly greater if the counselor to be seen was Black rather than White.

**Ethnicity**

The establishment of rapport is often considered to be an essential first step in the helping process and ultimate behavior change. Considerable research has been done exploring cultural factors in the therapeutic relationship. Authors have noted that the race of the therapist has important implications for black clients within these parameters.

In an early study, Phillips (1960) examined the likelihood of white therapists to attain satisfactory results from black clients. A population of elementary school boys, referred for counseling because of behavioral problems in the classroom, was seen by both white and black counselors.

Significant behavior changes were not noticed in those
children counseled by the white therapists. Phillips speculated that the white counselors were unable to overcome their clients' suspiciousness which may have been fortressed by racial barriers. However, it was suggested that rapport had been established within the black counselor/ black student combination, pre-empting a necessity to refer those clients for additional counseling.

In another early study, Carkhuff and Pierce (1967) examined the depth of self-exploration in initial interview sessions as a function of therapist race and social class. The study entailed matching hospitalized females, who were diagnosed as schizophrenics, with lay counselors who were judged to be functioning at high levels of empathy, positive regard, and genuineness. The results suggested that race and social class of both patient and therapist had a significant effect upon patient depth of self-exploration and the effect of the patient variables was contingent upon the therapist variables.

In a more recent study, Stevens (1983) examined the relationship between trust, race of the therapist, and type of problem on black students' ratings of an initial interview. Fifty-five black males and 69 black females between the ages of 18 and 24 were used. Participants were administered the Cultural Mistrust Inventory (CMI) (Terrell and Terrell, 1981) and divided into groups of high and low cultural mistrust based upon CMI scores.
Conditions across the two groups entailed half of the subjects being interviewed by white therapists and half of the subjects being interviewed by black therapists. It was predicted that post interview ratings of the counselors would be influenced by the type of problem, racial identity versus vocational aspirations, the subject was asked to discuss. Contrary to the predictions, outcome measures seemed to be a function of race of counselor regardless of type of problem discussed or level of mistrust. Students tended to rate black interviewers higher than white interviewers.

Some authors speculate that factors other than race per se might account for the differential therapeutic outcomes observed within interracial therapeutic relationships. For instance, Williams (1970) suggests that black counselors are more effective in working with black clients than their white counterparts because of a familiarity with black clients. This point of view has empirical support.

Grantham (1973) defined similarity by sex, race, and comprehension of non-standard black English. He suspected that similarity between counselor and client using these variables would have a direct relationship on the progress made in therapy. Thirty-seven black students were seen in a taped, initial interview and given the option to return the following week by a team of 14 counselors, five of whom were Black. The students also completed an outcome questionnaire
at the end of the initial interview.

Results suggested that race was a factor in determining satisfaction with the black clients regardless of counselor facilitative characteristics or ability to comprehend non-standard black English. Overall, female counselors elicited a greater depth of self-exploration from their black clients than male counselors and high facilitative conditions on the part of black counselors made for low depth of self-exploration on the part of black clients.

Bryson and Cody (1973) looked at whether the race of the counselor related to the understanding between counselor and client, therefore having an effect on the counseling relationship. Black and white students were seen in a counseling session by eight graduate school counselors. The sessions were recorded and then rated by three trained judges. The results seemed to indicate that race of the counselor was a factor related to level of understanding. Black counselors understood black clients better than they did white clients.

The effects of race, social class, and level of helper empathy on client self-exploration was examined by Banks (1972). Thirty-two randomly selected high school students were divided into groups and seen by four black, male therapists and four white, male therapists. The students' parents' occupational and educational level was used to determine social class.
Counselors received ratings of high or low empathy before the sessions began and were divided into groups accordingly. The depth of client self-exploration and rapport ratings were used as dependent variables. Results indicated that racially similar dyads produced greater client self-exploration and a reportedly greater degree of rapport. Social class seemed to have no effect while counselor empathy was a source of effect in the interviews.

In summary, according to the literature, even when other variables are considered, race continues to have an impact on the therapeutic relationship.

Trust

Authors assert that trust plays an important role in the development of interpersonal relationships (Erikson, 1963; Rotter, 1967). Since counseling experiences are often couched in terms of developing special types of interpersonal relationships, it seems reasonable to speculate on the role of trust in therapeutic relationships. Indeed, authors have suggested that trust is an important aspect of the counseling relationship (Marmor, 1976; Rogers, 1942). It has been associated with variables such as willingness to self-explore, degree of self-disclosure, and therapeutic progress (Okun, 1976; Patterson, 1985).

Interracial relationships are special types of relationships in which the variable of trust might play a crucial role. Rotter (1967) defines interpersonal trust as
a generalized expectancy held by an individual that the word, promise, oral or written statement of another individual or group can be relied on. Some authors have proposed that Blacks have a tendency to mistrust Whites (Grier and Cobbs, 1968). It has been suggested that as a result of either being exposed to racism or treated unfairly by Whites, Blacks have become mistrustful of Whites. Terrell (1980) describes this phenomenon as cultural mistrust. If this notion is accepted, interracial relationships in therapeutic settings would be subject to a trust-mistrust variable.

Gardner (1971) posits that the initial stages of interracial relationships, particularly psychotherapeutic relationships, are handicapped because of cautious attempts by both parties to discern one another's racial attitudes. This initial cautiousness tends to retard the building of a working alliance within the therapeutic context. Vontress (1971) echoes this concern by suggesting that significant barriers in the counseling process might be built because of the difficulty black clients might have in trusting white counselors.

LaFromboise and Dixon (1981) examined the relationship between trustworthiness attributed to the counselor and its effect upon initial interactions within the therapeutic context. Their subject population of Native American Indians tended to suspend their degree of trust towards
white counselors until trustworthiness was earned by the counselor. Unless a subjective perception of trust in the counselor was established, further interactions were precluded by the subjects.

Briley (1977) looked at interpersonal trust as a factor in influencing clients' preference for counselor race and sex. He was concerned with determining whether counselees with different racial backgrounds preferred to be counseled by counselors with similar backgrounds and with discovering whom they preferred to talk with about specific problems.

The Counselor Preference Checklist and Rotter's Scale of Interpersonal Trust was completed by 340 college students. Results indicated that Whites chose black counselors for only a small proportion of problems and Blacks chose white counselors for an even smaller proportion. Black students had a lower level of interpersonal trust according to Rotter's scale.

Trust as a factor in therapeutic relationships also has implications when variables such as expectancies held by clients are considered. In a study mentioned earlier, Stevens (1983) addressed the relationship between race of interviewer, cultural mistrust level, and type of problem upon blacks' ratings of initial interviews. In addition to finding a main effect for race regardless of trust level or type of problem, there was also a significant two way interaction found for the combined effects of trust and race.
of counselor on rating satisfaction with the counselor. Black students with low levels of cultural mistrust who discussed their racial identity were more likely to rate white interviewers lower than did other groups. It was suspected that those students' expectations of the white interviewers were too high, resulting in lower evaluations.

Watkins, Terrell, Miller, and Terrell (in press) examined the effects of cultural mistrust on counseling expectations for black clients. Ninety-five black males and 94 black females participated in the study which consisted of two sessions with a counselor held one week apart. During the first session participants were administered the Cultural Mistrust Inventory and demographic information was gathered. The subjects were then divided into groups of high mistrust and low mistrust and seen by either a black counselor or white counselor in a second session. During the second session the participants completed the Expectations About Counseling: Brief Form questionnaire.

Results reflected a significant interaction between level of trust and race of counselor. Black subjects who scored high on the CMI and were seen by a white counselor expected the counselor to be less accepting, trustworthy, and expert. They also expected less from the counseling experience. Generally speaking, results indicated that in overall lower levels of trust, subjects' expectations about counseling were significantly affected, regardless of
counselor ethnicity.

In an earlier study, Wright (1975) examined the variable of trust and its relationship to expectations and perceptions related to the race of the counselor. Both black and white students were used in this study that entailed five counseling sessions. Subjects were divided into groups of high trust and low trust using Rotter's Interpersonal Trust Scale and subsequently seen in five sessions by either a black or white counselor in order for the study to reflect all possible conditions.

Prior to the first session, subjects were administered a questionnaire designed to assess their perception of counselor of the same race along four of five stated dimensions: empathic understanding, congruence, level of regard, unconditionality of regard, and willingness to be known. They were then asked to do the same, but for a counselor of different ethnicity. The above mentioned measures were retested at the end of the fifth counseling session to determine change in counselee perception after experiencing a counselor of the same or different ethnic group.

Results indicated that subjects indeed held preconceived notions about counselors of the opposite race. Black high truster's indicated that black counselors would significantly show a higher level of regard, congruence, empathy, and unconditionality than white counselors. Black
low-truster's expected black counselors to significantly exemplify regard, congruence, and empathy. White subjects failed to yield significant expectation differences across conditions. However, there was increased favorability in black subjects' perception of counselors of opposite race by the end of the five session study.

In summary, previous research indicates that trust tends to effect the therapeutic relationship to the extent to which client rapport can be established. Hence, in examining therapeutic relationships consisting of a black client and white therapist, level of trust held by the client adds to the mere racial dimension. Trust not only has an effect by coloring the initial interactions and ultimate outcomes, it also has relevance to preconceived notions before counseling begins.

Purpose

The purpose of this study was to explore the relationship between the degree of mistrust Blacks hold of Whites and the attitudes held by Blacks towards seeking professional psychological help. Previous research indicates that race of therapist plays a role in the process and outcome of psychotherapy. Research also seems to support the notion that level of trust held by black clients towards non-black therapists has an effect on the process and outcome of therapy. The hypotheses tendered by the present study represent a seemingly logical antecedent to
the above findings.

Since most counseling centers on predominantly white campuses are primarily staffed by white therapists, it is anticipated that potential black clients will see it as such and consequently tend not to seek help from the facility due to a general mistrust of the majority cultural group. Blacks with a high degree of cultural mistrust were expected to hold more negative attitudes towards seeking psychological help when compared to Blacks with a low degree of cultural mistrust.

Method

Participants

A total of 105 black undergraduate students enrolled at The University of North Texas were recruited. The group consisted of 51 males and 54 females ranging in age from 17 to 37. The average age of participants was 20.29 (SD = 2.6). The males had a higher average age (M = 20.72, SD = 2.24) than females (M = 19.89, SD = 2.6). The percentage of subjects with previous counseling was 14% and 26% for males and females respectively. Seventy-three percent of the males expected to be helped by a white therapist should they require counseling compared to 80% of the females. The percentage of subjects expecting to be helped by a black therapist was 24% and 20% for males and females respectively.
Instruments

One measure used was the Terrell and Terrell (1981) Cultural Mistrust Inventory (CMI). This instrument was developed to measure the extent to which respondents trust whites in various situations. This measure has 48 items which follow a 9-point Likert type format that ranges from strongly agree to strongly disagree. Individuals who score high on the CMI are seen as relatively more mistrustful of Whites than those who score in the low range. The inventory items have demonstrated low correlations with a social desirability measure. Between item correlations and the total scale score range from .34 to .47. A test-retest reliability estimate using a two-week interval has yielded a correlation of .82. Some convergent and discriminant validity has been demonstrated using the scale. The scale is presented in Appendix A.

Participants were also administered a modified version of the Opinion About Mental Illness Scale (OMI) originally developed by Cohen and Struening (1962). The scale was developed to identify salient dimensions underlying opinions about severe mental illness among hospital workers. It consists of 70 Likert type opinion items largely concerned with the cause, treatment, description, and prognosis of mental illness. Five factors have been delineated from the scale; A-Authoritarianism, B-Unsophisticated Benevolence, C-Mental Hygiene Ideology, D-Social Restrictiveness; and E-
Interpersonal Etiology.

Factor A (OMIA) represents authoritarian submission and anti-intraception with a view of the mentally ill as a class inferior to normals and requiring coercive handling. Factor B (OMIB) represents a benevolence toward patients which arises from a moral point of view which is encouraging, nurturant, but still acknowledging some fear of mental health patients. Factor C (OMIC) embodies the tenents of the creed of modern mental health professionals who view patients much like normal people. Factor D (OMID) emphasizes the desire to restrict mental patients both during and after hospitalization for the protection of society. Factor E (OMIE) reflects a belief that mental illness arises from interpersonal experiences (e.g. parental love and attention during childhood). High scores within each scale indicate an endorsement of the ideas represented by the scales.

Factor C was excluded from the modified version used in this study because of the marginally adequate internal consistency it has demonstrated (Struening and Cohen, 1963). Adequate measures of internal consistency along with satisfactory validity coefficients have been reported for the other factors. The scale is found in Appendix B.

The purpose of this study was to examine the relationship between level of trust and help seeking behavior. One of the instruments used to measure the latter
is a scale developed by Plotkin (1983) entitled **Help Seeking Attitude Scale (HSAS)**. This instrument has 41 items and follows a 4-point Likert format ranging from disagreement to agreement. High scores indicate favorable attitudes toward seeking help whereas low scores indicate unfavorable attitudes. Estimates of the scale's internal reliability have yielded a value of .87 which indicates relatively high internal consistency. It has also been found to correlate significantly with another similar measure developed by Fisher and Turner in 1970 ($r = .49, p < .001$). The scale is presented in Appendix C.

Another measure used was a modified version of the **Reid-Gundlach Social Service Satisfaction (R-GSSS)** scale which was developed to provide an overall satisfaction-with-service score (1983). The original version of the measure has 34 items which use a 5 point Likert format ranging from "strongly agree" to "strongly disagree". In addition to providing an overall satisfaction-with-service or total score (RGTS), the measure also yields three subscales reflecting reactions to the relevance (RGRS) or the extent to which a service corresponds to the client's perception of his or her problems, the impact (RGIS) or extent to which services reduce problems, and gratification (RGGS) or extent to which services enhance the client's self-esteem and contribute to a sense of power and integrity.

For the purpose of this study, the item format of the
R-GSSS was changed to future tense and "counselor" and "mental health center" was substituted for "social worker" and "agency" respectively. Low scores indicate anticipated satisfaction with service or the expectation that services will apply to the particular subscales in a positive manner. The R-GSSS has demonstrated good internal consistency with a total alpha of .95. The authors also report satisfactory alphas for the three subscales, ranging from .82 to .86. They also reveal that the three subscales are sufficiently independent and have high face validity. The scale is located in Appendix D.

Finally, a Background Information Questionnaire specifically devised for this study was filled out by all participants. General information regarding the subjects age, sex, college grade level, college major, grade point average, place of birth, and whether the subject had been in counseling before was gathered. Subjects were also asked to describe their perceptions of what a counseling facility offered. A copy of this questionnaire is located in Appendix E.

Procedure

Participants were administered the inventories in groups ranging from 15 to 25. After all participants in each session were seated, they were told the following:
Thank you for agreeing to participate in this project. My name is: (examiner's name) and this study is for the purpose of fulfilling some of the requirements for a student's masters degree. We will shortly distribute a packet to each of you. Each packet will contain four inventories. You should fill out the inventories in the order they have been placed in your envelope. Each inventory or survey provides straightforward directions for how it should be filled out. However, if after reading the instructions, you have questions, feel free to raise your hand and I will be glad to assist you. When you finish a survey, please turn it face down in front of you. Then take out the next inventory, read the instructions, and fill it out.

You are not required to put your names on any of the inventories and each individual's results will be held in confidence. Also, we are interested in the attitudes of people in general and not your individual opinions. Therefore, please select the answer which is closest to what you really believe. If at any time you feel that you do not want to finish filling out the inventories, you are free to leave. Although I will not be able to give you any experimental
credit, leaving will not affect your grades nor will you be penalized in any way.

Prior to distributing the actual envelopes containing the inventories, I will pass out a consent form. You should read it, and if you are willing to participate, sign the consent form and pass it to the front of the room. Are there any questions? Questions regarding procedures for filling out the inventories will be answered, all other inquiries will be answered with "do what you think is best" or some other similar ambiguous response.

The inventories were administered by four examiners: two white females and two black females. Each examiner was an advanced undergraduate student kept blind regarding the nature of the study but briefed regarding the instructions. Prior to administering the questionnaires to subjects, the examiners received a minimum of two hours of training on test administration procedures.

The CMI was the last inventory in each packet. However, to control for order effects, all other instruments were administered in a random order. After completing the packets, the subjects were thanked for their participation.

Results

As will be recalled, the purpose of this study was to examine the relationship between cultural mistrust and
attitudes towards mental health services in college students. It was predicted that individuals with high levels of cultural mistrust would be less willing to seek psychological services. To do this, black males and females were administered the CMI, which was used as an independent variable, the OMI, which was used as a covariate, and the HSAS and R-GSSS. These latter two inventories served as the outcome measures.

To more clearly differentiate between high and low mistrusters, the range of scores on the CMI was ascertained (98-230) and those scores falling between the 41st and 60th percentile were deleted from the actual analysis. As a result, twenty-two subjects scoring between 174 and 184 on the CMI were deleted from the analyses. The means and standard deviations of all measures for all groups are summarized in Table 1.

**Preliminary Analysis**

It is possible that participant's perception of mental health professionals may be a major contributor to their willingness to seek mental health services in addition to, or rather than, the extent to which they trust Whites. Therefore, prior to examining the hypothesis of this study, Pearson correlations were computed between participant's scores on the Opinions about Mental Illness scale (OMI), Help Seeking Attitude Scale (HSAS), and Reid-Gundlach Social Service Satisfaction (R-GSSS) subscales. See Table 2.
Table 1
Means and Standard Deviations for the CMI, HSAS, R-GSSS, and OMI

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1 = Group means are listed on the same line as the scale. Standard deviations are listed below the means.

2 CMI = Cultural Mistrust Inventory
HSAS = Help Seeking Attitude Scale
R-GSSS = Reid-Gundlach Social Satisfaction Scale
RGTS = Total score of the R-GSSS
RGRS = Relevance scale of the R-GSSS
RGIS = Impact scale of the R-GSSS
RGGS = Gratitude scale of the R-GSSS
OMI = Opinions About Mental Illness Scale
OMIA = Authoritarian scale of the OMI
OMIB = Benevolence scale of the OMI
OMID = Social restrictiveness scale of the OMI
OMIE = Interpersonal etiology scale of the OMI
Table 2

Pearson Correlations Between All Measures

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Table Continues
Table 2 - Continued

* significant, $p < .05$

** significant, $p < .01$

*** significant, $p < .001$

1 = Cultural Mistrust Inventory
2 = Help Seeking Attitude Scale
3 = Authoritarian scale of the OMI
4 = Benevolence scale of the OMI
5 = Social restrictiveness scale of the OMI
6 = Interpersonal etiology scale of the OMI
7 = Relevance scale of the R-GSSS
8 = Impact scale of the R-GSSS
9 = Gratification scale of the R-GSSS
10 = Total score of the R-GSSS

Since significant correlations are found between these measures, the data were analyzed using a 2 (High vs. Low) X 2 (Male vs. Female) MANCOVA. The covariates were participant's scores on the OMI. The outcome measures consisted of scores on the HSAS and R-GSSS.

The MANCOVA yielded no significant differences for the main effect of gender (Wilks Lambda= .929, approximate $F (5,71)= 1.08, p < .37$). However significant differences were found for the main effect of Mistrust Level (Wilks Lambda= .853, approximate $F (5,71)= 2.43, p < .04$) and for the Gender by Mistrust interaction (Wilks Lambda= .848,
approximate $F(5,71) = 6.83, \ p < .03$.

Since a significant main and interaction effect were found, univariate $F$-tests were computed to further identify where differences existed. The main effect of Mistrust Level yielded significant differences for the Help Seeking Attitude Scale ($F(1,75) = 6.83, \ p < .01$); Reid-Gundlach Total Score (RGTS) ($F(1,75) = 7.03, \ p < .01$); Reid-Gundlach Relevance Score (RGRS) ($F(1,75) = 7.20, \ p < .009$); Reid-Gundlach Impact Score (RGIS) ($F(1,75) = 5.01, \ p < .02$); Reid-Gundlach Gratitude Score (RGGS) ($F(1,75) = 6.00, \ p < .01$). Univariate $F$-tests revealed no significant differences for the interaction effect.

Since significance was found for the main effect of Mistrust Level, Tukey's method of post hoc analysis was employed to further explore differences among high mistrusters and low mistrusters. No significant differences were found between groups for the RGRS. However, males with low degrees of cultural mistrust scored higher than males with high degrees of cultural mistrust on the HSAS ($p < .01$). In addition, females with low degrees of cultural mistrust scored higher on the HSAS than males with high degrees of cultural mistrust ($p < .01$).

On the RGIS, females with low levels of cultural mistrust scored lower than males with high degrees of cultural mistrust ($p < .05$). Comparisons of group differences on the RGGS showed that males with low degrees
of cultural mistrust scored lower than males with high degrees of cultural mistrust \((p < .05)\). Finally, on the RGTS, females with low levels of cultural mistrust scored lower than males with high degrees of cultural mistrust \((p < .05)\).

As a peripheral interest unrelated to the main hypothesis, Pearson Correlations were computed between all measures used. As expected, the subscales within the OMI were significantly correlated \((p < .001)\) as were the subscales within the R-GSSS \((p < .001)\). Cultural mistrust scores correlated significantly with the HSAS \((p < .05)\), the OMIA \((p < .05)\), and all scales of the R-GSSS \((p < .001)\). The HSAS correlated significantly with the OMIA, OMID, and OMIE \((p < .001)\) along with the RGRS, RGIS, RGTS \((p < .001)\) and RGGS \((p < .05)\) respectively. The complete matrix is provided in Table 2.

Discussion

The purpose of this study was to explore the relationship between the mistrust level and attitudes toward seeking professional psychological help among Blacks. No significant differences were found for the main effect of gender. Males and females did not differ significantly in their attitudes toward seeking psychological services.

This result is consistent with findings from other studies. For example, Lorion (1974) explored attitudes and expectations about therapy held by male and female clients.
However, no differences were found for gender. Similarly, Thompson and Cimbolic (1978) attempted to identify factors related to black students' use of a counseling center and found no significant effects for the gender of client or counselor. More recently, Halgin, Weaver, Edell, & Spenser (1987) investigated the relation of attitudes toward obtaining psychological help as a factor of gender and depression. Again, no significant differences were found. Thus, previous studies, including the results of the present study, suggest that gender is not an important variable when considering help seeking attitudes. It should be noted that most studies which have not found gender differences have used college populations.

However, others (Veroff, Kukla, & Douvan; 1981) have reported differences in numbers of males and females actually visiting clinics. Previous research using client populations has shown that females attend mental health centers more frequently than males (Gove & Tudor, 1973; Gove, 1984; Kessler, Brown, & Browman, 1981; Neighbors & Howard, 1987). Although this trend might be accounted for by suggesting that females have a higher incidence of mental illness than males, it is also possible that females are more willing to seek mental health services.

Thus, despite the findings of this study as well as previous research, it would be premature to conclude that males are as willing to seek mental health services as
females. Additional studies exploring the relationship between gender and help seeking attitudes and behavior should be done using clients experiencing emotional distress prior to concluding that no differences exist between males and females regarding help seeking.

Results of this study were consistent with the prediction that individuals with high levels of mistrust of Whites would be less willing to seek psychological services than those individuals with low levels of mistrust. These findings are also consistent with the results of previous investigators; thus, suggesting that trust is indeed an important factor in helper/helpee relationships. LaFromboise and Dixon (1981) found that a lack of trust for the therapists precluded further interactions by their Native American Indian subjects. Briley (1977) found that Blacks who were classified as mistrustful using Rotter's Scale of Interpersonal Trust, chose to be seen by white counselors in only small proportions. Wright (1975) also used Rotter's scale to determine high and low trusters among black clients. His results indicated that trust differentially reflected preconceived notions held by the subjects of their white counselors.

Watkins, Terrell, Miller & Terrell (in press) found that highly mistrustful Blacks expected less from counseling regardless of the race of the therapist. A significant interaction effect in the study suggested that black clients
assigned to white therapists expected the therapists to be less accepting, trustworthy, and expert. Thus, research seems to consistently indicate that highly mistrustful Blacks are reluctant to seek therapy.

The significance found within the complete correlation matrix between the mistrust scores and dependent measures are also consistent with the findings related to the main hypothesis. However, the negative correlation between mistrust scores (CMI) and authoritarian ideology (OMIA) along with the positive correlation between help seeking attitude (HSAS) and authoritarian ideology (OMIA) were of interest even though they were not part of the main hypothesis.

If individuals with low levels of cultural mistrust hold more authoritarian views, perhaps the two factors can be further related to help seeking attitude. This speculative relationship implicating the notion of authoritarianism to help seeking attitude seems to be supported by the significant positive relationship between the help seeking attitude and authoritarian factor. Future studies might explore this relationship.

The results of this study have both theoretical and practical implications. Theoretically, the results of this study support the notion that differences in the extent to which Blacks mistrust Whites exist. Furthermore, the differences in the levels of mistrust seem to play a role in
Blacks' willingness to seek psychological assistance. At an applied level, results of this study suggest that if Blacks requiring mental health services are to seek help, efforts should be made to reduce their apprehensions related to interacting with Whites. Reducing the extent to which Blacks mistrust Whites might be helpful in increasing their willingness to seek professional psychological help when needed.

Although significant differences were found for help seeking attitudes between groups as a function of mistrust level, caution should be taken in interpreting the findings given the limitations of this particular study. One limitation is related to the population sampled. The attitudes of college students were used in this study; thereby limiting generalizations to other groups of Blacks. In addition, the participants were not part of an identifiable clinical population. The attitudes of Blacks who are actually experiencing problems that might require professional services should be examined before definitive conclusions are drawn. It is suggested that mistrust level might be related to socialization associated with specific geographical regions of the country. A sample of the attitudes of Blacks from different areas might yield different results.

Another limitation of this study relates to the outcome measures used. Plotkin's HSAS, a dependent measure used in
this study, was developed as an alternative to Fischer and Turner's help seeking attitude scale which was seen as potentially insensitive to ethnic cultures. However, the HSAS has not been utilized as extensively as the Fischer and Turner scale and should be employed in future studies in order to further demonstrate its utility and construct validity. Similar limitations exist for the R-GSSS, which was also developed as a research inventory.
Appendix A

Cultural Mistrust Inventory (CMI)
Cultural Mistrust Inventory (CMI)

Directions

Enclosed are some statements concerning beliefs, opinions, and attitudes about Blacks. 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 following scale:

1= Strongly disagree
2= Agree
3= Slightly disagree
4= Neither disagree nor agree
5= Slightly agree
6= Agree
7= Strongly disagree

Finally, there are no right or wrong answers, only what is right for you. If in doubt, choose the number which seems to most nearly express your present feelings about the statement. Please answer all items.

____ 1. Whites are usually fair to all people regardless of race.
____ 2. White teachers teach subjects so that they favor whites.
____ 3. White teachers are more likely to slant the subject matter to make blacks look inferior.
____ 4. White teachers deliberately ask black students questions which are difficult so they will fail.
____ 5. There is no need for a black person to work hard to get ahead financially because whites will take what you earn anyway.
____ 6. Black citizens can rely on white lawyers to defend them to the best of his ability.
____ 7. Black parents should teach their children not to trust white teachers.
____ 8. White politicians will promise blacks a lot but deliver little.
____ 9. White policemen will slant a story to make blacks appear guilty.
Appendix A - continued

10. White politicians usually can be relied on to keep the promises they make to blacks.

11. Blacks should be suspicious of a white person who tries to be friendly.

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

13. Probably the biggest reason whites want to be friendly with blacks is so they can take advantage of them.

14. A black person can usually trust his or her white co-workers.

15. If a white person is honest in dealing with blacks, it is because of fear of being caught.

16. A black person cannot trust a white judge to evaluate him or her fairly.

17. A black person can feel comfortable making a deal with a white person simply by a handshake.

18. Whites deliberately pass laws designed to block the progress of blacks.

19. There are some whites who are trustworthy enough to have as close friends.

20. Blacks should not have anything to do with whites since they cannot be trusted.

21. It is best for blacks to be on their guard when among whites.

22. Of all ethnic groups, whites are really the Indian-givers.

23. White friends are least likely to break their promise.

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

25. Whites can rarely be counted on to do what they say.
Appendix A - continued

26. Whites are usually honest with blacks.
27. Whites are as trustworthy as members of any other ethnic group.
28. Whites will say one thing and do another.
29. White politicians will take advantage of blacks every chance they get.
30. When a white teacher asks a black student a question, it is usually to get information which can be used against him or her.
31. White policemen can be relied on to exert an effort to apprehend those who commit crimes against blacks.
32. Black students can talk to a white teacher in confidence without fear that the teacher will use it against him or her later.
33. Whites will usually keep their word.
34. White policemen usually do not try to trick blacks into admitting they committed a crime which they didn't.
35. There is no need for blacks to be more cautious with white businessmen than with anyone else.
36. There are some white businessmen who are honest in business transactions with blacks.
37. White store owners, salesmen, and other white businessmen tend to cheat blacks whenever they can.
38. Since whites can't be trusted in business, the old saying "one in the hand is worth two in the bush" is a good policy to follow.
39. Whites who establish businesses in black communities do so only so that they can take advantage of blacks.
40. Blacks have often been deceived by white politicians.
Appendix A - continued

41. White politicians are equally honest with blacks and whites.

42. Blacks should not confide in whites because they will use it against you.

43. A black person can loan money to a white person and feel confident it will be repaid.

44. White businessmen usually will not try to cheat blacks.

45. White business executives will steal the ideas of their black employees.

46. A promise from a white is about as good as a three dollar bill.

47. Blacks should be suspicious of advice given by white politicians.

48. If a black student tries, he will get the grade he deserves from a white teacher.
Appendix B

Opinions About Mental Illness Scale (OMI)
Opinions About Mental Illness Scale (OMI)

Instructions

The following statements reflect various opinions about mental illness. Read each statement carefully and give your honest opinion regarding each statement. Please indicate on the line at the left of each item the number that comes closest to how you feel by using the scale from "1" to "6" described below.

1= Strongly agree
2= Agree
3= Somewhat agree
4= Somewhat disagree
5= Disagree
6= Strongly disagree

Please answer all items. Do not spend too much time on any one item. Remember, there are no right or wrong answers, only what is right for you. Your frank opinion is desired.

____ 1. If parents loved their children more, there would be less mental illness.

____ 2. One of the main causes of mental illness is a lack of moral strength or will power.

____ 3. Mental patients come from homes where the parents took little interest in their children.

____ 4. Although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of everyday life.

____ 5. The mental illness of many people is caused by the separation or divorce of their parents during childhood.

____ 6. People would not become mentally ill if they avoided bad thoughts.

____ 7. People who are mentally ill let their emotions control them; normal people think things out.

____ 8. If the children of mentally ill parents were raised by normal parents, they probably would not become mentally ill.
Appendix B - continued

9. When a person has a problem or worry, it is best not to think about it, but keep busy with more pleasant things.

10. Nervous breakdowns usually result when people work too hard.

11. The patients of a mental hospital should have something to say about how the hospital is run.

12. Mental illness is usually caused by some disease of the nervous system.

13. All patients in mental hospitals should be prevented from having children by a painless operation.

14. The small children of patients in mental hospitals should not be allowed to visit them.

15. It is easy to recognize someone who once had a serious mental illness.

16. Regardless of how you look at it, patients with severe mental illness are no longer really human.

17. There is something about mental patients that makes it easy to tell them from normal people.

18. If people would talk less and work more, everybody would be better off.

19. Even though patients in mental hospitals behave in funny ways, it is wrong to laugh about them.

20. People with mental illness should never be treated in the same hospital as people with physical illness.

21. A person who has bad manners, habits, and breeding can hardly expect to get along with decent people.

22. If the children of normal parents were raised by mentally ill parents, they would probably become mentally ill.
Appendix B - continued

23. A heart patient has just one thing wrong with him, while a mentally ill person is completely different from other patients.

24. To become a patient in a mental hospital is to become a failure in life.

25. Patients in mental hospitals are in many ways like children.

26. More tax money should be spent in the care and treatment of people with severe mental illness.

27. Although some mental patients seem alright, it is dangerous to forget for a moment that they are mentally ill.

28. A woman would be foolish to marry a man who has had a severe mental illness, even though he seems fully recovered.

29. Anyone who tries hard to better himself deserves the respect of others.

30. Our mental hospitals seem more like prisons than like places where mentally ill people can be cared for.

31. People who have been patients in mental hospitals will never be their old selves again.

32. The law should allow a woman to divorce her husband as soon as he has been confined in a mental hospital with a severe mental illness.

33. The best way to handle patients in mental hospitals is to keep them behind locked doors.

34. Many patients in mental hospitals make wholesome friendships with other patients.

35. Although patients discharged from mental hospitals seem all right, they should not be allowed to marry.

36. There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed.
Appendix B - continued

37. Anyone who is in a hospital for a mental illness should not be allowed to vote.

38. Every mental hospital should be surrounded by a high fence and guards.

39. Every person should make a strong attempt to raise his social position.

40. Most women who were once patients in a mental hospital could be trusted as baby sitters.

41. Most patients in mental hospitals don't care how they look.

42. Obedience and respect for authority are the most important virtues children should learn.

43. College professors are more likely to become mentally ill than are business men.

44. People who become successful in their work seldom become mentally ill.

45. There is hardly anything lower than a person who does not feel a great love, gratitude, and respect for his parents.

46. Every person should have complete faith in some supernatural power whose decisions he obeys without question.
Appendix C

Help Seeking Attitude Scale (HSAS)
Help-Seeking Attitude Scale (HSAS)

Instructions

The following statements represent attitudes about psychotherapy. Assume that the therapy is offered by a facility primarily staffed by white personnel. Please indicate on the line at the left of each item the number that comes closest to how you feel by using the scale from "1" to "4" described below.

1= Strongly agree
2= Agree
3= Disagree
4= Strongly disagree

There are no right or wrong answers; just choose the answer that represents your honest opinion. Try to answer as quickly as possible. Do not spend too much time on any one statement. Please remember to complete each item.

___ 1. Even if problems make a person feel quite upset, it is better to handle them by oneself than to go to psychotherapy.

___ 2. A person cannot always solve his problems by himself, even if he has above-average intelligence.

___ 3. A person should tell anyone he wants that he goes to a therapist.

___ 4. It's OK for a person to tell people outside his family that he goes to psychotherapy.

___ 5. Male therapists are more helpful to male clients.

___ 6. There is nothing embarrassing or shameful about going to psychotherapy.

___ 7. Psychotherapy is not very useful for emotional problems (e.g., nervousness, depression, etc.).

___ 8. Female therapists are more helpful to female clients.

___ 9. A person should recommend psychotherapy to a friend who has psychological problems.

___ 10. Most people will continue seeing a friend even if they discover that he is going to psychotherapy.
Appendix C - continued

11. A person should not go to a therapist who is younger than himself.

12. Psychotherapy is not worth the time and effort involved.

13. Older therapists give better advice.

14. Psychotherapy is not very useful for dating or marriage problems.

15. Psychotherapy is useful since problems will not necessarily disappear as time passes.

16. If a person tries hard enough, he can deal with any problem by himself.

17. The fact that a person goes to psychotherapy does not mean that his family has failed in some way.

18. A person who has never gone to psychotherapy is not necessarily healthier than someone who has.

19. Psychotherapy can be useful for family problems.

20. People with mild to moderate problems don't need psychotherapy.

21. Psychotherapy is not very useful for problems related to one's job.

22. People in any age group can be helped by psychotherapy.

23. Psychotherapy can be useful for sleep problems (e.g., difficulty in falling asleep, difficulty in staying asleep, etc.).

24. Psychotherapy can be useful for alcoholism.

25. Psychotherapy cannot help a person to become more self-confident.

26. Only people with severe mental illness should go to a therapist.

27. Anyone who needs psychotherapy is weak.
Appendix C - continued

28. A friend almost always gives more helpful advice than a therapist.

29. Most people who try psychotherapy will not be helped by it.

30. It is wrong to lose respect for a person because he cannot deal with a problem by himself.

31. Important responsibility should never be given to a person who has been hospitalized for past mental illness.

32. Family members are not disappointed in a person who goes to psychotherapy.

33. It is better not to talk about problems with a stranger such as a therapist.

34. There are many positive effects of psychotherapy.

35. Psychotherapy is not very useful for sexual problems.

36. Psychotherapy is not very useful for problems in self-expression.

37. A person should always ask for his family's advice regarding a psychological problem instead of going to a therapist.

38. Psychotherapy is not very useful for school problems.

39. A person does not develop a deeper understanding of himself or others through psychotherapy.

40. Psychotherapy can be useful for problems with social relationships (e.g., loneliness, conflicts with friends, etc.).
Appendix D

Reid-Gundlach Social Service Satisfaction Scale (R-GSSS)
Reid-Gundlach Social Service Satisfaction Scale (R-GSSS)

Instructions
Assume that you were advised to seek mental health services from a facility composed primarily of white staff. Please indicate on the line at the left of each item the number that comes closest to how you would feel by using the scale from "1" to "5" described below.

1= Strongly agree
2= Agree
3= Undecided
4= Disagree
5= Strongly disagree

__ 1. The counselor will take my problems very seriously.

__ 2. If I was the counselor I would deal with my problem in just the same way.

__ 3. The counselor I might get could never understand anyone like me.

__ 4. Overall, the counselor could be very helpful to me.

__ 5. If a friend of mine develops similar problems I would tell them to go to the mental health center.

__ 6. The counselor will ask a lot of embarrassing questions.

__ 7. I will always be able to count on the counselor to help me if I'm in trouble.

__ 8. The mental health center will help me as much as they can.

__ 9. I don't think the mental health center will have the power to really help me.

__ 10. The counselor will try hard but usually will not be too helpful.

__ 11. The problem the mental health center will try to help me with will be one of the most important in my life.
Appendix D - continued

12. Things will get better after I've gone to the mental health center.

13. After I've used the mental health center my life will be more messed up than ever.

14. The mental health center will always be available when I need it.

15. I will get from the mental health center exactly what I want.

16. The counselor will love to talk but won't really do anything for me.

17. Sometime I will just tell the counselor what I think he/she wants to hear.

18. The counselor will usually be in a hurry when I see him/her.

19. No one should have any trouble getting some help from this mental health center.

20. The counselor will sometimes say things I don't understand.

21. The counselor will always explain things carefully.

22. I will never look forward to my visits to the mental health center.

23. I will hope that I'll never have to go back to the mental health center for help.

24. Every time I talk to the counselor I will feel relieved.

25. I will be able to tell the counselor the truth without worrying.

26. I will usually feel nervous when I talk to the counselor.

27. The counselor will always look for lies in what I tell him/her.
Appendix D - continued

28. It will take a lot of courage to go to the mental health center.

29. When I enter the mental health center I will feel very small and insignificant.

30. The mental health center will be very demanding.

31. The counselor will sometimes lie to me.

32. Generally the counselor will be an honest person.

33. I will have the feeling that the counselor talks to other people about me.

34. I will always feel well treated when I leave the mental health center.
Appendix E

Background Information Questionnaire
Appendix E

Background Information Questionnaire (BIQ)

1. Age ______
2. Sex  Male    Female
3. College Grade Level
   Freshman ___    Junior ___
   Sophomore ___   Senior ___
4. College Major ________________________
5. Grade Point Average ______
6. Name of the city in which you were raised ________________________
7. Have you ever received counseling before?
   Yes    NO
8. Please check the services that you think are offered at a counseling or mental health center.
   Personal counseling ___  Occupational counseling ___
   Academic counseling ___  Group counseling ___
   Marital counseling ___   Other ___
9. Who do you think is most likely to offer the services to you in a counseling or mental health center?
   (Please check only one from each column)
   Male ___    White ___
   Female ___   Black ___
                 Hispanic ___
                 Oriental ___
                 Other ___
Appendix F

Informed Consent
Informed Consent

I, __________________________, freely consent to be a participant in this research project conducted in the spring semester of 1988 with Kim J. Nickerson and Dr. Francis Terrell as the principal investigators. The procedures to be followed and their purpose have been explained to me and I understand them. They are: I understand I will be asked to complete five questionnaires. My identity on the questionnaires shall remain anonymous. I understand that the purpose of the project is to examine the help seeking attitudes of black students through the use of the questionnaires. I understand that, after participation, if I should choose, I will be fully informed of the results.

The attendant discomforts and risks reasonably to be expected by my participation in this project have been explained to me, and I understand that they might be as follows: I may become tired or fatigued due to the length of the questionnaires. I understand that I should feel free to discuss any feelings I have due to my participation and that I may stop at any time.

I understand that the person who will conduct the interview will have no access to the results. If I desire feedback regarding the results, I understand that I should contact Kim J. Nickerson, Psychology Clinic, Terrill Hall, Denton, Texas 76203; telephone 817/565-2631.

I understand that this consent and data may be withdrawn at any time without prejudice. I have been given the right to ask and have answered any inquiry concerning the foregoing. Questions, if any, will be answered to my satisfaction. I have read and understand the foregoing.

Signature of Participant __________________________ Date ____________
References


