THE RELATIONSHIP BETWEEN RACE OF COUNSELOR, CULTURAL MISTRUST LEVEL AND WILLINGNESS TO SEEK PSYCHOLOGICAL TREATMENT AMONG MEXICAN-AMERICAN ADOLESCENTS

THESIS

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By

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The effects of cultural mistrust level and race of counselor on the willingness of Mexican-American adolescents to seek psychological help were examined in this experiment. A total of 79 Mexican-American adolescents consisting of 50 females and 29 males completed a Background Information Inventory, a modified version of the Cultural Mistrust Inventory, and the Help Seeking Attitude Scale. Five regression analyses were performed resulting in a significant interaction between cultural mistrust level and willingness to seek help. Mexican-American adolescents with high levels of mistrust were less willing to seek psychological treatment than those with a low level of mistrust. Results also indicated that females as well as individuals with higher levels of education were more willing to seek help than males and those with lower levels of education. Theoretical and practical implications are discussed.
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THE RELATIONSHIP BETWEEN RACE OF COUNSELOR, CULTURAL MISTRUST LEVEL AND WILLINGNESS TO SEEK PSYCHOLOGICAL TREATMENT AMONG MEXICAN-AMERICAN ADOLESCENTS

An on-going difficulty often encountered by therapists is the failure of patients to attend therapy sessions. A somewhat related problem is client termination from treatment prior to reaching the desired goals of therapy. It has been estimated that the attrition rate from mental health services falls between 30 percent and 65 percent (Baekland & Lundwell, 1975; Garfield & Bergin, 1971).

Numerous studies have been done exploring possible contributors to premature termination among adults (Baekland & Lundwell, 1975). However, the number of studies examining the correlates of non-attendance and drop out behavior among child and adolescent patients using mental health services is limited (Baekland & Lundwell, 1975). Also, lack of motivation to seek therapy and premature termination has not been adequately studied among child clients. This problem has been pointed out in a comprehensive review of drop out behavior among adults by Baekland and Lundwell (1975). These authors stated that parental attitudes, pathology and behavior are important contributors to children discontinuing treatment in eight out of 10 studies.
Unfortunately, most of the information presented in these studies was based on past records of the patients and antedotal observations by clinicians rather than systematic research and survey results (Baekland & Lundwell, 1975).

Although parental attitude and willingness to seek therapy has received very limited attention, researchers investigating the problems of non-attenders and terminators among children recently found that the parent’s or caretaker’s pathology may relate to whether their children drop out of therapy (Gould, 1985). Subjects consisted of 15.8 percent white, 26.3 percent black and 57.9 percent Hispanics. Both children and parents were assessed for psychiatric symptomatology. The Brief Symptom Inventory (Derogatis, 1975A) was used for parents which measured psychological stress in terms of reflecting, somatizing, obsessive compulsive behavior, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychosis. The Child Behavior Checklist (Achenback, 1978) was used to assess behavior problems in the children and was completed by both parents and teachers. Demographics were assessed regarding families’ socioeconomic status, source of referral to the clinic, and past psychiatric treatment of both child and the family. Results indicated no significant differences between drop-outs and attenders in terms of age, sex, ethnicity of the child or
the parent or caretaker who accompanied the child to the clinic. However, parents of non-attenders obtained higher scores on eight out of nine symptom factors on the Brief Symptom Inventory than parents of attenders. Also, children referred by schools were found to drop out more often than those who were not referred by schools. This study seems to suggest that sources of referral and parental pathology are important factors related to drop out behavior among children. However, support for the contribution of parental pathology was not found in an earlier study by McAdoo and Roske (1973) who compared fathers and mothers of "defectors and "continuers" of therapy using the Minnesota Multiphasic Personality Inventory (MMPI). Their results indicated that although mothers and fathers of defectors obtained slightly higher scores on many of the MMPI scales, the differences were not large enough to be significant. This study found no difference between the continuers and defectors groups related to parental pathology.

A similar conclusion was drawn by Weisz, Weiss and Langmeyer (1987) who studied 166 children who dropped out after the first interview and 138 children who remained in therapy for an average of 13 sessions. Both groups of children were compared on age, socioeconomic status, birth order, number of children living at home, and change in family due to divorce or separation. No significant
differences were found between continuer's and drop-out's demographic variables nor between their therapists' demographic variables. Moreover, drop-outs were also compared on the Children's Depression Inventory and Child Behavior Checklist. The results did not find drop-outs significantly different than remainders on the measures used. Parents' perception of the clinic and their children's experience at the clinic were also found to be non-significant. The authors conclude that children who drop out and those who attend outpatient therapy are so similar that drop outs should be accepted as a naturally occurring control group for outcome research. However, these researchers proposed that further evidence be found before these conclusions be accepted with confidence. They further suggest that future research may consider parental characteristics (i.e. attitudes and pathology to investigate drop out and nonattendance of therapy by child patients).

Various theories have been proposed to explain the unwillingness of the client to continue therapy. Freud was well aware of the tendency of his patients to discontinue treatment. He saw this lack of motivation to continue treatment as a resistance to treatment by the patient. According to Freud (1917, p. 294), as the process of therapy began "A violent opposition must have started against entry into consciousness of questionable mental
process" and this resistance seen in "opposition during psychoanalytic treatment sets itself up against...our efforts to transform what is unconscious to what is conscious. This is what we perceive as resistance." (Freud, 1917, p. 294). Freud emphasizes that resistance "brings work to a halt" in treatment and develops due to the emergence of repression (Freud, 1917, p. 294). In psychoanalysis, resistance and repression are viewed as milestones and recognized as the important events in the course of the therapeutic work. Thus, Freud viewed a refusal to attend therapy as a manifestation of a client's mental illness.

Rogers also focused on the problem of the client "who is not yet ready for therapy...is when he dimly perceives discrepancies in himself" (Rogers, 1965, p. 192). It was felt by Rogers that the client who is certain that he is incapable of making his own decisions... is annoyed or antagonistic" (Rogers, 1965, p. 213). According to Rogers it is rare that the client-centered therapist has difficulty handling such clients, sometimes a therapist does come across a situation where a client presents a lack of motivation to continue the process of therapy. In this situation Rogers has cautioned the therapist that "very minute deviations by therapist from an attitude of complete respect, understanding and acceptance may be responsible for
the client’s terminating therapy" (Rogers, 1965, p. 213). In non-directive therapy, when the client is perceived to express some kind of hostility, resentment, or negative attitudes, the prescription for the therapist is to provide the client with a safe environment of respect, empathy and acceptance, the pre-conditions for the client-centered therapy.

In contrast to the Freudian or Rogerian view of failure to continue therapy, behaviorists in general believe that the failure to attend or continue therapy and the related Freudian concept of repression are a result of some traumatic experience which results in the individual discontinuing (Skinner, 1974). Thus defensiveness is interpreted in terms of an effort to avoid aversive consequences which could be associated with aversive feelings, according to Skinner (1974). Further, Skinner also attacks the problem of control in therapy which may make the process itself aversive to the individual. For example, Skinner (1974, p. 199) is of the opinion that "the control of behavior is concealed or disguised in education, psychotherapy, and religion, when the role of teacher, therapist or priest is said to be to guide, direct or counsel, rather than to manage, and where measures which cannot be so disguised are rejected as intervention." The behaviorally oriented interventions according to Skinner’s
definition of "behaviorism" and its theory does not focus much on the problem of lack of motivation or discontinuation in therapy; rather Skinner views that non-behavioristic therapies may be exerting authority or control over individuals and may cause rejection of the intervention by an individual.

Previous research exploring premature termination and refusal to seek treatment among adults seems to support what would be predicted by all of the theories described in the preceding section. It is also possible that factors affecting drop out among adults may be applicable to parents who do not bring their children for psychological treatment or discontinue such treatment fairly early. Those variables which have been found to be related to premature termination in adults include education, income level, sex, ethnicity, trust level and the patient's opinion about mental illness.

The problems of premature termination and refusal to seek treatment have also been found to exist to a great extent within minority group clients. The following review will examine utilization of mental health services and drop out behavior of minority groups as well as predictors of minority clients' help seeking behavior.

**Minority Utilization of Mental Health Services**

A relatively consistent finding is that members of minority populations do not seek psychological services at
the same rate as non-minority clients. Further, those minority clients who do use mental health services tend to have a relatively higher drop-out rate prior to completing treatment. Barrera (1978) reviewed studies exploring ethnic group differences in utilization of mental health services. It was found that Mexican-Americans have a lower prevalence of mental health service usage than other ethnic groups. It was also found that the most common explanation for this finding was the lack of available bilingual-bicultural staff. More recently Hough, Landsverk, Karno, and Burnam (1987) obtained a sample of 1,243 Mexican-American and 1,309 non-Hispanic adults. These authors then examined the utilization of medical and mental health services by individuals with and without mental disorder, the utilization patterns of Mexican-Americans and non-Hispanic Whites, and the use of services in the Los Angeles sample with that in samples from Baltimore, Maryland; St. Louis, Missouri; and New Haven, Connecticut. Results indicate that there was an under-utilization of the health care delivery system by the Los Angeles Mexican-American population even among those with mental disorders. Wells, Hough, Golding, and Burnam (1987) reviewed data collected by the Los Angeles National Institute of Mental Health Epidemiologic Catchment Area Program. These authors found that Mexican-Americans, especially the less acculturated, had significantly lower
rates of use of outpatient services. Further, less acculturated Mexican-Americans made very little use of either mental specialists or the human services sector (e.g.; religious leaders). Among those with a recent psychiatric disorder, non-Hispanic Whites were seven times more likely to use outpatient mental health services than the less acculturated Mexican-Americans. Differences were greater for mental than physical health care.

Other surveys also seem to indicate that minority group clients continue to under-utilize mental health services. Berkanovic and Telesky (1985) investigated the reporting of illnesses, disability due to illness, and the decision to seek medical attention for illnesses among 193 Mexican-Americans, 100 Black Americans, and 751 White Americans in Los Angeles. Data were collected over a 1-year period study. Of the original 1,210 respondents, 1,092 participated in at least 1 re-interview. Following initial interviews, subjects were contacted by telephone every 6 weeks. Half of the subjects were asked to keep a memory aid. Hierarchical stepwise multiple regression showed some differences indicating that ethnicity affects health behavior through its interaction with other variables. Speculations are offered regarding the meaning and historical sources of the differences observed.
Research also indicates that Mexican-American adolescents and young adults do not use mental health services as often as non-minority peers. Even among Mexican-Americans who do seek treatment, the premature termination rate tends to be higher. Flaskerud (1986) examined the relationship between a culture-compatible approach to mental health service and utilization as measured by drop out and total number of outpatient visits in four public community mental health agencies in a metropolitan area. Participants consisted of 23.5 percent Mexican, 22.8 percent White, 18.1 percent Black, 17.1 percent Vietnamese, 16.8 percent Filipino, and 1.7 percent other ethnic group. A culture-compatible approach was effective in increasing utilization. Three culture-compatible components were the best predictors of drop out status: language match of therapists and clients, ethnic/racial match of therapists and clients, and agency location in the ethnic/racial community. Pharmacotherapy, education, previous treatment, and a diagnosis of psychosis were significantly related to remaining in therapy.

Several reasons have been proposed for the failure of minority clients to continue treatment. Most authors have focused on the failure of the black client to attend therapy. Grevious (1985) attempted to identify some of the major barriers to effective therapy with blacks as
well as propose strategies to overcome them. This author suggest that since many Black clients are seen by White therapists, differences between Blacks and Whites in language patterns and cultural traditions may inhibit interaction. Blacks may also harbor negative feelings about therapeutic assistance and thus approach it reluctantly. Therapist variables may also interfere with treatment. The author proposes that many white therapists hold negative perceptions of low-income Black families and tend to provide less effective services. However it is pointed out that there is no guarantee that Black therapists will always be more effective than their White counterparts. Therefore, the author suggests that when beginning therapy with low-income Black families, it is essential to recognize the importance of race. The initial session is critical for engaging the client because many Blacks who present for therapy are not self-referred. They are forced to attend therapy by schools, courts, or the police. To gain a better understanding of the client, it is usually advisable to observe the entire family in its own environment.

Sanchez and King (1986) examined some possible reasons for the under-use of university counseling services by Mexican-American students. A questionnaire was completed was by 29 female and 41 male Mexican-American and 56 female and 47 male White students. Both ethnic groups tended to
seek help from friends and relatives in about the same proportions. Also both groups preferred trained counselors to less well-trained para-professionals. White subjects reported higher levels of extra-psychic stress. Mexican-American men were the least inclined to use counseling services. The more committed a Mexican-American subject was to Mexican-American cultural values, the more important it was for a counselor to be Mexican-American and to speak Spanish.

Minority Therapy

While most authors have attempted to explain why blacks tend to terminate therapy prematurely, more recent authorities have offered explanations of this tendency among Hispanics. Mckinley (1987) reviewed studies exploring the effectiveness of therapy with minority clients. It was observed that previous research relatively consistently found that hispanics in the United States mainland underutilize mental health services and drop out of treatment sooner than dominant culture group members. The authors believe that one reason for this problem is that the socio-cultural value orientation and expectations of the hispanic patient are discordant with the values and expectations of the therapist. More specifically the authors believe that therapists with knowledge of the culture will be more effective in establishing rapport with Hispanic patients and
in helping them to increase the effective use of mental health services.

Other researchers have focused on exploring the role of racial and ethnic factors in relation to effective psychotherapy and offer suggestions for working with minority clients. Sue and Zane (1987) looked at the role of cultural knowledge and culture-specific techniques in the psychotherapeutic treatment of ethnic minority group clients. Recommendations that admonish therapists to be culturally sensitive and be aware of the culture of the client have not been very helpful. Such recommendations often fail to specify treatment procedures and to consider within-group heterogeneity among ethnic clients. Similarly, specific techniques based on the presumed cultural values of a client are often applied regardless of their appropriateness to a particular ethnic client. It is suggested that cultural knowledge and culture-consistent strategies be linked to the two basic processes of credibility and giving. Analysis of these processes can provide a meaningful method of viewing the role of culture in psychotherapy and also provides suggestions for improving psychotherapy practices, training, and research for ethnic-minority populations.

Minrath (1985) suggests that exploring the patient's cultural background and inquiring about customs, lifestyle,
language, and the use of idioms express the therapist's desire to learn about and understand the socio-cultural world of the patient and communicate a genuine interest while nurturing the development of empathy. The author argues that negative attitudes by both the client and therapist often interferes with the therapeutic process. More specifically it is proposed that clients tend to believe that the therapist will not be able to understand their problems while the therapist often believes the client will be unmotivated.

Sue and Sue (1977) point out that many mental health professionals have noted that racial and ethnic factors may act as impediments to counseling. Misunderstandings that arise from cultural variations in verbal and nonverbal communication may lead to alienation and/or an inability to develop trust and rapport. An analysis of the generic characteristics of counseling reveals three variables that interact in such a way as to seriously hinder counseling with third-world groups: (a) language variables - use of standard English and verbal communication; (b) class-bound values - strict adherence to time schedules, ambiguity, and seeking long-range solutions; (c) culture-bound values - individual centered, verbal/emotional/behavioral expressiveness, client to counselor communication, openness and intimacy, cause-effect orientation, and mental and
physical well-being distinction. These generic characteristics are contrasted with the value system of various ethnic groups.

Smith (1985) examines the various types of stress that members of racial minority groups experience, including stressors of out-growing status (social isolation, marginality, and status inconsistency) and racial roles ("dominants" and "tokens"). External (economic resources and social support) and internal (locus of control, learned helplessness, and self-concept) mediators of stress are also discussed. Hypotheses about the life-stress processes and racial minorities, including Dohrenwend and Dohrenwend's (1981) victimization hypothesis, a differential exposure hypothesis, a vulnerability hypothesis, an additive burden hypothesis, and a chronic burden hypothesis are outlined. Propositions comprising a theory of life stress, race, and culture are presented based on the conceptualization of life stress as a process consisting of life events, personal dispositions and internal mediating factors related to stress and social situations and external mediating sources of stress. A stress-resistant-delivery model for counseling racial minorities is provided that involves identifying the sources of stress clients face, outlining and implementing stress-resistant forces, and deciding on a method of delivering services to clients.
Bonner and Everett (1986) assessed the effects of client preparation and problem severity on children's and parents' understanding, attitudes and expectations of child psychotherapy. Thirty-eight children (aged 6-12) with one of their parents served as Subjects. Half of the children and parents received preparation information, and the other half were not prepared. Following preparation vs. no-preparation procedures, children and parents completed questionnaires assessing problem severity, knowledge of and attraction to therapy, and prognostic expectations. Parents completed the Child Behavior Checklist, and therapists rated problem severity and expectations for treatment outcome. Results indicate that preparation increased children's' and parents' knowledge of therapy, attraction-receptivity to therapists and treatment, and expectations for therapy outcome. Children and parents were found to be quite attracted and receptive to psychotherapy and to have very positive expectations for treatment outcome. Findings indicate that therapists saw the children's' problems as more severe and had lower prognostic expectations than did children and parents. No relation was found between problem severity and attraction-receptivity to treatment or expectations for treatment outcome.

Adelman and Taylor (1986) argue that prevailing interpretations of minors' reluctance to participate in
treatment tend to emphasize personal deficiencies, pathology, and inappropriate motivation. Two major concerns related to minors' reluctance for treatment are highlighted, focusing on the possible bias of interventionists when they interpret reluctant behavior as due to personal deficiencies and as inappropriately motivated and on the circumstances under which reluctance may be the result of appropriate negative perceptions of such interventions as counseling/therapy, testing, or a special education program.

Trust

One other variable that has been explored as a possible explanation of minority clients' unwillingness to attend therapy and pre-mature termination involves the trust level of culturally different clients in the therapeutic situation. This variable of cultural trust has been most consistently studied with regard to the black client.

It has long been recognized that many blacks do not trust whites. Ridley (1984) refers to this characteristic as cultural paranoia. This author believes that this trait interferes with effective therapy with blacks. Individual verbal psychotherapy often places the black client in a paradoxical situation. Although client self-disclosure is generally considered essential for maximizing therapeutic outcomes, complex intrapersonal, interpersonal, and social factors often affect the black client’s willingness to self-
disclose. Regardless of the black client's level of self-disclosure, white-therapist/black-client relationships tend to result in unhealthy consequences for the client.

Various theorists have objected to Ridley's characterization of blacks being culturally paranoid. Ashby (1986) states that Ridley's (1984) use of the term "healthy cultural paranoia" presents the black client as more disturbed than is actually the case. Although the mode of disclosing for the black client may include a healthy mistrust of whites and the white society, this mistrust is based in reality. However, paranoia is not based in reality; it is distorted mistrust. The author concludes that the term "healthy paranoia" is self-contradictory, ambiguous, and represents another instance of "blaming the victim". Bronstein (1986) also believes that Ridley's (1984) article presents the black client in an unfavorable light by describing him/her in terms of having a "healthy cultural paranoia" and exhibiting hostile behavior in order to exercise a personal sense of power. The author states that Ridley does not present the other side of the non-disclosing black client. That is he does not deal with the white therapist and his/her feelings and experiences when dealing with the black client. Thus, it is argued that non-minority therapists need to come to an understanding of how living and working in a racist society have shaped their own
perceptions and behavior which in turn have an effect on the minority groups they are studying. However, Ridley (1986) maintains that the term "healthy cultural paranoia" is accurate and that the danger lies not in its content, but in its misapplication. It is felt that the label if used correctly, can be a beneficial tool for treatment. Although some debate exists regarding the most accurate usage to describe and define the tendency of blacks to mistrust whites, most experts believe that this characteristic is relatively common among blacks and that it affects both their willingness to attend therapy as well as being open during therapy sessions.

Empirical studies seem to indicate that the lack of trust of whites can impede the therapeutic process. Ponterotto, Anderson, and Grieger (1986) examined the attitudes toward counseling and counselor's ethnicity among 69 female and 38 male Black 17-46 year old students at a medium-sized, predominantly White public university subjects completed a 75-item questionnaire containing a demographic inventory, a racial identity scale, answered questions pertaining to preferences for a racially similar therapist or psychologist, and ranked the sources of help they preferred for personal problems (e.g., clergy, faculty member, dean, parent, friend, counselor, psychiatrist). The results revealed that men in the encounter stage of racial
identity most highly valued seeing a counselor of the same ethnicity. Also, the use of available university psychological services received a low ranking for both males and females. The authors propose that Black students' attitudes toward counseling are likely to be a function of personal characteristics (sex) and personalized values toward the black culture itself (racial identity).

There is also some empirical support for the notion that trust is an important variable among children and adolescents in the way they interact with others. Rotenberg, & Pilipenko (1983-84) investigated the role of children's trust in peers of (1) mutuality, which is the correspondence between children's trust in each other; (2) temporal consistency which is the consistency of behavior across time and situations; and 3) helpfulness to peers. Kindergarten, second-grade, and fourth-grade children were tested. The children judged how much they trusted their peers and hypothetical peers who were either emporally consistent or temporally inconsistent. It was found the less the children were trusted by peers, the less they trusted peers.

Rotenberg (1980) selected children enrolled in either kindergarten, second, and fourth grades. All children were presented then given a series of stories depicting actors varying in the amount of helping they promised to do and
whether or not they actually helped. Children's' judgments of trust of the actors, their explanations for their judgments, and (for 1 set of stories) their selection of a borrower of their favorite toy, were obtained. The pattern of findings for all 3 measures indicated a developmental change in the bases of trust, changing from one emphasizing behavior to one emphasizing the consistency between promises and behavior. The judgments of trust by kindergarten children also provided evidence that young children may, to some extent, base their trust of others on whether or not others say "nice" things.

Summary and Purpose

A continuing problem in the field of psychotherapy is the motivation of the client to complete the treatment. Previous research has found that age, sex, race, educational level and social class correlate with early termination from therapy among adults. However, the area of non-readiness and under-utilization of mental health services by child and adolescent populations has been virtually ignored. It is possible that parental help seeking behavior and attitudes towards mental health and coping strategies impact on the child's capacity or ability to come for psychological treatment.

Research has also consistently shown the problems of utilization of mental health services and premature
termination to occur to an even greater extent among
minority group clients. It has been found that many members
from minority group populations tend to mistrust whites and
that this mistrust adversely affects their performance in
assessment settings. One variable which might also affect
minority adolescents' willingness to attend therapy is the
extent to which they mistrust whites. This study explored
the relationship between cultural mistrust level and the
extent to which minority group adolescents are willing to
participate in treatment. More specifically, it was
predicted that high mistrust adolescents will be less
willing to attend therapy than minority adolescents with a
low level of cultural mistrust.

Method

Participants

A total of 79 Mexican-American male and female
adolescents from sixteen to nineteen years of age and
attending a high school in the southwest were used in this
study. Of this sample, 29 were male and 50 were female.
Half of the participants from each gender were asked to
pretend that they were scheduled to see a White counselor.
The remaining participants were asked to pretend they were
scheduled to see a Mexican-American counselor.

Measures

All participants were given the following three
measures. The first being the modified version of the
Terrell & Terrell (1981) *Cultural Mistrust Inventory* (CMI). This inventory consists of 48 items which follow a nine point Likert-type scale ranging from "strongly agree" to "strongly disagree." This inventory has demonstrated a low correlation with a social desirability test. Also a two week test-retest reliability estimate of .82 has been found. Between item correlations and total scores on the CMI range from .34 to .47. This instrument has also been used to measure the mistrust level of black clients examining the occurrence of a higher rate of premature termination of treatment of black clients who were seen by white counselors. A higher level of mistrust measured by the CMI appeared to correlate highly with a higher rate of premature termination among highly mistrustful black clients who were seen by white counselors in comparison to highly mistrustful black clients who were seen by black counselors (Terrell & Terrell, 1984). A slightly modified version of the CMI was used for the purpose of the present study. It was used to measure the mistrust level of Mexican-American individuals toward providers of mental health services if such services are provided primarily by white staff. Therefore the word "Mexican-American" was substituted for "black." A copy of this inventory has been included in Appendix A.

All participants were also given the Fisher and Turner (1970) *Help Seeking Attitude Scale* (HSAS). This scale is
frequently used to measure attitudes of culturally diverse individuals towards seeking professional psychological help. This scale consists of 29 items and is scored on a four-point Likert format ranging from disagreement to agreement. The internal reliability of the scale in its standardization sample of 212 individuals was .86 (see Ahluwalia, 1988). Further, reliability has been conducted using another sample of 406 subjects. The results yielded a reliability estimates of .86 for two weeks, .89 for four weeks, .82 for six weeks, and .73 for two months. Factor analysis of this scale revealed four factors consisting of (I) Recognition of Personal Need for Professional Psychological Help; (II) Stigma/Privacy in Reference to One's Problems; (III) Interpersonal Openness as Regards One's Emotional Problems; and, (IV) Confidence in Mental Health Professionals. Low correlations have been found between the items on the Fisher and Turner Scale and a measure of social desirability. This scale has also been reported to discriminate between individuals who have had previous experience with a mental health professional and individuals who do not have such experience. A copy of this questionnaire is available in Appendix B.

Finally, all participants were given a Background Information Inventory especially designed for this study. The purpose of this questionnaire was to obtain descriptive
information about the participants used in this project. This survey provided information regarding student's age, gender, grade level, academic performance, and parental socioeconomic level. A copy of this questionnaire is available in Appendix C.

Procedure

Participants were obtained in the following manner. Initially four teachers who teach tenth, eleventh and twelfth graders announced in their classes that an individual would like to survey students regarding their attitudes toward other people and their feelings about seeking help for different problems. Those students who were interested in sharing their opinions were asked to raise their hands and the examiner passed out a packet of questionnaires to them. The students who wished to participate were given the following instructions.

"We are interested in exploring your opinions about several different topics. First, we would like information about how you feel about other people. Second, we would like to know what you feel about seeking help if you were having problems. Finally we will be asking you some questions about yourself so that we will be able to see how certain groups of teen-agers like you feel about the above topics. There are no right or wrong answers on any of the questions you will be asked to answer so please give your
honest opinions. Also, we are only interested in how people in your age range feel instead of your specific opinions and you do not have to put your name on any of the questionnaires. Because no one will be able to identify who filled out what questionnaire, please feel free to answer the questions as you really feel. The instructions on all of the questionnaires are self-explanatory. However, if you have difficulty understanding some of the words or what you are supposed to do, simply raise your hand and I will help you. Finally, your participation in this project is voluntary. If at any time you decide you do not want to fill out the questionnaires, simply bring your papers to me unfinished. You will not be punished in any way if you choose not to participate."

Results

This study explored the relationship between level of cultural mistrust and willingness of Mexican-American adolescents to seek psychological treatment. To do this, five regression analyses were performed to explore possible relationships between these variables. The predictor variables consisted of Cultural Mistrust Level, Gender, Age, Income, Education Level, Counselor Ethnicity, and Grade Point Average. The criterion variables were scores on each of the four subscales of the Help Seeking Attitude Scale (HSAS) as well as the overall score.
The means and standard deviations of participants' Age, Education Level, Income, GPA, and scores on the CMI and HSAS are summarized in Table 1.

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\(^1\)HSASI = Recognition of Personal Need for Professional Psychological Help Scale

\(^2\)HSASII = Stigma/Privacy in Reference to One's Problems Scale

\(^3\)HSASIII = Interpersonal Openness as Regards to One's Emotional Problems Scale

\(^4\)HSASIV = Confidence in Mental Health Professionals Scale

\(^5\)HSASV = Overall score of the 4 scales
The correlations between all predictor and outcome variables may be found in Table 2.

Results of the first regression, using the Recognition of Personal Needs for Professional Psychological Help subscale of the HSAS as the criterion variable, indicated that the strongest predictor of scores on this subscale was participants' Gender ($B = .35$, $t(78) = 3.20$, $p < .002$) with females having higher means.

On the Stigma/Privacy in Reference to One's Problems subscale of the HSAS, Mistrust Level was found to be the most salient predictor ($B = -.32$, $t(78) = -2.74$, $p < .007$). Additionally, GPA was found to be a significant predictor ($B = -.26$, $t(78) = -2.30$, $p < .02$).

For the Interpersonal Openness as Regards to One's Emotional Problems subscale, the most significant predictor of scores was Mistrust Level ($B = -.33$, $t(78) = -3.11$, $p < .002$). However Gender was also significant ($B = .28$, $t(78) = 2.68$, $p < .009$). Table 3 indicates that females had significantly higher mean scores on this scale than males.

On the Confidence in Mental Health Professionals subscale, Gender was most predictive of scores ($B = .38$, $t(78) = 3.68$, $p < .0004$), with Mistrust Level being the second strongest predictor ($B = -.24$, $t(78) = -2.38$, $p < .019$). Finally Education Level was also found to be a significant predictor ($B = .230$, $t(78) = 2.20$, $p < .03$).
Table 2

Correlations Among All Predictor and Criterion Variables (N = 79)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Gender</th>
<th>Education Level</th>
<th>Income</th>
<th>GPA</th>
<th>Counselor Ethnicity</th>
<th>Cultural Mistrust</th>
<th>HSASI&lt;sup&gt;1&lt;/sup&gt;</th>
<th>HSASI&lt;sup&gt;2&lt;/sup&gt;</th>
<th>HSASI&lt;sup&gt;3&lt;/sup&gt;</th>
<th>HSASI&lt;sup&gt;4&lt;/sup&gt;</th>
<th>HSASI&lt;sup&gt;5&lt;/sup&gt;</th>
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<tbody>
<tr>
<td>Age</td>
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<td>.709**</td>
<td>.125</td>
<td>-.367**</td>
<td>-.099</td>
<td>.115</td>
<td>.094</td>
<td>.182</td>
<td>-.070</td>
<td>-.012</td>
<td>.058</td>
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<tr>
<td>Gender</td>
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<td>.025</td>
<td>.124</td>
<td>.122</td>
<td>-.003</td>
<td>.351**</td>
<td>.039</td>
<td>.286*</td>
<td>.364**</td>
<td>.372</td>
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<tr>
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<td>-.178</td>
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<td>.178</td>
<td>.148</td>
<td>.118</td>
<td>.169</td>
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<tr>
<td>Income</td>
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<td>.324**</td>
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<td>-.092</td>
<td>-.101</td>
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<td>-.226</td>
<td>-.304**</td>
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<td>HSASI&lt;sup&gt;1&lt;/sup&gt;</td>
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<td>.745**</td>
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<td>HSASI&lt;sup&gt;4&lt;/sup&gt;</td>
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</tbody>
</table>

* p < .05;  ** p < .01

<sup>1</sup> HSASI = Recognition of Personal Need for Professional Psychological Help Scale
<sup>2</sup> HSASI<sup>2</sup> = Stigma/Privacy in Reference to One's Problems Scale
<sup>3</sup> HSASI<sup>3</sup> = Interpersonal Openness as Regards to One's Emotional Problems Scale
<sup>4</sup> HSASI<sup>4</sup> = Confidence in Mental Health Professionals Scale
<sup>5</sup> HSASI<sup>5</sup> = Overall score of the 4 scales
Table 3

Means and Standard Deviations of Males and Females on the HSAS Subscales

<table>
<thead>
<tr>
<th></th>
<th>MALES</th>
<th>FEMALES</th>
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<td></td>
<td>M</td>
<td>SD</td>
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<td>HSASII</td>
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<td>4.38</td>
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<tr>
<td>HSASV</td>
<td>41.93</td>
<td>11.41</td>
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</table>

HSASI = Recognition of Personal Need for Professional Psychological Help Scale
HSASII = Stigma/Privacy in Reference to One’s Problems Scale
HSASIII = Interpersonal Openness as Regards to One’s Emotional Problems Scale
HSASIV = Confidence in Mental Health Professionals Scale
HSASV = Overall score of the 4 scales

For the overall HSAS, Gender was found to be most predictive ($B = .39$, $t(78) = 4.00$, $p < .0002$), with Cultural Mistrust being the next most predictive of scores on the HSAS ($B = -.33$, $t(78) = -3.34$, $p < .001$), and Education Level being the final predictor of the criterion variable ($B = .28$, $t(78) = 2.83$, $p < .005$).
Discussion

The major purpose of this study was to investigate the relationship between cultural mistrust level and the extent to which minority group adolescents are willing to seek psychological treatment. It was predicted that Mexican-American adolescents with a high level of mistrust would be less willing to seek therapy than those with a low level of mistrust. This hypothesis was supported by the results of the study. Cultural mistrust was found to be the most significant predictor of the Stigma/Privacy subscale and the Interpersonal Openness subscale and was a significant predictor on three of the four subscales.

The significant relationship that was found between cultural mistrust and willingness to seek treatment is consistent with the findings of previous research. In a study conducted by Terrell and Terrell (1984) exploring the relationship between counselor ethnicity, cultural mistrust, and premature termination, it was found that Blacks with a high level of mistrust who were seen by a White counselor had a higher incidence of premature termination from counseling than did highly mistrustful Blacks who were seen by a Black counselor.

Watkins and Terrell (1988) in their study concerning cultural mistrust and counseling expectations in Black client-White counselor relationships found that highly
mistrustful Blacks who were assigned to White rather than Black counselors generally had lower expectations of counseling and expected the counselor to be less accepting, trustworthy, and knowledgeable. This study was later extended by Watkins, Terrell, Miller, and Terrell (1989) to examine more closely specific expectational variables within Black client-White counselor relationships. The results indicated that Blacks who are highly mistrustful regarded the White counselor as less credible and less able to help them with four problem areas: general anxiety, shyness, inferiority feelings, and dating difficulties. The authors suggest that White counselors may wish to pay special attention to these problem areas when dealing with highly mistrustful Blacks.

Ridley (1984) has also explored the relationship between cultural mistrust and effective therapy with minorities. His studies have focused mainly on the relationship between Black clients and White therapists. Ridley coined the term "healthy cultural paranoia" to describe this trait of Blacks who mistrust White therapists. Ridley believes that this mistrust also leads to unhealthy consequences such as premature termination and reluctance to disclose on the part of Black clients.

Other researchers have explored the role of trust in relation to minority clients and the counseling process.
Research by Vontress (1971) and LaFromboise and Dixon (1981) has shown that it may be difficult for minority clients to trust White counselors and that this mistrust may impede and present barriers to the therapeutic process for example, establishing rapport with minority clients may be greatly hampered if clients have a high level of cultural mistrust.

Although not the major purpose of this study, it is interesting to note that Gender and Educational Level were also found to be highly predictive of willingness to seek help. More precisely, females were found to be more willing to seek treatment than males and students with higher levels of education were more willing to seek help. Research has shown that there are gender differences in relation to seeking psychological help. For example two-thirds of all clients seeking help were females (cited in Good, Dell, & Mintz, 1989). It has been suggested by Good, Dell, and Mintz (1989) that a possible source of men’s unwillingness to seek help is the adherence to the traditional male gender role. They conducted a study to explore this relationship and found that traditional attitudes about the male role in society, concern about expressing affection toward other men, and concern about expressing emotions were related to males’ negative attitudes toward seeking professional psychological help and to fewer reports of past help seeking behavior.
Additional research concerning gender differences within the counseling process has shown that women are more willing to disclose than men (DeForest & Stone, 1980), females tend to have higher overall expectations about counseling than males, and that females expect to be more open, more highly motivated and to accept responsibility for their behavior in counseling situations (Hardin & Yarico, 1983). Subich (1983) in her research also concluded that females expect stronger facilitative conditions, more personal involvement in counseling, and a more positive counseling outcome than males.

Although a significant relationship was found between cultural mistrust and willingness to seek treatment, there are some limitations in this study. One limitation involves the problem of generalizing the results due to the fact that a relatively small sample size was used whose parents were from middle-class socioeconomic backgrounds. The results may be a function of this particular sample rather than a reflection of the preferences and attitudes of Mexican-American adolescents in general. Also because this was basically an alogue study, the results may not accurately predict actual behavior in certain situations. In general, participants used in this study were not actually seeking treatment and, based upon observations by both teachers and the experimenter, the adolescents in this study were not
experiencing any noticeable undue emotional difficulties. Thus, clients actually experiencing emotional distress, regardless of trust level, may be equally willing to seek psychological services. Finally, other methodological considerations such as the use of a modified version of the CMI which was originally developed using Black college students may place limits on the results of this study.

Assuming that similar results are found in other studies, results of this project may have both theoretical and applied implications. On a theoretical level the results of this study would imply a need to identify other possible ethnic and cultural differences of minorities. For example Cross, Parham, and Helms (in press) have suggested that minorities often proceed through developmental stages in the process of developing cultural awareness. Studies exploring whether Mexican-Americans proceed through stages and the relationship between these possible attitudinal changes and behaviors in general as well as help seeking activities would be useful.

On a practical level the findings of this study suggest that it may be useful to consider devising ways of motivating Mexican-American clients who are wary of Whites but experiencing emotional difficulties to seek treatment. Also, it may be beneficial to consider ways of decreasing the high mistrust some Mexican-Americans feel toward Whites.
in order to increase the possibility that they will seek help when experiencing emotional distress.

On a broader, more speculative level the results may suggest a need for increasing the awareness and sensitivity of counselors toward the issues of race and cultural mistrust as well as how these factors may interact with the therapeutic relationship. One way to increase the awareness of counselors would be for training programs to actively recruit minorities and to require courses pertaining to ethnic minorities and the issues involved in counseling them. Also it would be helpful to emphasize the heterogeneity within minority groups. For example reluctance to disclose among Mexican-Americans may be a function of such factors as coping styles, personality traits and experience with racism.
Appendix A

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

Directions

Enclosed are some statements concerning beliefs, opinions, and attitudes about minority people. 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  5 - Slightly Agree
2 - Disagree  6 - Agree
3 - Slightly Disagree  7 - Strongly Agree
4 - Neither Agree or Disagree

The higher the number you choose for the statement, the more you agree with that statement. For example, if you slightly agree with a statement, you would choose the number 5 which appears beside the label "slightly agree". The same principle applies for the other labels. Finally, there are no right or wrong answers, only what is right for you. If in doubt, circle the number which seems most nearly to 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 Mexican-Americans look inferior.
4. White teachers deliberately ask Mexican-American students questions which are difficult so they will fail.
5. There is no need for a Mexican-American to work hard to get ahead financially because whites will take what you earn anyway.
6. Mexican-American citizens can rely on white lawyers to defend them to the best of their ability.
7. Mexican-American parents should teach their children not to trust white teachers.

8. White politicians will promise Mexican-Americans a lot but deliver little.

9. White policemen will slant a story to make Mexican-Americans appear guilty.

10. White politicians usually can be relied on to keep the promises they make to Mexican-Americans.

11. Mexican-Americans should be suspicious of a white person who tries to be friendly.

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

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

14. A Mexican-American can usually trust his or her white co-workers.

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

16. A Mexican-American cannot trust a white judge to evaluate him or her fairly.

17. A Mexican-American 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 Mexican-Americans.

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

20. Mexican-Americans should not have anything to do with whites since they cannot be trusted.

21. It is best for Mexican-Americans 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. Mexican-Americans 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.

26. Whites are usually honest with Mexican-Americans.

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 Mexican-Americans every chance they get.

30. When a white teacher asks a Mexican-American 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 Mexican-Americans.

32. Mexican-American 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 Mexican-Americans into admitting they committed a crime which they did not do.

35. There is a need for Mexican-Americans to be more cautious with white businessmen than with anyone else.

36. There are some white businessmen who are honest in business transactions with Mexican-Americans.

37. White store owners, salesmen, and other white businessmen tend to cheat Mexican-Americans 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 Mexican-American communities do so only so that they can take advantage of Mexican-Americans.

40. Mexican-Americans have often been deceived by white politicians.

41. White politicians are equally honest with Mexican-Americans and whites.

42. Mexican-Americans should not confide in whites because they will use it against you.

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

44. White businessmen usually will not try to cheat Mexican-Americans.

45. White business executives will steal the ideas of their Mexican-American employees.

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

47. Mexican-Americans should be suspicious of advice given by white politicians.

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

Attitude Toward Seeking Professional Psychological Help Scale
Attitude Toward Seeking Professional Psychological Help Scale

Instructions

Below are a number of statements pertaining to psychology and mental health issues. Read each statement carefully. Next pretend you were scheduled to see a White (or Mexican-American) counselor. Indicate your agreement (0), probable agreement (1), probable disagreement (2), or disagreement (3). Please express your frank opinion in rating the statements. There are no "wrong" answers, and the only right ones are whatever you honestly feel or believe. It is important that you answer every item. Please circle the number corresponding to your level of agreement on the appropriate answer sheet (e.g., If you probably agree with a particular statement, circle "1" on the answer sheet).

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
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</thead>
<tbody>
<tr>
<td>Agreement</td>
<td>Probable Agreement</td>
<td>Probable Disagreement</td>
<td>Disagreement</td>
</tr>
</tbody>
</table>

1. Although there are clinics for people with mental troubles, I would not have much faith in them.  
2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.  
3. I would feel uneasy going to a psychiatrist because of what some people would think.  
4. A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist.  
5. There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem.  
6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.

8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.

9. Emotional difficulties, like many things, tend to work out by themselves.

10. There are certain problems which should not be discussed outside one's immediate family.

11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.

12. If I believed I was having a mental breakdown, my first inclination would be to get professional help.

13. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.

14. Having been a psychiatric patient is a blot on a person's life.

15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.

16. A person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help.

17. I resent a person—professionally trained or not—who wants to know about my personal difficulties.

18. I would want to get psychiatric attention if I was worried or upset for a long period of time.

19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

20. Having been mentally ill carries with it a burden of shame.

21. There are experiences in my life I would not discuss with anyone.
22. It is probably best not to know everything about oneself.

23. 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.

24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears without resorting to professional help.

25. At some future time I might want to have psychological counseling.

26. A person should work out his own problems; getting psychological counseling would be a last resort.

27. Had I received treatment in a mental hospital, I would not feel that it ought to be "covered up".

28. If I thought I needed psychiatric help, I would get it no matter who knew about it.

29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.
Appendix C

Background Information Inventory
Background Information Inventory

1. Sex: _______ Male _______ Female

2. Age: _______ Years

3. Grade Level: _______

4. Ethnic Background:
   _______ White _______ Mexican-American
   _______ Black _______ Native-American
   _______ Asian _______ Other

5. Usual Academic Performance:
   _______ A’s _______ B’s _______ C’s _______ D’s

6. Parent’s Occupation:
   ____________________________ Father
   ____________________________ Mother

7. Parents Marital Status:
   _______ Married _______ Divorced _______ Separated

8. Please list in order of preference the 3 people or places you would go to for help if you had an emotional or personal problem.
   1. __________________
   2. __________________
   3. __________________
References


reporting illnesses, disability and physician visits for illnesses. *Social Science and Medicine, 20*, 567-577.


