

MENTAL HEALTH ASSESSMENTS FOR AFRICAN  
AMERICANS: AN ANALYSIS OF CLINICIAN  
EXPLICIT AND IMPLICIT PREFERENCES,  
PRACTICES, AND PERCEPTIONS

by

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**Abstract**

This exploratory study investigated the complexities of race and racial preferences in mental health as it relates to clinical decision making with African American clients. African Americans seeking mental health services face several unique barriers including the potential for racial bias, prejudice, discrimination, and racist norms that may inform a clinician's ability to accurately diagnose and provide the most appropriate treatment. This mixed methods study used an electronic survey to collect demographic and perceived effectiveness information, and asked mental health professionals to provide a detailed description of what has worked with African American clients during the assessment portion of treatment. After the completion of the survey, Greenwald, Mcghee and Schwartz's (1998) implicit associations test (IAT) collected the implicit racial preference of the participants. Semi-structured interviews further explored participant attitudes, perspective and beliefs of assessing African American clients. Two MANOVAs and a Chi-square were completed to analyze the data. Condensed implicit racial bias as identified by IAT score was found to be statistically significant with self-reported effectiveness of Mental Health Assessments with Black clients.

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## CHAPTER 1: INTRODUCTION

Providing the most appropriate mental health services relies heavily on the information obtained during the initial assessment by the mental health clinician. Much of the existing literature that explores the reasons in which poor outcomes prevail for Black and African American clients seeking and receiving mental health services, explores the perceptions, attitudes and beliefs of the clients themselves (Corrigan, 2004; Mishra, Lucksted, Gioia, Barnet, & Baquet 2009; Pomales, Claiborn & LaFromboise, 1986; Poston, Craine & Atkinson, 1991; S. Sue & Zane, 1987; Terrell & Terrell, 1984; Whaley, 2001). Although the client's experiences and presentation are important, the clinician is in a position of power and in control of diagnosis, prognosis and treatment plans of the client regardless of the client's desires. If assumptions about the client are made without considering what is within normal limits of the clients identified culture, there is a possibility that the clinician's bias is informing clinical decision making rather than the client's world-view. Racial experiences of clients that are rooted in a culture of power and oppression require awareness of both the client's perspective of themselves as racial beings and a clinician's awareness of their own racial biases. Considering these clinical complexities within the Black community can mean more appropriate client care (Blair et al., 2013).

Recent literature has focused on the barriers that have prevented the Black and African American community from seeking mental health treatment (Copeland & Snyder, 2011; Hackett, 2014). Much attention has also highlighted the importance of lessening the stigma in seeking mental health services among the Black community, but very little has been focused on getting Black and African American individuals the most appropriate treatment (Snowden, 2003).

Previous articles, studies and books have discussed cultural considerations for individuals who identify as Black or African American (Copeland & Snyder, 2011; Ertl et al., 2010; Liang, Matheson, & Douglas, 2016; Whaley & Geller, 2007); however, there appears to be a disconnect between theory and practice (Burkard & Knox, 2004). Even less studied is how clinician bias informs interpretations of the data collected during the initial assessment (Edwards, Burkard, Adams, & Newcomb, 2017). Cultural competency trainings for clinicians offer ethnocentric perceptions of how psychiatric disorders can be conceptualized from the dominant culture's perspective but does not necessarily offer specific tools or interventions to collect phenomena specific to the culture (Foltz, 2012). Many tools are available that can be used to assess cultural related symptoms or even to gain an understanding of how racial experiences impact mental illness; however, it is not known how many clinicians are aware or utilizing these available tools.

Ideally, the Diagnostic Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association [APA], 2015) serves as a guideline for identifying specific symptoms that together make up an underlying mental disorder. Theoretically, by knowing what disorder a client has, a mental health professional can better understand which interventions would be most appropriate for treatment. This model can easily become a color-blind approach that does not consider the racial experiences of individuals. Using a deficit model during the initial assessment while working with individuals who identify as Black or African American, particularly without knowledge of specific cultural norms can easily and inadvertently become a measure of assimilation or acculturation (Lindsey, 1998). This dissertation explores both racial bias of practicing clinicians and their

perceptions of what is effective during an initial assessment, with a focus on assessments within the Black community.

### **Problem Statement**

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) (2015) review of the National Survey on Drug Use and Health data among adults aged 18 or older, Black clients with mental illness are underrepresented in outpatient mental health services and over represented in inpatient mental health services. In 2015, Black males made up 2% of the total US population by race and gender, but those between the ages of 15 and 34 accounted for 15% of all deaths resulting in deadly force by law enforcement logged for the year (Swaine et al. 2015). Of all deaths that occurred as a result of deadly force by law enforcement, 246 deaths were of people who had documented mental illnesses. The potential psycho-social stressors of intersectionality are apparent for Black individuals with mental illnesses. Furthermore, race specific phenomena such as racial battle fatigue, internalized oppression, acculturation, White fragility and others can meet the criteria for mood disorders however are considered culturally appropriate responses to racial experiences (David, 2014; Tappan, 2006).

The previously mentioned racial phenomena is not specific to clients. Clinicians personally dealing with these race-specific experiences can be making clinical judgements based in inherent bias (Pearson, Dovidio, & Gaertner, 2009; Snowden, 2003). Clinicians not only bring personal cultural values to the assessment but also utilize tools to assess, diagnose and intervene that were typically made for use within the dominant culture (Liang et al., 2016). Both clients and clinicians bring a set of learned cultural experiences, beliefs, and values with them to mental health service providers that they may or may not be

aware of. The dominant culture in the United States has many racialized norms that may not be realized by the individuals who benefit or suffer from these norms. This can create complex situations when it comes to the client and provider relationship, especially if each identifies differently racially. To best understand the complexities and the significance and intersections of race within the mental health field, Critical Race Theory will be used as a theoretical foundation for this dissertation.

### **Theoretical Framework**

The most appropriate theoretical framework to best understand the use of color blind models within the mental health field is Critical Race Theory (CRT). CRT analyzes the persistence of race and racism in various fields. The original CRT scholars including Delgado, Stefancic, and Harris (2001), Crenshaw (1988, 1991), P.J. Williams (1997), and Harris (1993) worked to understand the ways in which racism was enabled and they confronted these practices in order to move closer to the goal of racial liberation. CRT was used to analyze existing research, develop appropriate methodology and interpret data that are gathered. Although much of what is discussed can be applied to any cultural background, for the purpose of being concise and specific this dissertation will focus on how the color-blind model affects the Black and African American community.

CRT uses an epistemological lens to frame fields like mental health in understanding how both individuals and systems interpret race or race related issues (Patton, Harper, & Harris, 2015). CRT in this study was used to understand how race informs clinician perspectives of clients and subsequently clinical decision making. CRT originated during the civil rights movement with a focus on the legal system and the systems of racial power and oppression (Delgado et al., 2001). The context of its origin parallels its use in the mental health field as

culture and race are becoming a prominent and heated issue of discussion within the field as the nation becomes more racially charged. Racism in its obvious overt forms may be identified and receive natural consequences including disciplinary actions (Crenshaw, 1991), particularly when perpetrated by a clinician in a professional setting. Racism in its covert form may be inadvertent; however, the consequences may not affect the individual perpetrating them (Crenshaw, 1988; Delgado et al., 2001). These phenomena have dangerous results in a field such as mental health in which a clinician holds not only a position of power but also employs potentially invasive interventions to change cultural norms perceived as problematic.

### **Intersectionality**

The intersections among mental illness/health and Black identity are extremely relevant to the context of this study. One component of CRT is inclusive of the multiple systems of power and oppression that can be experienced by people of color (Crenshaw, 1991). Most notably, intersectionality explores the intersections of identity that face oppressions and privileges that cannot be experienced by the same individual separately (Crenshaw, 1991). Intersectionality understands that although all Black people may experience systematic racial oppression, Black women also face gender oppression while Black men may enjoy male privileges. Crenshaw (1991) asserted that women of color experience both racial and gender discriminations simultaneously although they are separate systems of oppression. Mental health can be another dimension of an individual's identity that faces potential oppressions that may play into the stigmas associated with being a person of color with mental illness. To better understand how the interdependent systems of Black identity and mental illness/health overlap, the historical significance of racism and healthcare at large must be considered.

## **Context and Background**

Black and African American individuals have a very unique psychosocial history that affects many aspects of their everyday life. Studies focused on psychosocial understanding of individuals within the Black and African American community often have an ethnocentric view that is deficit based and without further context such as socioeconomic status, community, or salient identity (Valencia, 1997). For example, within the mental health professional community, norms have been established such as African Americans are reluctant or unable to seek mental health treatment (National Alliance on Mental Illness [NAMI], n.d.). The context and history are often either excluded as to why the Black community might be reluctant to seek mental health treatment or only considers the dominant cultures perspective of history. It is important at this juncture to discuss the origins of CRT as it intersects with the mental health system.

CRT's origin in the legal system was a seemingly obvious necessity for a move towards racial equity. During 1882-1962, 4,743 documented lynchings took place in the United States (Work, 2010). Of those lynchings, 3,446 (72.7%) of the individuals were Black (Work, 2010). Many of the White individuals lynched were killed for attempting to help Black individuals or being overtly against lynchings of Black people (Bell, 1995).

A majority of these legal killings took place during the Jim Crow era. The worst year during Jim Crow era being 1892 with 161 Black people lynched in the US (Tuskegee University, 2010). In 2015, 258 Black individuals were killed by law enforcement in the US (Swaine et al., n.d.). In 2015, Black males made up 2% of the total US population by race and gender (U.S. Census Bureau, 2016), but those between the ages of 15 and 34 accounted for 15% of all deaths resulting in deadly force by law enforcement logged for the year (Swaine et al., n.d.). Of all deaths

that occurred as a result of deadly force by law enforcement, 246 deaths were of people who had documented mental illnesses (Swaine et al., n.d.). The dangers of intersectionality become evident for Black individuals with mental illnesses.

Black individuals are at risk for specific psychosocial threats including but not limited to poverty, exposure to violence, racism, prejudice, and systematic oppression that can inhibit their ability to receive effective or honest healthcare (Mekawi, Bresin, & Hunter, 2016). This was the case for the infamous Henrietta Lacks, the Black woman who possessed the first immortal cell line HELA cells (Greely et al., 2013). Henrietta Lacks went to the doctor for treatment of a tumor and rather than receive treatment, her tumor was studied without her knowledge or permission. After her death, Mrs. Lacks' tumor was removed without consent from her family, and the cells were cloned and used to create vaccines for things like polio and to better understand other illnesses (Greely et al., 2013). Mrs. Lacks' children were also called in for testing without any further clarification about why to see if they had similar biology and at no point were they informed that their mother's biology was being used to advance medicine or even that it was unique. It was 1975 (21 years after the discovery and use of her immortal cells) that the Lacks' children were informed of the use of their mother's biology for the advancement of medicine (Gamble, 2014). It is worth noting that the Lacks children lived in poverty while Mrs. Lacks' cells were sold at a high price as they were in high demand in the medical community (Greely et al., 2013).

The Henrietta Lacks story is unfortunately not a unique experience in healthcare as similar instances occurred with the Tuskegee Syphilis experiment in which 600 impoverished Black men were studied without treatment (Hackett, 2014). The purpose of this study was to see how untreated syphilis manifested. The study began in 1932 and an effective treatment was available around 1947,

but the participants were not made aware or treated (Gamble, 2014; Greely et al., 2013). The study went on for 25 more years ending in 1972 after a whistleblower made the lack of treatment known (Gamble, 2014; Greely et al., 2013). Many of the participants in the study were told they were being treated for “bad blood” which was a term used during the time that could mean anemia, syphilis or fatigue. The researchers were aware of the contagious nature of syphilis; however, it is not clear if education about this disease was provided to the participants (Gamble, 2014; Greely et al., 2013). Greely et al. (2013) noted that as a result of not receiving treatment, 40 wives contracted syphilis and 19 children were born with the sexually transmitted disease. This entire study was being supervised by the U.S. Public Health Service, so essentially the government allowed these Black individuals to suffer and in some situations, die for the “advancement of knowledge” (Gamble, 2014; Greely et al., 2013).

The Henrietta Lacks case and the Tuskegee syphilis experiment encouraged distrust in health care among the Black community. Incidents like these set a precedent of suspicion and worry that the consumer's best interest may not be at the forefront of the healthcare providers working with them. With the recency of these systematic deceptive actions in seeking help, it is no wonder that the Black and African American communities have ambivalence in seeking treatment. With less than 2% of clinicians identifying as Black or African American possible risks of seeking treatment include: 1) It is very unlikely that the mental health professional will be a member of the Black or AA community; 2) A non-Black service provider may lack cultural competence in understanding the complexities of the Black experience including the historical significance; 3) A non-Black service provider may have adopted the racist norms of society and commit microaggressions in session; 4) White fragility may occur, particularly if the Black

or AA consumer is seeking change in dealing with race-based issues; and 5.) The mental health professional may be fully aware of all of the cultural complexities possible when working with a client who identifies as Black or African American; however, they are using a color-blind approach and not able to capture and subsequently effectively intervene for race-based experiences (APA, 2015).

### **Purpose**

The purpose of this mixed method study was to explore the perceptions, beliefs and attitudes clinicians have when working with Black clients and understand how these characteristics inform clinical perceptions of effective assessment practices. This study focused on clinicians' perceived effectiveness when working with Black clients during the mental health assessment portion of treatment. An exploration of clinician implicit racial bias was examined with demographic variables and perceived effectiveness.

### **Significance**

This research is significant as it aims at better meeting the needs of Black and African American individuals seeking and receiving mental health services. Ideally, this dissertation will serve as an opportunity to consider the holistic experience of all individuals involved in mental health treatment and how they understand themselves as intersectional beings. Hopefully, this will also offer an opportunity for clinicians to better understand any inherent biases and implications on how to best work with clients who identify within the Black community.

Although the color-blind approach poses many potential risks to Black Americans seeking mental health treatment, it is assumed that this can be an inadvertent consequence when attempting to prioritize treatment for some of the more severe symptoms of mental disorders. In this sense, high risk symptoms that

typically necessitate crisis evaluations do not necessarily require obtaining cultural or racial experiences to identify how to best meet the client's needs. This is, however, an area of concern as Black individuals are overrepresented in inpatient mental health (IPMH) services and underrepresented in outpatient mental health (OPMH) services (Substance Abuse and Mental Health Services Administration [SAMSHA], 2015). Clinical decision making requires clinicians to practice some immediacy to determine the most pressing goal of treatment for every clinical event. Therefore, it is apparent that there is a concern Black individuals are overrepresented in IPMH services.

### **Research Questions**

The main research questions of this dissertation are as follows:

1. What do Clinicians perceive are effective MHA practices with Black clients?
2. How are perceived effective assessment practices related to the demographic and IAT variables?
3. What is the relationship between implicit racial bias (IAT categories) and perception of clinician effectiveness and clinician characteristics?

### **Definitions of Terms**

**Black and African Americans.** The terms Black and African American are regularly used interchangeably. The discussion on the terminology used to refer to people of African descent is a dissertation in itself. Black typically refers to having phenotypes characteristic of African descent (Eckstein, 1994). African American denotes African ancestry or ethnicity and American nationality (Harris, 1993). Much can be discussed about the Afrocentricity related to how individuals

of African descent empowered the term Black, as opposed to negro or colored. For the purpose of this dissertation, the term Black refers to all individuals of African ancestry, including both those of slave descent (who arrived involuntarily) and recent immigration (whose arrival was voluntary) living in America.

**Colorblindness, and strategic colorblindness.** Colorblindness as defined by Neville, Worthington, and Spanierman (2001) as “the belief that race should not and does not matter” (p.60). Strategic colorblindness as defined by (Apfelbaum, Sommers, & Norton, 2008) is “avoidance of talking about race – or even acknowledging racial difference – in an effort to avoid the appearance of bias” (p.918). This understanding of colorblindness is not exclusive to White individuals and can be possessed by all races. Skin color and by extent, race, can be perceived in a manner similar to that of any generalization, and can accompany bias either conscious or unconscious. If left unchecked, the biases can lead to negative attitudes or actions that can severely impact the therapeutic relationship.

**Culture, ethnicity and race.** Culture and by extension, ethnicity refer to a shared identity of any subgroup of people (D.W. Sue & Sue, 2012). More specifically culture can be used to describe any groups of people with similarities, whereas ethnicity usually represents a group of people who have spent a reasonable amount of time together and as a result have similar physical traits, identities and histories. The identities of people within these ethnic subgroups is characterized by a variety of beliefs, practices, values, ideals, language and other attributes. Race typically refers to the phenotype associated with a specific ethnicity (D.W. Sue & Sue, 2012). Race and ethnicity are often used interchangeably both within the Black community and in the dominant culture. Race is a socially constructed concept that has had astounding effects on the way that individuals are treated in society. The use of race and ethnicity in this study

were dependent on the tool used or the previous article that denoted certain groups. Due to the nature of this study, from this point on Black and White will be capitalized to denote the proper noun describing the groups.

### **Enculturation, acculturation and subsequent combinations.**

Enculturation is the process in which an individual learns and subsequently adopts characteristics from the culture of origin (Rogers-Sirin, 2013). Acculturation, refers to the result of two or more cultures adapting to one another due to close and repeated socialization (D.W. Sue & Sue, 2012). Assimilation is a result of low enculturation and high acculturation and refers to the level of which an individual adopts the norms of the dominant culture and abandons the characteristics of the culture of origin (Cokley & Helm, 2007). Sometimes assimilation can cause dissonance, particularly if the dominant culture has negative beliefs, stereotypes or values regarding a characteristic that an individual possesses and cannot change. This phenomenon is called internalized oppression and is explained by David (2014) as the feelings of inferiority or shame and resulting destructive behaviors due to adopting negative stereotypes about one's own group.

Separation is the opposite of assimilation with high enculturation and low acculturation and described by Rudmin (2003) as the rejection of the dominant culture by an individual and only adhering to the norms from the culture of origin. Integration is the byproduct of high enculturation and high acculturation. Integration refers to adopting the norms of both the culture of origin and the dominant culture (Cokley & Helm, 2007). Marginalization is the result of low enculturation and low acculturation in which an individual rejects the norms of both the culture of origin and the dominant culture (Cokley & Helm, 2007; Rudmin, 2003). Figure 1 illustrates the relationship between enculturation, acculturation and each corresponding category. Acculturative stress is explained as

the stress related to an individual moving from one culture to another (Joiner & Walker, 2002).

		Acculturation	
		<i>Low</i>	<i>High</i>
Enculturation	<i>Low</i>	Marginalization	Assimilation
	<i>High</i>	Separation	Integration

*Figure 1.* Description of the different combinations of acculturation and enculturation by level of intensity adapted from Cokley and Helm, 2007 and Rudmin, 2003.

**Intersectionality and salient identity.** Any one individual is composed of multiple identities that encompass race, ethnicity, gender, age, sex, sexual preference, religion, political party etc. A person cannot separate these inherent identities and experience them in isolation, rather they exist in combination. These combinations of multiple intertwining identities are referred to as intersectionality (Yakushko, Davidson, & Williams, 2009).

It is important to note that a Black/White racial dichotomy exists both empirically and socio-culturally that does not reflect the people who do not easily fit into either category (Gnanadass, 2014). While it is critical for clinicians to take into account culture it is also important clinicians do not assume a client's culture. This is why, how an individual identifies themselves is the most reliable source of how an individual understands themselves existentially.

At any given point in time during a lifetime, an individual's most relevant identity comes to the forefront, this is called a salient identity (Yakushko et al., 2009). Salient identities cannot be assumed; however, individuals who identify as Black or African American are very often assumed to have race as a salient identity. Although this dissertation focuses only on the dimensions of race and ethnicity, it is acknowledged that Black individuals are intersectional beings who may have a more relevant salient identity that could be better accommodated by research specific to that identity.

**Oppression, privilege and White fragility.** Oppression refers to “structures of forces and barriers that tend to immobilize and reduce a group or category of people” (Frye, 1983, p. 11). Privilege refers to the unearned, and sometimes unnoticed, benefits granted to the dominant group as a consequence of exploiting the oppressed (Crenshaw, 1991). The most commonly studied privileges include White privilege and male privilege. In both instances, the privileged party is often unaware of their privilege as they have never been without it. In the instance of White privilege, one of the included privileges is living in a society that largely protects and insulates White individuals from race-based stress (P.J. Williams, 1997). An inadvertent result of this is the “inability to tolerate racial stress” (Diangelo, 2011, p. 54). White fragility refers to the psychological phenomenon that occurs when a White individual experiences defensiveness due to even minimal amounts of racial stress (Neville et al., 2001).

**Mental health professionals.** For the purpose of clarifying for this dissertation, mental health professionals refer to anyone with a professional degree in psychology, counseling or any other field that trains them to work in mental healthcare. The term “mental health professionals” is inclusive of psychiatrists,

therapists, social workers, counselors, psychologists, psychiatric nurses and other clinical positions. Mental health professionals will be referred to as clinicians.

**Assessment and approaches.** Mental Health Assessment (MHA) is the initial clinical interview in which a mental health clinician determines the change a client is seeking. This interview can consist of one event or multiple events (Pomeroy & Wambach, 2015). The MHA is typically when a diagnosis, prognosis and treatment plan is determined by the client and clinician (Kilgus, Maxmen, & Ward, 2016). A variety of approaches can be used during any and all stages of therapy. Some approaches include psychodynamic therapies, cognitive behavioral therapies (CBT), postmodern therapies, humanistic and existential therapies, and systems therapies. The approach used is largely dependent on the training and profession of the clinician, as well as the interventions that will be most effective for the client (Pomeroy & Wambach, 2015).

**Deficit and strength-based approaches.** A deficit based approach to a MHA is one in which clinicians become skilled at easily identifying symptoms, deficits and disorders. Rashid and Ostermann (2009) warn that clinicians using a deficit approach can easily 1) perceive symptoms as most important and central to therapy while positives are seen as a byproduct; 2) reinforce negative biases of clients who see themselves existentially as broken or in need of fixing; 3) reduce a holistic view and paint an incomplete picture of the client who has inherent strengths and opportunities for growth; and 4) become very skilled at “diagnosing and treating only symptoms and weaknesses” (p. 490). A strength-based approach is one in which both the deficits and strengths are considered (Corcoran, 2009). A clinician using a strength based approach can use the strengths identified by the client in the treatment plan. For clients who are unable to identify inherent

strengths, a clinician using the strength based approach documents and includes a section about identifying inherent strengths in the treatment goals.

**Implicit Associations Test.** The Implicit Associations Test (IAT) is a measure of associations that explain underlying implicit attitudes. The IAT was originally introduced by Greenwald, McGhee and Schwartz (1998), and measures a variety of associations about genders, disabilities, weight, skin-tone, weapons, age, sexuality, religion, and a variety of races including Asian, Native American, and Black. The IAT can only measure the association of two factors; therefore, the race IAT used for this study only focuses on Black and White individuals.

### **Summary**

This study hopes to contribute to an increasing body of work centered on effective mental health services for the Black community in the U.S. Effective psychological intervention requires a thorough understanding of the change the client is seeking as it relates to how they see themselves and how they identify. Establishing best practices for completing initial assessments within the Black community is necessary to ensure that all individuals within this community receive effective interventions. Effective interventions are also largely dependent on a phenomenological approach free of stereotypes or imposing bias from the mental health professional.

The current climate of mental health treatment is largely deficit based and hyper focused on impairments (Rashid & Ostermann, 2009). This approach can easily be a practice in forced assimilation if the assessing clinician is not aware of how their inherent biases are informing their clinical decision making. If racial experiences are related to the change the client is seeking, further investigation is required to determine if the experiences are within normal limits of the client's culture and if they necessitate intervention.

## CHAPTER 2: REVIEW OF THE LITERATURE

This dissertation assumes that the goal of any mental health service provider is to implement specific interventions to improve the quality of life of the individual they are working with. In order to do this, best practices indicate that an initial interview be completed to understand what change is being sought out by the consumer. More specifically this study explores the relationship between Black Americans and mental health. This literature review also discusses racial phenomena specific to the Black community as it relates to mental health. Critical Race Theory is a framework that is used as a lens to analyze the ways in which race is relevant to Black individuals seeking mental health services. Although the Black community is the focus of this dissertation, many of the concepts can be applied to alternative cultural identities.

### **Critical Race Theory**

When discussing color-blindness in mental health as it relates to Black or African American individuals, it is essential to consider Critical Race Theory (CRT). Originally linked to the legal system, CRT works under the assumption of a system of power and oppression that is based on cultural perceptions of race (Haskins & Singh, 2015). CRT was born of Black lawyers expressing dissatisfaction with the legal system and the tradition of civil liberties inherently benefitting only White Americans (Delgado et al., 2001). P.J. Williams (1997), one of the original proponents of CRT describes the US legal system as being based on ideals of assimilation, color blindness and integration. In fact, there are significant parallels between the legal and mental health fields when race is considered.

Like the legal system, healthcare inherently takes a color blind, deficit approach to treatment. Race is seen as a characteristic disconnected from individual identity, or worse, race is believed to not matter at all (Harris, 1993). When considering mental health, this denies Black and African American individuals' validation in that their racial experiences, including prejudice, discrimination, racist norms in the form of structural racism, microaggressions, historical servitude, exist. When specific events of these racial experiences are offered in session, a counselor utilizing the color-blind model potentially perpetuates these experiences as the exception rather than the norm. This experience in itself can be invalidating and re-traumatizing to an individual seeking help for dealing with racial experiences.

CRT expects that victims of systematic racism attempt to counteract prejudice, racism and discrimination (P.J. Williams, 1997). These attempts can manifest in different ways depending on the unique experience of the individual. CRT works to understand the socio-cultural dynamics that shape the current and historic values of American culture. Race is a social construct that along with power and oppression have had a major influence on American society. That influence is not limited to the existence of slavery, Jim Crow laws redlining or the erasure of the contributions that Black individuals have made to American society. A large component of American heritage is the intergenerational effects that have been passed down from parent to child including but not limited to the proposed Post Traumatic Slave Syndrome (PTSS) (DeGruy, 2005) but also learned racism. CRT also focuses on those who either inadvertently or advertently perpetuate racism either to maintain power or because they are unaffected by it (Crenshaw, 1991).

CRT is especially concerned with the racial experiences of all individuals in a caste system reliant on race (Crenshaw, 1988; Harris, 1993). CRT critically examines how the experience of a person who identifies as Black is an experience that is loaded with historical and current oppression that is difficult to explain empirically due to intersectionality (DeGruy, 2005; Harris, 1993).

### **Black Identity**

The Black Experience examined by CRT theorists Harris (1993), P.J. Williams (1997) and Crenshaw (1988; 1991) is found to be a focal point in how Black individuals are treated in American Society. Within the Black community the terms Black and African American are used interchangeably. The term Black is used to describe people of African descent based on a phenotype rather than individual ethnic identity (P.J. Williams, 1997). The term Black also typically denotes slave ancestry and has historical significance that goes back to the civil rights movement in which the Black movement insisted on the use of Black rather than Negro (Harris, 1993). In the U.S., the term African American usually refers to an individual who is familiar with the ancestral country in Africa from which they came (Crenshaw, 1991). The relevance of identity is a theme within the Black community that is crucial to determine as it relates to individual mental health.

The complex ancestry of Black individuals of slave descent makes it difficult to identify ethnically with any specific ethnic groups in Africa. A single person can identify ethnically as having multiple ethnicities; however, present physically as being of African descent, and therefore, face prejudice, discrimination, and other forms of racism despite personal identity. Many Black individuals with Slave ancestry have European as well as Indigenous, Hispanic and Arab ancestry as a result of progeneration between slaves and White Slave masters and the diaspora (Crenshaw, 1988).

This convoluted ancestry is why colorism is relevant when it comes to the Black experience. Colorism as defined by Kerr (2005) is “inclusion or exclusion from organizations, institutions, and social groups based on hue or African facial features” (p. 271). Passing is a term that has been used to describe an individual with African and European ancestry with light skin and features more typical of Europeans who deny their Black identity and refer to themselves as White (Harris, 1993; Kerr, 2005; P.J. Williams, 1997). Even within the Black community the relationship between hue and social elitism becomes evident through socialization. The media also plays a role in this when fewer positive images are of darker skinned Black individuals. This term meant and can still mean the difference between economic and political success, privilege or oppression, and how an individual is treated by society (Harris, 1993).

Keith and Monroe (2015) offer that people of color (POC) with dark skin report more difficulty in the arenas of occupation, wages, and romantic options when compared to people who hold the same racial identity than those with lighter skin tones. The phenomena of passing and the subsequent privileges of passing is not only relevant in the dominant society, but even within the Black community. The terms “light skin” and “dark skin” have connotations to designate beauty, value, and intelligence. To provide historical context, slaves with one Black parent and one White parent were preferred to provide duties within the house, compared to darker skinned slaves who worked outside perpetually (Hunter, 2007).

The Black experience can occur in dissonance at times and can be both a detriment and strength to an individual's mental health, depending on the perspective. During the process of the mental health assessment, for example, consider an individual who identifies as Black or African American who is

attempting to counteract the previously mentioned constructs. This individual given a Burns anxiety inventory (Beck, Ward, Mendelson, Mock & Erbaugh, 1961) can be interpreted as having anxiety. This same individual given a resiliency scale (Connor & Davidson, 2003; Wagnild & Young, 1993) can be interpreted as having extreme resilience. Dialectical thinking is required to understand that both can occur in the same individual.

In the same way that the legal system has roots based in color blindness, the healthcare system in large part does not recognize racial experiences as being relevant in understanding the problem or as a role in treatment. The mental health field today is not currently made to accommodate dissatisfaction or resilience due to racial experiences. Although suggestions have been made by a variety of handbooks on culturally competent counseling, there is no formal standard of practice in collecting racial experiences during the initial interviews. The client is not the only person in the therapeutic relationship who has experienced race related events that have shaped who they are in the person. The clinician is also a racial being who may have race as the most salient aspect of their identity. This is relevant when considering unconscious bias when working with Black individuals.

### **Racial Identity**

Cross (1971) proposed that Black individuals are socialized under a system of oppression that causes a unique psychosocial development. Cross described the deficit nature of much of the research focused on Black individuals. Cross goes on to explore how a dominant nature focused on how well (or poorly) an individual of another race is able to adapt to the dominant culture is a poor measurement of social success. Through his discontent with the research of his time, Cross explored the mental health of Black individuals under a more appreciative inquiry lens. Through this work, Cross developed the theory of Black development or

“Nigrescence.” The five stages of Black development include 1) Pre-encounter, 2) Encounter, 3) Immersion/Emersion, 4) Internalization, and 5) Internalization-Commitment stages.

**Pre-encounter stage.** The pre-encounter stage describes the time before an individual knows themselves as a racial being. This is marked by the first event in which a Black individual is made aware of their Blackness which is the beginning of the encounter stage. Cross (1971) describes the dissonance that may occur when a Black individual is transitioning from the pre-encounter stage to the encounter stage. Cross ascertains that Black individuals are socialized in American society to believe colorblindness is fact. That is, Black individuals are socialized to believe that race does not matter. The transition from the pre-encounter stage to the encounter stage marks a new racialized worldview.

**Immersion/emersion stage.** The immersion/emersion stage occurs after the immediate shock of a racialized world wears off and the Black individual become equip with a much more critical analysis of how the world works. During this stage of Cross’s (1971) Black development model, the Black individual may immerse themselves in all things Black while simultaneously isolating and attempting to avoid other groups. During the immersion/emersion stage, the Black individual is still insecure about their racial identity and can overcompensate by outwardly expressing Black pride while defaming White culture and perceiving it as the antithesis of Black culture.

**Internalization-commitment stage.** The internalization stage marks security of a Black individual’s racial identity and comfort with the exploration of relationships with members of other races. The final stage, the internalization/commitment stage is distinct by the Black individual’s security and appreciation of their own Black identity as well as comfort and appreciation of

other races (Cross, 1971). These stages of Black development are not static or linear and can be repeated throughout the individual's lifetime. The stages can be dependent on a social context including a Black individuals access and exposure to other Black individuals or culture, media, political context and other social phenomena.

Cross's (1971) goal was to normalize the experiences of Black individuals who live in a culture with racist norms. Cross pointed out the importance of seeing the resiliency of Black individuals who live in a culture that systematically oppresses them. In order understand and accurately diagnose individuals who identify as Black or African American, it will require many clinicians to unlearn racist norms, stereotypes and systematic oppression, and purposefully create new mental models. CRT provides an understanding of the dominant culture's influence on each individual who is a part of the larger society. In mental health, a historical understanding is necessary to understand the complexities of why the taxonomy that is the Diagnostic Statistical Manual of Mental Disorders APA, (2015) was not made for individuals of color (Lindsey, 1998).

### **Mental Health in the U.S.**

According to the U.S. Census Bureau (2016), 76.9% of Americans identify as White, 13.3% of Americans identify as Black or African American, 17.8% of Americans identify as Hispanic or Latinx, 5.7% identify as Asian or Asian American, 2.6% identify as two or more races and 0.2% identify as Native Hawaiian and other Pacific Islander. The National Institute of Mental Health (NIMH) organizes and publishes national data on mental health. NIMH's SAMHSA reviewed the National Survey on Drug Use and Health data among adults age 18 or older to present average annual estimates by race/ethnicity(SAMHSA, 2015). Participants in this survey were civilian, non-

institutionalized, US residents aged 12 or older. These interviews were completed in both Spanish and English in part (sensitive information) by audio computer assisted self-interviewing and (demographic data) by interviewers.

The SAMHSA (2015) review revealed that out of all adult individuals who used OPMH services in 2014, most identified as two or more races at 17%, with White adults behind at 16.6%. Black adults accounted for 8.6% of adults who used mental health services. Although this number is significantly lower than those who identify as two or more races or White individuals, this is still more than the 7.3% of Hispanic individuals or 4.9% of Asian individuals who are receiving some form of OPMH services. Black adults between the ages of 35 to 49 were the most likely to utilize OPMH services than any other Black individuals. Black adults with Medicaid or Medicare were the most likely to participate in OPMH services among the group at 15.8%, with Other insurance in second 10.1% and private insurance accounting for only 5.6% of the group. This can be compared to the Hispanic group with 11.5% of individuals with Medicaid/Medicare, 10% with multiple insurance types, and 7.7% of individuals within the group with private insurance participating in OPMH. When identifying unmet needs of individuals with any mental illness who want to participate in OPMH services, Black individuals identified cost/insurance 45.4%, structural barriers 31.6%, prejudice and discrimination 25.3%, low perceived need 24.5% and the belief services would not help 5.3% as barriers preventing them from getting their needs met. Among Black individuals with a serious mental illness, cost/insurance 51.7%, prejudice and discrimination 31.2%, structural barriers 31%, low perceived need 19.7% and the belief that services would not help accounting for 5.5% of the reasons for not using OPMH services. According to the report, 32.2% of Black women with mental illness and 25.3% of Black males with mental illness received

some form of OPMH service within that year. Black and Hispanic individuals were tied with 3.1% estimation of having a serious mental illness. White individuals accounted for 4.3% who were estimated to have a serious mental illness.

Black individuals in the SAMHSA (2015) review were the most likely to be involved with inpatient mental health services at 1.4%. As the second least likely to participate in OPMH services behind Asian Americans, and the most likely to require inpatient hospitalization there is an identified need to adapt to Black individuals who need mental health services. These descriptive statistics indicate that the issue is not that Black individuals do not need services, rather they are not getting the services that benefit them, or at the very least preventing the need from inpatient services.

The SAMHSA (2015) review indicates that of the individuals with a serious mental illness, 48% of Black males and 61.3% of Black females used OPMH services. Of the Black individuals with a serious mental illness, 71.4% had Medicaid or Medicare only. This can be compared to the 77.6% of White individuals with serious mental illness that have Medicaid or Medicare insurance coverage. Although it appears Black individuals are receiving OPMH services more often than Hispanic or Asian populations, these descriptive statistics do not provide context including OPMH being a requirement or referred by an external agency/entity. When considering the populations as a whole these descriptive statistics become even more interesting.

Much of the previous research done on Black individuals is deficit in nature, and does not account for the differences within the group. Empirical research focused on contributing to the limited body of research among Black individuals and mental health typically only accounts for race, albeit sometimes

gender, but rarely accounts for identity. A major premise of this study is that a Black individual socialized in the American South may have completely different racial experiences than that of a Black individual socialized in California. Furthermore, a clinician uneducated on those differences or how to collect that information is potentially making clinical decisions on assumptions or bias. Previous mental health research that is inclusive of the Black community was explored through a CRT lens.

### **Black Individuals and Mental Health**

The SAMHSA (2015) analysis revealed few differences among groups when identifying perceived discrimination as a barrier for receiving OPMH services. Schulz et al. (2006) hypothesized that everyday discrimination was linked with poor physical and mental health. The Schulz et al. (2006) study explored the longitudinal relationships between perceived discrimination and health among Black women who lived in Detroit. A survey and subsequent interviews were conducted among Black women aged 18 or older living in the East side of Detroit that was highly segregated by race with 97% of the population identifying as Black. The first wave included the survey in 1996 and the interviews were conducted during the second wave in 2001. Participants were randomly selected from those who met the criteria of being 18 or older and caring for one or more child younger than 18. The survey consisted of a self-reported Likert scale asking general questions about perceived health, along with a portion of the survey including the Center for Epidemiologic Studies Depression Scale (CES-D).

The Schulz et al. (2006) study found that over time, change in perceived discrimination was linked to a change in depression symptoms and self-reported health. Specifically, an increase in reported discrimination was correlated with an

increase of depressive symptoms despite all other demographic data including age, education, income and baseline scores. This study identified a limitation of perceived discrimination possibly influenced by previous mental health status. The article does not go into detail about what is meant by this. Another possible limitation is that half of the women who began the study were lost to attrition.

The Schulz et al. (2006) study illuminated the effects of discrimination on the basis of race among mood related symptoms in Black women. This study did not compare the effects of everyday discrimination among Black women to any other groups. The study did not explore socialization, acculturation, enculturation or identity as possible outliers. Perhaps further exploration of acculturation and enculturation would have provided insight into the socialization effects of perceived discrimination as it relates to mood symptoms. Previous studies that explore possible socialization effects provide insight into how American culture possibly shapes and normalizes perceptions around mental health.

The theme of socialization's effect on seeking or receiving OPMH services was explored further by A. Williams and Justice (2010). This study explored the attitudes of Black male students who attended four Texas universities that were either predominantly White universities (PWU) or a historically Black college or university (HBCU). A total of 212 Black males were surveyed using the Attitudes Toward Seeking Professional Psychological Help Scale. This study sought to explore why Black males were not seeking counseling and the reasons they do not participate, as well as a comparison of the attitudes regarding counseling among the HBCUs and PWUs (A. Williams & Justice, 2010).

A. Williams and Justice (2010) found no significant difference regarding the attitudes about counseling between the Black males who attended a HBCU and those who attended a PWU's. Furthermore, the attitudes of the participants were

largely negative. The study also found that lower level (freshmen and sophomore) Black males at one HBCU had a more positive attitude towards counseling than the upper level (junior and senior) Black males. The reasons that were identified as barriers for seeking and receiving counseling services by participants in this study include negative stigmas, signs of weakness, and embarrassment. This study identified that even Black males socialized in adulthood by White peers at a PWU still have negative attitudes regarding counseling.

The theme of socialization as a barrier is continued in other studies. Much of mental health culture is based in Western perceptions. Miranda, Siddique, Belin, and Kohn-Wood (2005) explored the differences in self-reported mood symptoms and substance abuse among Black women born in the US, Africa and the Caribbean. This comparative study sought to see differences and similarities of rates of mental illness among US born Black women and Caribbean born Black women. This study only focused on women receiving Women, Infants and Children (WIC) programs, or using Title X family planning or low income pediatric clinics.

A total of 9,151 self-identifying Black women were interviewed using the WE Care screening interview with 913 who were born in Africa, 273 who were born in the Caribbean and the remaining 7,965 US born (Miranda et al., 2005). The study notes that a majority of the US women interviewed (95%) were under the age of 43. The foreign born Black women were slightly older, had more children and were more educated on average. Less than 1% of all of the women reported substance abuse problems of any kind. Mental health treatment was also low among the groups with 2.6% of the US born Black women, 0.8% of the African-born Black women and 2.6% of the Caribbean-born Black women participating in some form of OPMH treatment.

The Miranda et al. (2005) study found that Black women who were foreign born were less likely to self-identify with mood disorder symptoms than US born Black women. One of the main limitations discussed in the study is levels of acculturation among the US born and the normalization of mood symptoms in Western society. It is worth noting that the data collection process did not specifically identify acculturation levels among the women. Levels of somatic symptoms were much higher in the Black women born in the Caribbean and Africa than the US born Black women.

The previous study explored the differences among Black women dependent on where they were born. The theme of socialization is explored further by Epstein, Black and Gonzalez (2017) who explored the differences among perceived needs among White and Black girls. Epstein, et al. explore the potentially lifelong ramifications of perceptions among Black girls in their study on perceived innocence among adults. This study is largely based in CRT principles as the article explicitly states “The results are rooted in the legacy of racial discrimination in this country, which historically included responding to Black youth’s child-like behavior more punitively” (Epstein et al., 2017, p. 4).

Participants of the Epstein, et al. (2017) study were 325 adults 74% White, 62% female, 39% were between 25-34 years old, 69% held a post-secondary degree. The adults came from various backgrounds all over the US who were recruited through an online service. Participants completed a survey either on Black or White girls that used a 5-point Likert scale to respond to various questions about perceptions.

The Epstein et al. (2017) study found that compared to White girls of the same age, adults perceived Black girls in need of less nurturing, less protection, less support, less comfort, are more independent, know more about adult topics

and sex as early as age five. This study hypothesizes that these perceptions may contribute to harsher punishment by law enforcement and educators, and may potentially lead to fewer mentorship opportunities (Epstein et al., 2017 p. 4).

The Epstein, et al. (2016) study investigated the prevalence of perceived stereotypes associated with the Black female archetypes including Sapphire, Jezebel, and Mammy. The Sapphire archetype is one associated with emasculating, loud, angry, aggressive, stubborn and unfeminine characteristics. The Jezebel archetype associates hyper sexuality, seduction and exploiting male weaknesses as its main qualities. The Mammy archetype characteristics include self-sacrifice, nurturing, loving and asexual qualities. These archetypes are persistent not only in American history but are also present in all forms of present day media, normalizing the perceptions that these archetypes are the summation of Black women. These perceptions gone unchecked, can inadvertently lead to actions based on these interpretations and responding more harshly to shape Black girls who demonstrate behaviors not perceived as traditionally feminine.

The Epstein et al. (2017) study provides insight into the perceptions that adults may hold regarding young Black girls and the consequences of those perceptions. Similar perceptions held by clinicians presents dangers to Black clients. According to Harris (1993) the relationship between a clinician and the client is one of the most important factors involved in clinical effectiveness. One of the barriers in closely examining perceptions of clinicians is that explicit measures are subjected to external factors, including the desire to be politically correct, researcher race/bias, fear of being perceived as prejudice and other factors (Krieger et al., 2010; Krieger et al., 2011; Sălăgean, 2017). Implicit measures have been used to better understand individual automatic and sometimes unconscious bias.

## **IAT**

The Epstein et al. (2016) study demonstrates the implicit perceptions held by adults about Black girls in the U.S. The aforementioned consequences of these perceptions of the Epstein et al. (2017) study and how Black girls are treated within the U.S. society is assumed to have an effect on the mental health of Black girls. Further research is required to better understand the sociological effects of the perceptions uncovered by the Epstein, et al. study. Clinicians working with Black girls, or any other members of the Black community holding similar beliefs may be making clinical decisions on based on these biases. The Implicit Associations Test (IAT) assists in uncovering implicit biases of individuals and may be useful in understanding how individual experiences shape how clinicians view the world (Greenwald et al., 1998).

The IAT measures differential association of two target concepts with an attribute (Greenwald et al., 1998). Not inherently interested in race, the IAT has been useful in diagnosing social associations, otherwise known as implicit attitudes (Greenwald et al., 1998). The IAT uses a sorting activity combined with a discriminating task and an attribute task while measuring the response times of the participant. One of the original experiments by Greenwald et al. (1998) used the IAT procedure to measure implicit attitudes regarding Black and White names while asking the participants to associate the names as pleasant and unpleasant word meanings. This study also asked participants (who consisted of White students, 12 male and 14 female) to complete an explicit attitude measure consisting of five self-rated questionnaires that measured race-related attitudes and beliefs. The results of the study indicated that not only were the implicit and explicit scores opposite, but the IAT results of a majority of the participants indicated a strong preference for White individuals over Black individuals.

The IAT has since been used to measure implicit attitudes regarding a variety of attitudes that may not be accurately captured using explicit measures. The IAT has been compared to other implicit measures and found to have similar outcomes (Cunningham, Preacher, & Banaji, 2001). The IAT has been favored by researchers interested in attitudes since its introduction by Greenwald, et al. (1998) nearly two decades ago as an indirect measure of attitudes. Prior to the use of indirect (implicit) measures, direct (explicit) measures were used to assess attitudes. Eagly and Chaiken (1993) assert that explicit measures are often comprised of an attitude chosen by the participant at the time the measure is taken. Greenwald and Banaji (1995) alternatively argue that implicit measures uncover unconscious, automatic attitudes regardless of whether the participant wants to disclose them. The differences in the data collected by explicit and implicit measures provide a better understanding when combined by researchers. As a result, researchers concerned with a full understanding of unconscious bias as well as the participants chosen attitudes use both explicit and implicit measures (Gattol, Sääksjärvi, & Carbon, 2011).

Different IATs have been used to analyze complexities in mental health. Tan, Jordan-Arthur, Garofano, and Curran (2017) used the IAT to explore attitudes of mental health trainee's attitudes towards White heterosexual, lesbian and gay couples adopting Black children. Tan et al. used both the IAT and explicit measures and compared the measures. The trainee's explicit measures indicated over 80% of the participants had no strong preference in adoptive family while the IAT indicated implicit preferences for the lesbian couples. The inconsistencies among the implicit and explicit results in the Tan et al. study is not uncommon.

Blair et al. (2013) similarly used explicit and implicit measures to understand how racial bias effected perceptions of care among Black and Latinx

clients. Two IATs were used (one used Black and White races, the other Latino and White races) to measure implicit attitudes. The explicit and implicit measures again had very low congruence as the clinicians indicated low explicit racial bias and IAT scores indicated strong preferences. The Blair et al. study also found a negative association among Black clients and clinician IAT scores: “The stronger that clinician’s implicit preference for Whites over Blacks, the lower Black patients rated them” (Blair et al., 2013, p. 46). This study indicated that the implicit racial bias of primary care clinicians was related to the quality of clinical relationships within the Black community.

The Blair et al. (2013) study is one of many that explores how clinician implicit racial bias informs clinical decision making in healthcare (e.g., Burkard & Knox, 2004; Oliver, Wells, Joy-Gaba, Hawkins, & Nosek, 2014). Very few articles use implicit and explicit measures to understand how clinician racial bias informs clinical decision making in mental health. The implicit attitudes of a clinician can inform the clinical decision-making process when working with specific populations during a mental health assessment.

### **Assessment**

The initial clinical interview is arguably the most significant portion of treatment for the client and the clinician. This is the first interaction that many clients have with a mental health professional and has the potential to set the perception of mental health treatment in general. The potential outcomes of using a color-blind approach facing Black clients during the clinical assessment has already been established empirically (Burkard, Knox, Groen, Perez, & Hess, 2006; Edwards et al., 2017; Zhang & Burkard, 2008). In order to fully understand how to approach the clinical interview with clients who identify as Black, existing best practices were explored. Although many studies identify the necessity for clinical

assessments (Carlat, 2016; Foltz, 2012; Gara et al., 2012), but also best practices for working with the Black community (Delphin-Rittmon et al., 2015; Edwards et al., 2017; Mekawi et al., 2016). Very few articles offered practical advice on how to effectively identify the change a Black client is seeking while being aware of the level of acculturation of the client. Clinician practices for a clinical assessment were explored for the purpose of this study.

Best practices regarding the initial psychiatric assessment are dependent on a variety of factors including 1) managed care or how the service is being paid; 2) the reason for the referral; 3) the discipline of the clinician; and finally, 4) the approach being used (Carlat, 2016; Foltz, 2012; Gara et al., 2012; Pomeroy & Wambach, 2015; Rashid & Ostermann, 2009; Snowden, 2003). In the medical world, it would be unethical and irresponsible to schedule a client for surgery without identifying what is wrong with the client. The mental health field is no different from other healthcare in that it is unethical and irresponsible to plan (sometimes very invasive) interventions without identifying and understanding the change that the client is seeking.

### **Managed Care**

Managed care refers to the process in which mental health, substance abuse and other services are managed within fixed budgets (Ridgely, Giard, Shern, Mulkern & Burnam, 2002; Tompkins & Perloff, 2004). The American Medical Association (AMA, 2005) specifically outlines that managed care provide “medically necessary” services defined as

health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing and treating an illness, injury, disease or symptom in a manner that is in accordance with generally accepted standards of medical practice". This means that a clinician is left to determine what services are medically necessary for each client. (p. 23)

The purpose of managed care is to improve incentives by rewarding efficiency and better performance of systems (Tompkins & Perloff, 2004). Rate setting for mental health and substance abuse services becomes very complex as it involves consideration of the total dollars available and methods of distributing the funds to specific agencies and services (Tompkins & Perloff, 2004). Advocates of managed care focused on efficiency often emphasize best practices that are ideally evidence based for treating clients in a cost-effective and clinically effective manner.

Managed care is relevant to the information obtained during assessment and clinician bias as a majority of the people with severe mental illness in the U.S. are either insured by Medicaid or uninsured (SAMHSA, 2015). Specifically, the majority of Black individuals who receive OPMH or IPMH services are publicly insured by programs such as Medicaid (SAMHSA, 2015). If a clinician or public agency is billing to a public insurance agency for a service, they must meet the requirements of the managed care policy (AMA, 2005). If an insurance policy indicates they will pay for a one hour assessment annually, the likelihood that a clinician will spend more unpaid time on an assessment is low. When analyzing the differences in standard rates for services by insurance providers, it can appear that managed care is highly political. This creates a need for evidence based best practices to establish a standard of care for these specific services.

The managed care of an agency is largely dependent on the State and local regulations on organizing services. Managed care in healthcare is inclusive of insurance provider networks and what and how services are paid for. Tompkins and Perloff (2004) completed a meta-analysis to analyze the managed care of public mental health and alcohol and other drug (AOD) services in the state of Arizona. State level managed care required intake forms, clinical assessments and

encounter forms before any services would be paid for. The intake forms would include demographic data and the primary services of need, while encounter forms included dates and types of services, the dollar values of these services and the primary diagnosis of the client.

Tompkins and Perloff (2004) identified that clinical assessments in Arizona were required for clients who were enrolling into treatment and included an evidence based tool called the Arizona Level of Functioning Assessment (ALFA). Tompkins and Perloff (2004) emphasized that despite the requirement, only 38% of clients involved with the study had initial assessments that were available. Concerns had long been raised about the completeness of the assessment data that had been submitted to the State. These concerns had been a source of conflict perceived to be a “burden imposed on clinicians” particularly because clinicians perceived clients to not value the services offered (Tompkins & Perloff, 2004, p. 100).

The population of the Tompkins and Perloff (2004) study was inclusive of 33,208 adult clients with Medicaid or without insurance between 1995 and 2000. The demographics of the clients were 68% White, 25% other which included Hispanics and Native Americans and 7% Black. Three client categories were identified as General Mental Health (GMH), Serious Mental Illness (SMI) and AOD. The study did not specify the criteria for each group; however, demographics for each group were offered. Of all of the groups, Black clients were most represented in the SMI group making up 13% of the SMI population (73% White and 14% other). Second place was the AOD group with Black clients making up 8% of the AOD population (67.6% White and 24.9% other), and GMH services last with Black clients making up 5.8% of the GMH population (73.4% White and 20.8% other). Again, these data represent Black clients as severe and

requiring more intensive services than they do with general mental health services. When examining the “required” assessments available for each group, 43% of clients in the AOD group had available assessments, while the GMH group had 34% and the SMI group had 41% available. This study does not indicate how or what clients were being treated for without a clinical assessment or how the services were paid for without meeting the managed care requirement.

There is a political theme among empirical research studies that clinicians may perceive clients who receive services that are paid by Medicaid as not valuing the services as they are not required to pay a fee. This perception may influence the clinical decision making of a clinician, but research on this specific theme is required. Ridgely et al. (2002) created a tool that can be used to differentiate between programs that are “free” to clients (paid by Medicaid) versus services that require clients pay a fee. The purpose of this tool was to address managed care’s effect on access to care, clinical practice and client outcomes.

### **Reason for Referral**

Assessments can be requested by schools, law enforcement, the legal system, family members and by the clients themselves. The purpose of the assessment can rely on the reason a consumer is referred as it can vary from ruling out a mental illness, court ordered treatment or simply seeking change. Many times when the client is referred by an external party, it is generally for the purpose of seeing what services would be most appropriate to change some identified deficit. It is rare, if not unheard of for other agencies to send clients to seek mental health services because they are gifted or performing exceptionally in society. This can possibly play a role in why most mental health assessments are deficit in nature (Rashid & Ostermann, 2009). This also plays a role in the stigmatization of mental health treatment in the Black and African American

individuals (Copeland & Snyder, 2011; Hackett, 2014). Mandated or suggested mental health treatment is a quite literal sign of impairment in some areas of society.

### **Clinician Discipline**

The differences among the specialties of mental health clinicians includes the differences between the scopes of practice but is not limited to the scope of competency (Carlat, 2016). The scope of practice is the specified legal limits to each respective profession. The scope of competence is a category within scope of practice that is inclusive of these limits and includes additional training and experience (Ridgely et al., 2002). Cultural competency training would ideally make a clinician more competent widening the scope of competence. Additional trainings or experience would not allow a clinician to work outside of the scope of practice.

A psychiatrist is a medical doctor who specializes in preventing diagnosis and treating mental illnesses typically through medication and other medical monitoring. A psychologist is a clinician with a doctoral degree specializing in the psychological testing and treatment of mental illnesses. Both marriage and family therapists and clinical social workers have master's degrees in either counseling, social work or a related field that provides training on assessing and treating mental illnesses through counseling or psychotherapy. A psychiatric or mental health nurse can in some states dependent on licensing and scope of competency assess and treat clients by providing psychotherapy or prescribing and/or monitoring medications.

Specific laws and ethics are delineated by professional organizations. Psychiatrists typically have the American Psychiatric Association (APA), Marriage and Family Therapists have the American Association for Marriage and

Family Therapy (AAMFT). Social workers have the National Association of Social Workers (NASW) and the Clinical Social Worker Association (CSWA) that specifies ethics related to the biopsychosocial model of assessment, diagnosis, counseling and case management. Mental health nurses have the American Psychiatric Nurses Association (APNA). Although all of these professions have differing approaches for meeting the client's needs, all of these professions and specific ethical organizations express the importance and ethicality of conducting an initial assessment before treating any clients for OPMH services.

### **Approach**

**Information collection.** The diagnosis, prognosis and treatment of Black clients are largely dependent on the information collected during the MHA. Agar, Reed, and Bush (2002) explored the collection and documentation of abuse during the MHA. Agar et al. found a significant increase of documented abuse histories when use of a form that includes a section inquiring about abuse histories during initial assessment was used, 46 % of 26 cases in which a form with an abuse section was used, compared to 22.1% of 136 cases in which initial assessment was completed without a form including a section on abuse. Some of the reasons offered as to why abuse history was not collected during initial assessment without the form includes poor rapport, more immediate needs and concerns, time restraints, fears of making the disturbance worse and “abuse not considered relevant to current therapeutic goals” (Agar et al., 2002, p. 539). Most significantly there were 58 cases with abuse previously reported in outpatient records; however, abuse was not indicated or documented in the clinical assessment. The reason offered for the elimination of history of abuse was perhaps the assessing clinician did not read any previous documentation prior to assessing the client. The Agar et

al. (2002) study suggested developing policies and training to effectively and accurately document all relevant histories, in this case abuse.

### **Deficit verses Strength-based**

The theme of using an inductive approach rather than deductive approach during a MHA is emphasized when identifying symptoms. A deficit based approach typically used in clinical assessment would focus only on the impairments and use tools that easily list them. If the Burns Depression (Beck et al., 1961) and/or Anxiety scale was used during initial assessment and symptoms were listed without etiology, a mood disorder diagnosis would provide context for theoretical empirical interventions to treat the encompassing symptoms. This approach essentially views the victim as broken, and treatment serves to “fix” the impairments according to what is normal of the dominant culture (Hackett, 2014; Rogers-Sirin, 2013). These scales used to measure mood symptoms offer a more specific list of symptoms but without collecting strengths, an incomplete view of the client is being used.

In a color-blind deficit based approach, deficits are typically assumed. Carlat (2016) presumes that the only assumption that can be made in the initial psychiatric interview is that an individual is suffering. Carlat also assumes that the only role that a mental health professional has is to “ease suffering”. This author also believes the purpose of the initial interview is to identify which treatment would be most appropriate for the individual, rather than diagnosis seeking. This approach can meet the needs of clients who are themselves of a deficit mentality (Rashid & Ostermann, 2009). On the other hand, Kilgus, Maxmen and Ward (2016) define MHA as “a time limited, formal process that collects clinical information from many sources in order to reach a diagnosis, to make a prognosis, to render a biopsychosocial formulation, and to determine treatment” (p. 43).

A strengths-based approach can offer more holistic and contextual information about the purpose the worry serves. A common misconception about strength based assessment is that a clinician utilizing this approach highlights strengths while neglecting the deficits (Rashid & Ostermann, 2009). Conversely, strength based assessment seeks to identify both deficits and strengths of a client (Rashid & Ostermann, 2009). Tools that capture the individual's cultural experiences offer even more insight into how the individual perceives themselves as a racial being that could be the difference between a diagnosis of a mood disorder or a psychotic disorder (Pomeroy & Wombach, 2015). A strength based assessment could potentially perceive the excessive worry as a protective factor or survival skill, and include ways to utilize this strength in the treatment plan to achieve the sought-after change. Alternatively, Pomeroy and Wambach (2015) refer to the initial assessment as not one event, but rather as an on-going collaborative understanding between the assessor and assessed gathering info about context, world-view, and desire to change.

Clinical assessment can also be dependent on the scope of practice of the clinician. For example, a psychiatrist is more likely to explore medical related symptoms whereas a clinical counselor is typically focused on psychological and behavioral interventions only. For the purpose of this dissertation, the psychiatric interview was the most appropriate portion of treatment to collect racial experiences as it eludes to understanding and identifying presenting problems for the purpose of diagnosis, prognosis and treatment. More specifically, each clinician has a unique scope of competence in which trainings, experiences and education provides varying levels of understanding and expertise to use with each client.

Included in the scope of competency is the approach or approaches that each clinician uses with clients. Understandably, part of the assessment is to determine which theory would be most appropriate for a particular consumer. During the course of degree obtainment, most mental health providers are taught a variety of theories and how to use each with diverse clients. For each respective theory, the structure of treatment differs. Subsequently assessment practices differ based on the underlying treatment goals of each approach.

### **Cognitive Behavioral Theory**

Cognitive Behavioral Theory (CBT) pioneered by Dr. Aaron Beck (Beck et al., 1961) seeks to assist clients in realizing negative thinking with the goals of changing thoughts and behaviors. Many CBT interventions have been recognized by SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP). NREPP (SAMHSA, 2015) collects a list of evidence based programs and interventions and classifies them on the basis of effective outcomes, promising outcomes, ineffective outcomes, or inconclusive outcomes. NREPP (SAMHSA, 2015) also identifies the specific population in which the treatment was utilized. Although NREPP lists CBT as having multiple legacy items with effective outcomes, there are not any evidence based CBT practices listed specific to the Black community.

Using a CBT approach, clinicians aim at guiding clients to identify and change schemas or interpretations of the world, automatic thoughts and overgeneralizations (Beck et al., 1961). Some of the main interventions of CBT include cognitive restructuring, systematic desensitization, reframing, labeling distortions, Socratic questioning, and finding alternatives (Beck et al., 1961). These interventions are taught collaboratively by the clinician to assist the client in meeting therapeutic goals.

Cognitive restructuring challenges a client to provide evidence for any maladaptive or irrational beliefs, judgements or assumptions (Beck et al., 1961). The goal is to assist the client in making decisions based in fact, rather than the filter of individual past experiences. Systematic desensitization gradually pairs coping skills with an identified stressor. This intervention requires that the clinician have a thorough understanding of the stressor and its effect on the client (Beck et al., 1961).

Reframing often used in a CBT approach offers alternative perspectives to an event, idea or phenomena that are perceived by the client negatively (NREPP, 2015). Labeling distortions focuses on identifying and labeling negative interpretations of events (Beck et al., 1961). Socratic questioning allows a therapist to fully identify the change the client is seeking and explores irrational beliefs and worldviews while simultaneously causing the client to reflect. Finding alternatives is purposefully assisting the client to consider all possible perceptions of an event or possible outcomes.

All of the interventions characteristic of CBT may not be used in the initial assessment, but clinicians well versed in CBT may utilize some upon the first meeting (Beck et al., 1961). The initial goals of the beginning stages of treatment include establishing rapport and creating a safe and supportive environment between the clinician and the client (NREPP, 2015). Typical CBT practitioners provide psychoeducation on the goals of CBT, identify the goals of the client, and use functional analysis during the initial assessment process (Beck et al., 1961).

The functional analysis, typical of a CBT assessment, seeks to find relationships that better explain the target behavior the client is seeking to change (Beck et al., 1961). This approach is not inherently deficit, and perceives the identified behavior as learned through individual experiences. In many ways,

CBT is set up in a way that allows for a thorough understanding of racial experiences if allowed there by a clinician. Appropriate Socratic questioning that collects racial experiences would require a clinician to be knowledgeable of the nuances of the specific culture and what is within normal limits. On the other hand, CBT Socratic questioning paired with reframing and labeling distortions poses risks for subjectivity from clinician bias. CBT clinical interviews also risk the potential for highlighting the negatives if a clinician is not purposefully using a strength-based assessment (Beck et al., 1961).

Szasz (1961) specifically warns of the dangers of clinicians quickly labeling clients and the potential of removing the intricacies that make individuals uniquely human. Although CBT works to label distortions rather than the clients themselves, Rashid and Ostermann (2009) offered that clinicians become experts at identifying deficits in clients. These risks are compounded if a clinician has an underlying racial bias. Rashid and Ostermann (2009) pointed directly to the DSM suggesting that the assessment “labels affliction, anticipation, altruism, and humor as coping mechanisms” (p. 752). These concerns are not restricted to CBT, however, Rashid and Ostermann (2009) proposed the idea that CBT interventions including but not limited to reframing, cognitive restructuring, finding alternatives and labeling distortions, are extremely vulnerable to bias.

### **Client Centered Therapy**

Client Centered Therapy (CCT) also known as person-centered therapy, was created by Carl Rogers in 1940 (Rogers, 2007). CCT is a humanistic, existential theory that focuses on creating congruence between a client’s immediate and idealized self. This therapy technique teaches clients to focus on changing things within their control in the immediate moment rather than focusing on things in the past or future as they cannot be changed (Rogers, 2007). Some of

the main interventions used by CCT clinicians include non-directive therapy, unconditional positive regard, reflective empathy, locus of control, congruence and immediacy (Rogers, 2007).

Non-directive therapy occurs when the clinician meets the client with immediacy where they are without leading the therapeutic discussion (Black, 2005). Unconditional positive regard is a non-judgmental approach to therapeutic discussion in which the clinician uses non-judgmental language so as not to inadvertently persuade the client to perceiving the clinician's perspective of what is acceptable or not acceptable behavior (Rogers, 2007). This intervention allows the client to feel unconditionally respected and attempts to eliminate a possible position of power for the clinician. Reflective empathy is when the clinician is able to accurately interpret the meaning behind verbal communication and reflect the feelings and message back to the client. This intervention allows the client to feel understood (Black, 2005).

Locus of control is an intervention that teaches the client all of the things that the client has control over in the immediate moment (Rogers, 2007). Congruence is the level at which a clinician is able to be transparent and accurately express immediate and genuine feelings, thoughts, and beliefs without a professional barrier. Immediacy is the ability of a clinician to focus on things within the session including behaviors, verbal and non-verbal communication that occurs in the immediate moment (Rogers, 2007).

Although CCT is not inherently strength based, it was designed by Rogers to consider and respect culture (Rogers, 2007). CCT does not purposely collect and use the strengths of the consumer to use to meet client goals; however, the therapeutic relationship between the client and clinician is purposefully collaborative (Black, 2005). This relationship allows for the opportunity to discuss

and collect racial experiences if important to the client. This makes the interpersonal relationship between the client and clinician of utmost importance in order for a CCT approach to be successful.

Blair et al. (2013) studied client perceptions of care and implicit bias regarding race among clinicians using a CCT approach. A separate study was completed prior that examined implicit and explicit bias among clinicians from three healthcare organizations (Blair et al., 2013). The Implicit Association Test (IAT) was used to examine implicit bias and Likert scales were used to identify explicit bias among clinicians. A phone survey was administered to 2,908 clients in Colorado who identified as Black, Latino or White. The clinicians in this study identified as 54% female, 75% White and “50% had more than 10 years of clinical experience” (Blair et al., 2013, p. 45). The results indicated that two-thirds of the clinician sample had implicit bias against individuals who identified as Black or Latino while reporting little explicit bias against either group. Blair et al. also found a strong negative correlation between strong implicit bias for Whites over Blacks among clinicians, and low ratings of perceived interpersonal care among clients.

### **Solutions Focused Theory**

Solutions Focused Theory (SFT) was established in the 1980s by the Mental Research Institute (De Shazer & Dolan, 2012). SFT is an inherently strength-based approach that seeks to assist the client in making changes using innate internal and external strengths. The interventions often used in SFT include exception and miracle questioning, scaling and coping questions, affirmations, and presupposing change (De Shazer & Dolan, 2012). An SFT clinician assumes the role of a coach and uses the aforementioned interventions to both identify and achieve the goals of the client (De Shazer & Dolan, 2012). The ultimate goal of

SFT is to assist the client in using inherent strengths to explore and create solutions for proposed change (Smock et al., 2008).

Exception questioning is an intervention used to assist the client in identifying a time in which they experienced the change that they are seeking (De Shazer & Dolan, 2012). This assists the client in perceiving the change as achievable, provides hope and promotes a more optimistic worldview (Smock et al., 2008). Miracle questioning assists the client in identifying what the change that they are seeking would look like. Questions focus on the client illustrating their life if they miraculously achieved all of the established goals (De Shazer & Dolan, 2012). Scaling questioning is when a clinician asks a client to both create and self-rate a Likert scale to identify what the client perceives as ideal and worst-case scenarios (De Shazer & Dolan, 2012). After the scale is created, the clinician then asks the client to rate where they are currently on the scale they made, and what they would need to achieve the established goals.

Coping Questions are used by a clinician who is working with a client who finds it difficult to have hope for a more positive future. The purpose of this intervention is to both validate the client's experiences and acknowledge the resilience or other strengths that allow them to continue (Corcoran, 2009). With affirmations clinicians acknowledge the progress of a client. Presupposing change is an intervention focused on maintaining the strength-based aspect of this theory. This intervention assists the client in changing deficit thinking and language to use more strength based language. Words like 'problem' are exchanged for 'change' to account for both deficits and strengths (De Shazer & Dolan, 2012).

The initial assessment goals of SFT are identifying both strengths and deficits in the frame of the change that the client is seeking (Corcoran & Pillai, 2009; Kim, 2008). SFT clinicians use strength-based language even upon first

contact so as not to lead client in either directions. The clinician assists the client in illustrating the ideal future to establish goals and includes a proposed plan of using the client's innate strengths to achieve those goals (Corcoran & Pillai, 2009; Kim, 2008).

There is little to no research that currently exists on the effectiveness of a SFT approach within the Black community. Wright, Badesha, and Schepp (2014) use case studies to demonstrate the use of an SFT approach during a risk assessment to determine the necessity for psychiatric hospitalization. Wright et al. purport that even in the riskiest situation, viewing both the deficits and collecting strengths, abilities, resources and hopes allows the clinician to make a more informed and balanced assessment of the client and subsequent needs.

Potential limitations of using an SFT approach during the initial assessment includes the possibility of subjectivity and bias from the clinician. Identifying strengths and assessing the achievability of potential goals requires a clinician to be aware of all possible bias. Some possible benefits of using an SFT approach is that as it is a strength based approach, it allows for the use of tools that can collect cultural experiences (Burkard & Knox, 2004). The beginning phase of SFT seeks achievable goals, strengths and envisioned ideal future (Smock et al., 2008). If a client mentions goals related to race based experiences, this provides an opportunity for SFT clinician to explore how race informs the client's worldview.

The clients reason for referral and type of payment, in addition to the clinicians training and background, and approach used by the clinician does not provide enough insight to account for the inequities faced by Black clients. Empirical research has speculated that Black client beliefs, attitudes or perceptions of mental health services may account for some of the inequities. Although the

clients themselves have no control over the diagnosis given to them during assessment, the perceptions of Black clients has been profusely studied.

### **Perceptions of Black Clients**

Managed care, the reason for referral, clinician discipline and approach have not explained the over representation of Black clients involved with IPMH services or the disparities in diagnosis. The chair of psychiatry at Howard University Dr. Lawson infamously stated at the 2012 National Medical Association Annual Convention and Scientific Assembly “Lower quality care begins at diagnosis” (as cited in Helwick, 2012 p. 3). Black clients have been found to have significantly higher rates of schizophrenia diagnosis, despite being found to have no significant differences when compared to White clients in a blind study that reviewed the cases of 610 psychiatric clients while removing client race (Gara et al., 2012). The study contributes the over diagnosis of psychotic disorders within Black clients to the overvaluing of psychotic symptoms among clinicians. Despite clinicians being in control of client diagnosis, client perspectives have largely been studied to account for possible treatment disparities.

The attitudes and perceptions of mental health services among Black individuals have been studied pretty extensively from the client perspective. Much less has been explored regarding the attitudes and perceptions of Black individuals seeking or receiving mental health treatment from the clinician perspective. Many previous studies explored the ways in which Black individual’s perceptions, attitudes and overall beliefs have influenced seeking and receiving mental health treatment (Pomales et al., 1986; Poston et al., 1991; S. Sue & Zane, 1987; Terrell & Terrell, 1984; Whaley, 2001).

Much of the research conducted focused on Black clients perspectives uses the scale created by Terrell and Terrell (1984). Terrell and Terrell found that early

dropout rates for Black clients was directly related to client trust of the clinician in addition to clinician niceness. Terrell and Terrell identified four ways that Black individuals are mistrustful of White individuals including 1) educational and training settings, 2) political and legal systems, 3) work and business and 4) personal relations, all of which complete the cultural mistrust inventory (CMI). The CMI measures cultural mistrust in each domain and was found to be a significantly correlated to early termination rates among Black clients.

Whaley (2001) hypothesized that the overrepresentation of Black clients in IPMH services was due to a cultural mistrust and subsequent negative attitudes occurring among Black clients towards non-Black service providers. This hypothesis and subsequent study was in response to the disproportionate number of schizophrenia diagnosis among the Black community. Whaley (2001) used the Terrell and Terrell (1981) cultural mistrust inventory to assess Black clients distrust of White clinicians. Of the 154 participants recently admitted to an inpatient psychiatric hospital in NY, 70% agreed with the statement “Black and White clinicians are equally good in diagnosing mental health problems” (Terrell & Terrell, 1981, p. 254). Similarly, 72% of the participants in Whaley’s (2001) study agreed with the statement “People are more comfortable with clinicians of their own ethnic/racial group” (p. 254). Whaley’s study found a significant correlation between high ratings of cultural mistrust and the belief that people are more comfortable with individuals within their own ethnic/racial group. Black clients are unlike White clients in that they are not able to easily access a Black clinician as Black clinicians are underrepresented within the mental health profession.

The underrepresentation of Black clinicians in the field makes it likely that Black clients get a White clinician when seeking OPMH services. Pomales et al.

(1986) also explored the perceptions of Black clients had about White clinicians. Pomales et al. studied the relationship between the racial identity among Black clients and their perceptions of cultural competency among White clinicians. The 54 students participating in the study were characterized as either at the internalization or encounter stages of the Cross (1971) Black development model. The study utilized a “culture-blind” approach rather than a colorblind approach that focused on clinicians who either acknowledged various aspects of an individual's culture or ignored them.

The willingness of a clinician to address the cultural differences with a client of a different culture is referred to as dissimilarity confrontation (S. Sue & Zane, 1987). The participants in the Pomales et al. (1986) study were shown one of two videos featuring a White female clinician working with a Black client who either exhibited culture-blind behaviors or culture-sensitive behaviors and dissimilarity confrontation. In the video that demonstrated a White clinician with cultural sensitivity and dissimilarity confrontation, the clinician acknowledged the client's Blackness and expressed an openness to exploring cultural components of the change the client was seeking (Pomales et al., 1986). The video that featured the clinician with cultural-blind behaviors displayed the clinician ignoring the client's Blackness and did not pursue further exploration of the client's culture. The study hypothesized that Black students in the internalization stage would have a higher tolerance for White clinicians' cultural competency and view the clinicians more equally than the students in the encounter stage.

The Pomales et al. (1986) study found that although the students in the internalization stage did view the clinicians equally, they were rated equally low in cultural competency. The study found that clinicians that exhibited cultural sensitivity were perceived as more competent by all participants. The Pomales et

al. study found that cultural sensitivity was clearly related to perceived competence but not the potential of building a relationship. These differences were identified as a possible limitation of watching a video rather than actually participating in an interview with a clinician. One of the other limitations acknowledged by the Pomales et al. study was the difficulty in generalizing and considering intersectionality as of the 54 participants, 43 were men and only 11 were female. Although this study provided insight to Black males' perceptions of clinician cultural sensitivity as it related to inherent racial identity, the reliability for Black women was low. The final characteristic discussed of the Pomales et al. study found that all participants rated both White clinicians moderately positive at best.

The theme of cultural sensitivity of the clinician and the relationship with Black clients was further explored by Poston et al. (1991). Poston et al. explored any possible links between acknowledging the cultural differences and how comfortable Black clients were self-disclosing with White clinicians. The researchers asked for volunteers among Black individuals utilizing services offered at a Afro-American community center in southern California to respond to a request to assist in evaluating the qualifications of a White applicant for a counseling job at the center. The participants in this study included 31 Black men and 22 Black females (53 Black participants). The design used made up resumes and letters of application that purposefully identified the made-up applicant's sex and method of acknowledging cultural differences (either acknowledging and willing to explore or ignoring).

Poston et al. (1991) used Terrell and Terrell's (1981) CMI to measure cultural mistrust among participants and compared it to the participants' willingness to self-disclose measured by the self-disclosure scale (SDS) and

perceived counselor credibility which was measured using the counselor effectiveness rating scale (CERS). The study found a significant inverse correlation between participant level of mistrust and perceived clinician credibility. The Posten et al. study found willingness to self-disclose, perceived clinician credibility, and clinicians dissimilarity confrontation to be directly correlated although not at statistically significant levels. Intersectionality was considered at the data analysis portion of this study as there was some evidence that found willingness to self-disclose to a White clinician increases with more income and decreases with more education. The study speculated these findings may be due to Black individuals with higher income levels being required to trust White individuals in order to be successful. The education component was speculated as Black individuals who are highly educated may be exposed to more of the oppressions that Black individuals faced by White individuals which may lead to less willingness to self-disclose.

### **Summary**

Research indicates numerous inequities facing Black clients seeking or receiving mental health treatment. The inequities have been explored in comparison to other races, among Black clients from different populations and through the eyes of Black individuals. Many speculations have been made to understand the underrepresentation of Black clients in OPMH services and the overrepresentation of Black clients involved in IPMH services (SAMSHA, 2015). Overarching themes emerge related to the socialization of Black individuals living in the U.S., specifically how race informs the epistemology of Black clients and those who work with them. The perceptions of clinicians working with Black clients have been studied much less in comparison.

## CHAPTER 3: METHODOLOGY

### **Introduction**

Previous studies have demonstrated that Black client experiences of mental health services are different from those of other ethnicities who seek and receive treatment (Helwick, 2012; Pomales et al., 1986; SAMHSA, 2015; Terrell & Terrell, 1984; Whaley, 2001). These differences can contribute to the inequities in access to treatment, quality of care, and subsequent early withdraw from treatment among Black clients (Delphin-Rittmon et al., 2015; Snowden, 2012). These inequities have been previously explored through the eyes of Black clients and the possible role that the inherent perceptions, attitudes and beliefs have had on the therapeutic relationship. Delgado et al. (2013) explained:

Our social world, with its rules, practices, and assignments of prestige and power, is not fixed; rather, we construct with it words, stories and silence. But we need not acquiesce in arrangements that are unfair and one-sided. By writing and speaking against them, we may hope to contribute to a better, fairer world. (p. 3)

Echoing the ideas of the prominent CRT scholars, this study hoped to provide an analysis of the inequities experienced by Black mental health clients through the explorations of the perceptions of mental health clinicians.

### **Purpose of the Study**

The purpose of this study was to explore the worldview of mental health clinicians who have worked with Black clients with the goal of collecting current practices. Specifically, this mixed method study was to explore the perceptions, beliefs and attitudes clinicians have when working with Black clients and understand how these characteristics inform clinical perceptions of effective assessment practices. This study focused on clinicians' perceived effectiveness

when working with Black clients during the mental health assessment portion of treatment. An exploration of clinician implicit racial bias was examined with demographic variables and participant self-reported perceived effectiveness.

### **Research Questions**

The main research questions of this dissertation were as follows:

1. What do Clinicians perceive are effective MHA practices with Black clients?
2. How are perceived effective assessment practices related to the demographic and IAT categories?
3. What is the relationship between implicit racial bias (IAT categories) and perception of clinician effectiveness and clinician characteristics?

### **Participants**

The participants of this study were required to have some previous professional training that made them qualified to conduct mental health assessments. The participants included counselors, therapists, social workers, psychologists, psychiatric nurses and interns, associates, residents and trainees of each profession. The participants self-identified the profession that best described them. The participants represented a variety of racial and ethnic backgrounds. The specific demographics of each participants are listed in chapter 4.

A purposeful sampling method was used to obtain professional participants for this study who have previously provided individual type, mental health services. Mental health clinicians were recruited using snowball method of sampling so as to include as many participants as possible that fit the inclusivity requirements. Participants were asked to have other interested mental health

clinicians email the researcher so that a link for the Qualtrics survey and IAT could be emailed to them.

### **Research Design**

This mixed methods study included both quantitative and qualitative instruments that are discussed in detail. A mixed methods design was chosen to best understand the overall attitudes, perceptions and beliefs of mental health clinicians who work with Black clients and simultaneously obtain best practices. The sequence of the methods utilized included giving the informed consent question first, followed by the demographic questions, then the effectiveness questions with the qualitative question last. After the completion of the qualitative question, participants are asked if they are willing to participate in an interview, and if so to provide contact information. After the completion of the electronic survey, Qualtrics automatically routed participants to complete the private IAT. Those who completed the survey were asked to volunteer to be interviewed which is explained later. Each of these aspects is described in detail in this chapter.

### **Instrumentation**

The quantitative and qualitative instruments are described in this section.

#### **Quantitative**

Three types of quantitative questions were used in the Qualtrics survey. The questions included: demographic questions, effectiveness questions and the IAT. The demographic and effectiveness questions included in the Qualtrics survey were researcher designed. The demographic questions were as seen in Appendix A:

1. What is your gender?
  - a. Female

- b. Male
  - c. Other (Please State)
  - d. Decline to State
2. What is your age
- a. 18-24 years old
  - b. 25-34 years old
  - c. 35-44 years old
  - d. 45-54 years old
  - e. 55-64 years old
  - f. 65-74 years old
  - g. 75 years or older
3. Your ethnicity (Pick one)
- a. White
  - b. Hispanic or Latinx
  - c. Black or African American
  - d. Native American or American Indian
  - e. Asian / Pacific Islander
  - f. Multi-ethnic
4. What is the highest degree you have received?
- a. Trade/technical/vocational training
  - b. Associate's degree

- c. Bachelor's degree
  - d. Master's degree
  - e. Professional degree
  - f. Doctoral/medical degree
5. Which best describes your current profession or internship?
- a. Psychiatrist (e.g., M.D.)
  - b. Psychologist (e.g., Psy.D., Ph.D.)
  - c. Counselor/Therapist (e. g., LMFT, LPCC, MFTI, MFTT, MFCC)
  - d. Social Worker (e. g., LCSW, MSW)
  - e. Mental Health Nurse (Psychiatric nurse/tech, Nurse practitioner)
  - f. Substance Abuse Counselor (e.g., RAS)
6. At what kind(s) of Agency do you currently provide services? Pick One:
- a. County mental health
  - b. Specialty mental health,
  - c. Non-profit organization,
  - d. Private practice
  - e. Other (Specify)
  - f. Multiple (Specify)

7. Do you complete the assessment over the course of multiple sessions? Yes/no
8. What is the average length of time it takes you to conduct a mental health assessment?
  - a. Less than an hour
  - b. 1 to 2 hours
  - c. 2 to 3 hours
9. Approximately how many individual (not family, couples or group) clients did you provide services to last week?
10. Are you currently or in the past year have you provided direct mental health services to an individual client? Yes/No
11. Which entities do your African American clients bill to the most?
  - a. Private Insurance
  - b. Cash
  - c. Medicaid
  - d. Medicare
  - e. Other (Please Specify)\_\_\_\_\_
12. Have you participated in any cultural competency training which included Black culture over the last 5 years (e.g., University courses, conferences, CEUs). Yes/no

The effectiveness questions included in the Qualtrics survey consisted of three questions asking participants to rate their perceived effectiveness. The questions were as follows:

1. On a scale of 1-10 how effective are you during Mental Health Assessments with Black Clients?  
1(not effective) 2 3 4 5 6 7 8 9 10 (highly effective)
2. On a scale of 1-10 how effective are you during Mental Health Assessments with White Clients?  
1(not effective) 2 3 4 5 6 7 8 9 10 (highly effective)
3. On a scale of 1-10 how effective are you during Mental Health Assessments?  
1(not effective) 2 3 4 5 6 7 8 9 10 (highly effective)

These effectiveness questions served as an explicit measure of participant effectiveness. The sequence of the effectiveness questions in the electronic survey was as previously listed.

The final quantitative instrument used was the race IAT. The IAT is an empirical and valid tool that has been used to compare implicit associations for nearly two decades (Greenwald et al., 1998). The IAT procedure was used to measure implicit attitudes using a sorting activity while measuring reaction times. The IAT is favored over explicit measures of attitudes as it is not subject to external factors including what the participant believes is politically correct, influence by the researcher, and other factors that may influence participant attitudes (Gattol et al., 2011). Multiple versions of the IAT have been used to study attitudes regarding products, religions, weight, disabilities and race. Although there are multiple IATs that study a variety of races, this study used the race IAT that uses Black and White races as the measured associations.

The race IAT requires participants to sort traditionally Black and White names as well as Black and White faces while discriminating between pleasant and unpleasant word meanings (Greenwald et al., 1998). The response times during the discrimination activity is measured and results indicate participant implicit racial preference. Table 1 indicates the possible categories that a participant could score on the IAT.

Table 1

*Possible IAT Scores*

Preference for African American			Neutral	Preference for European American		
Strong	Moderate	Slight	No preference	Strong	Moderate	Light

The general IAT procedure was studied by Gattol et al. (2011) and compared to attitudes measured on six attribute dimensions and found to be reliable in measuring attitudes individuals may not be conscious of. The race IAT was compared to three other implicit attitude measures by Cunningham et al. (2001) and found to have convergent validity in measuring implicit attitudes in two confirmatory factor analyses. Although the IAT has demonstrated reliability and convergent validity, Blanton et al. (2009) warn of using the IAT to predict future discrimination behaviors. Blanton et al. analyzed previous studies suggesting that race IAT scores may predict discriminatory behaviors and found poor levels of predictive validity. This study did not use the IAT to predict future behaviors. This study used the IAT only to understand how implicit racial bias may inform on clinical decision making and understanding when working with the Black community.

The validity of the IAT procedure has been sustained by various meta-analyses (Costa, Bandira, & Nardi, 2013; Greenwald, Poehlman, Uhlmann, &

Banaji, 2009; Hofmann, Gawronski, Gschwendner, Le, & Schmitt, 2005). The reliability however of the IAT has been in question particularly by individuals who are taking the test for the first time (Rezaei, 2011). Other studies suggest that any questions regarding the reliability of the IAT are due to the minimal effects of comfortability with the procedure; however, repeated testing increases reliability (Greenwald et al., 2009; Lane, Banaji, Nosek & Greenwald, 2007; Rezaei, 2011).

### **Qualitative**

There were two qualitative instruments used in this study. The qualitative instruments used in this study included one qualitative survey question that follows:

Tell me about a single effective experience in which you conducted a mental health assessment with a Black client. (Possible things to consider: reason for referral, diagnosis, MHA tools used, why was it effective).

The other qualitative instrument used in this study included a semi-structured interview that further explored the explicit attitudes of clinicians working with Black clients. The interview questions were structured to explore the research questions (see Appendix B). The general structure of the questions included:

1. What do you see as the purpose of the assessment?
2. How do you establish rapport/support with your clients during assessment?
3. What makes an assessment successful?
4. How does your approach vary with clients of different ethnic groups?
5. How do you think you scored on the IAT?
6. What does your IAT score mean to you?

7. Did your IAT results change your beliefs about your perceived effectiveness? How so?
8. How do you work differently with Black clients?
9. What recommendations do you have for other clinicians working with Black clients?

This semi-structured format allowed the researcher to further probe when necessary and adapt to the participants (Bailey, 2007).

### **Data Collection**

Prior to beginning the data collection process, the researcher obtained IRB approval from Fresno State University. All participants were required to review the electronic informed consent (Appendix C; Appendix D) that reviews the purpose and procedures of this study. Participants were made aware of any possible risks and the confidentiality of the study. Participants were provided with the contact information of the researcher and the chair of the institutional review board in the event participants had questions related to their rights.

The researcher wrote an email to a variety of organizations requesting participants to contact the researcher via email directly. The organizations contacted by the researcher include the Association of Black Psychologists (ABPsi), the National Institute of Mental Health (NIMH), the counseling services for California State University (CSU) Fresno, CSU Northridge, CSU Fullerton, CSU Long Beach, CSU Dominguez Hills, CSU San Diego, CSU San Marcos, CSU Bakersfield, CSU Los Angeles, CSU East Bay, CSU Humboldt, and various clinics including but not limited to Kings View, Adventist Behavioral Health and Behavioral Health in Kings county, La Ventana Treatment Center in Thousand oaks CA, and other clinics dependent on referrals from participants. The researcher located the list of chapters on the ABPsi website and sent an email to

the contact person informing that person that the researcher is a doctoral student in need of mental health clinicians who have worked with Black clients and are interest in participating in this research study. The researcher asked the organization contact person to email the survey link only to organization members. The researcher asked that the survey not be posted on social media to ensure that only clinicians would respond. A similar method was used when contacting the CSUs health and psychological services center to ensure that only clinicians and student interns were sent an email requesting participants. Individuals who expressed their interest were added to a listserv and later emailed a link with the survey and the IAT.

### **Quantitative**

The survey used to collect data for this study was hosted by Qualtrics. A private link was included after the survey questions that allowed the participant to take the race IAT. Project Implicit, the organization in control of the electronic IAT were contacted by the researcher and asked to use the race IAT. Project Implicit gave support for use of the race IAT in this study.

### **Qualitative**

Participants interested in completing an interview identified themselves at the end of the survey by providing contact information. Interviews took place over the phone with the use of google voice which allowed for the interview to be recorded, and in person using a Macbook and microphones to record the audio responses. Selection for the interviews were based on implicit racial preference and participant ethnicity. Table 2 indicates the intended individuals who were to be selected to participate in the interviews.

Table 2

*Interview Participants by Identity and IAT Score*

Identity by IAT Score	Preference for Black	Do not Prefer Black
White Participants	2 Interviews	2 Interviews
Black Participants	2 Interviews	2 Interviews
Other Participants	2 Interviews	2 Interviews

There was a focus on early returns in identifying interviewees. The open-ended interview questions served as guidelines to be asked during the interview with subsequent probing questions as needed. The interview was conducted and the participants were thanked and informed of how to access the results in the future. The mp3 files of the recorded interview were sent to be transcribed by an online human transcription services called Rev.com. The interviews were reviewed for edits.

### **Data Analysis**

This mixed methods study analyzed both quantitative and qualitative data; however, the study provided information and captured perceptions, beliefs and attitudes of clinicians working with Black clients. The main data intended by this study was the perceived effectiveness among clinicians working with Black clients. Overall perceptions of White clients effectiveness was also collected for comparative purposes. The data analyzed only includes completed surveys and interviews. The quantitative and qualitative data were analyzed differently using different software.

### **Quantitative**

Demographic data were reported along with effectiveness and perceptions. Crosstabs with frequencies and percentages were calculated to compare

demographic data and effectiveness scores from the survey to IAT categories. A Multivariate ANOVA (MANOVA) was used to address the research question: What is the relationship between implicit racial bias (IAT categories) and perception of clinician effectiveness and clinician characteristics? The three dependent variables for the MANOVA included the mean scores for:

1. Overall perceived effectiveness
2. Perceived effectiveness with White clients
3. Perceived effectiveness with Black clients

The effectiveness DVs were scored using a Likert scale of 1 (low) to 10 (high). Two MANOVA's were completed, one with all IAT categories (slight, moderate, strong preferences for European American and African American and no preference) and the other MANOVA with the condensed IAT categories (preference for European Americans, no preference and preference for African American). The independent variable for the MANOVA was the categories of racial preferences specified by the IAT simplified to the three levels of 1 for Black, 2 for no preference and 3 for White because there was insufficient data to do analyses with all seven categories given above. A chi-square test of independence was used to determine significant relationships between condensed categories. The categorical variables include Type of payment; MHA multiple sessions; Length of MHA; Age; Gender; Ethnicity; Highest Degree Earned; Profession Type; Cultural Competency Training; Agency; Individual experience within last week; and IAT results. These categories correspond with questions 3-14 on the survey.

### **Qualitative**

Qualitative research methods are used to gain understanding of the subtleties of human behavior (Creswell, 2014). In this study, the human behavior

explored includes the perceptions of effectiveness among clinicians working with Black clients. This study used grounded theory to collect as much information as possible then later analyzes how it all fits together to create meaning as explained by Glaser (1978). The qualitative data were analyzed using NVIVO software to code the themes identified by the researcher. Both substantive and theoretical codes were identified using open and selective coding as described by Glaser (2001). Multiple responses were coded multiple times depending on the emergent themes of the data. Even if only a limited number of clinicians participated in the study, Bhattacharya (2017) explains that individuals who do participate in qualitative research will reveal individual epistemology and how they have come to understand their experiences as truths. The phone interviews were recorded and transcribed for further coded using NVivo software. NVivo software is specifically designed to assist in the coding and organizing process in mixed methods or qualitative studies (QSR International, n.d.).

The reliability and validity of qualitative research is largely dependent on objectivist truths. Bhattacharya (2017) identifies that epistemology is developed through experiences and creates the ways in which individuals perceive the world. Truth, reality and meaning therefore are subjective and cannot be generalized as each individual has unique experiences. Bhattacharya (2017) explains “The assumption in this kind of knowledge making is that with appropriate processes, verifiable information can be recorded and reported objectively, and repeatedly with similar results, thus generating predictability and generalizability” (Bhattacharya, 2017, p. 1).

The qualitative questions in this study largely depended on trusting the participants to be honest about previous experiences with Black clients. The reliability in this study was largely dependent on the principles specified by the

CRT theoretical framework. Creswell (2014) identifies that issues of validity in qualitative studies include trustworthiness, credibility and authenticity. The use of multiple procedures of the survey and the subsequent interviews increases the validity of the design. The electronic survey served to minimize the possibility that participants feel influenced by the race of the researcher.

### **Delimitations of the Study**

As mentioned in the literature review, Black individuals are underrepresented in OPMH services and over represented in IPMH services (SAMSHA, 2015). The inclusion of only Black clients limited the possibility that clinicians have worked with the desired emphasized populations. Nonetheless, OPMH services was chosen to gauge the perceptions of Black clients to understand experiences of perceived effectiveness during assessment. Assessment was the chosen section of treatment as literature denotes that Black clients have high dropout rates so the likelihood of exploring a consistent understanding of effectiveness during any other portion of treatment was less than that of the assessment portion.

The specific professions that were chosen as the respective ethical organizations included mental health assessment as an ethical and legal standard prior to treatment. Mental health case managers were not included because the scope of practice does not include mental health assessments. Finally, individual treatment mode was chosen as a majority of managed care policies include individual therapy as meeting medical necessity. Many managed care policies typically specify that medical necessity criteria be met. Family or couple's modes of therapy may not be included in the managed care policy. This study wanted to be inclusive of clinicians working with a variety of SES backgrounds, thus individual mode of therapy was chosen. It is worth noting that Marxist Criticism

was considered as a lens to view the relevant topics in mental health; however, it was determined that even the socio-economic and class differences could be further attributed to historical prevalence of systemic racism including slavery.

The final delimitation that has been previously discussed is that this research study only focuses on Black and White inherent biases. Many other races exist and will hopefully be included in this study; however, due to the nature of the specific IAT used, a binary exists with this study. This specific IAT was chosen to provide specificity and further research using alternative race IATs is encouraged.

### **Limitations of the Study**

This study attempted to include various clinicians working all over the U.S. The professions may have different names and managed care policies dependent on the State. This might have limited the selection criteria of participants included in the data analysis. This study was limited due to the underrepresentation of Black individuals as mental health professionals. A majority of respondents come from California as this is the researcher's state of origin and more resources are known in that state.

One limitation concerns the ability to take the case studies as fact. Trustworthy information is desired but participants may want to say what is politically correct as only the quantitative section collects implicit attitudes. Bhattacharya (2017) explains that qualitative research is not concerned with fact, but rather accepts the truths collected as unique understandings of individual truths based on experiences. The implicit racial bias in this study is not a measure of individual prejudice, but is better explained by individual experience and exposure. Lastly, researcher bias informs on the entire dissertation and presents a unique limitation based on the researcher's experiences.

The final limitation identified in this study was the small number of participants who completed the IAT. After completion of the Qualtrics survey, participants were re-directed to complete the IAT. Some participants expressed to the researcher that they stopped with the IAT, and exited the browser prior to completion. Participants also expressed feeling nervous while taking the IAT and leaving with the plans of returning later so as to better focus, but participants are not allowed to return. Participants also expressed to the researcher that the IAT did not properly load after completion of the Qualtrics study. As a result, nearly half of the participants who completed the Qualtrics survey did not complete the IAT. The full IAT (seven levels) was unable to be used for statistical analysis due to small number of participants. The condensed IAT categories (Prefer European Americans, No Preference, and Preference for African Americans) were used for most of the statistical analyses.

### **Positionality Statement**

This study was informed by the worldview of the researcher who identifies as a Black woman. The researcher works as a mental health clinician in a non-profit community mental health clinic as a crisis worker who conducts psychiatric evaluations to determine the necessity of inpatient psychiatric hospitalization, as well as conducts screenings to determine eligibility for services on the basis of “medical necessity.” The experiences of many of the Black clients who were served at the clinic were expressed to the researcher, assumingly because of the researcher’s apparent race.

The researcher’s background in social justice began long before becoming a mental health professional. Growing up in predominantly White private and public schools, the researcher became aware of the differences of experiences of individuals within the Black community compared to individuals not in the Black

community at a very early age. Eventually struggling with internalized oppression led to the researcher's first referral for mental health services. The researcher's experience with OPMH services, specifically with a non-Black service provider, was one that could be described overall as positive. The specific racial stress of the researcher was not addressed by the mental health service provider, and the researcher went through all of the stages of Cross's (1971) racial identity development model.

During the researcher's academic career, other members from the Black community shared similar racial experiences and opposition to OPMH services. Multiple layers of oppression and fear of further oppression was the overarching theme expressed of Black individuals who opposed OPMH services. As a member of the community with inherent privileges as a mental health clinician, the researcher chose to use the privilege to serve the Black community by challenging the healthcare system to aspire to better meet the needs of its Black clients. This research study hopes to challenge the dominant and deficit narratives that exist both empirically and socially that blame Black clients for their poor treatment outcomes in mental health.

## CHAPTER 4: RESULTS/OUTCOMES

The purpose of this mixed methods exploratory study was to identify clinician explicit and implicit preferences, and practices and perceptions of African Americans participating in mental health assessments. Critical Race Theory (CRT) was the framework that served as a lens to understand the relationship among race and mental health services. The focal point of this study included self-reported beliefs, practices and perceptions of clinician effectiveness as well as the implicit racial preference as measured by the Implicit Associations Test (IAT).

The results of this mixed methods exploratory study consist of two parts that were examined separately: quantitative and qualitative components. The quantitative analysis examined clinician demographics as they relate to perceived effectiveness with Black clients during assessment. The qualitative analysis explored clinician responses of perceived effectiveness during the assessment portion of mental health treatment with Black clients. The data were gathered from various mental health professionals who voluntarily participated in an electronic survey, IAT, and subsequent interviews.

### **Quantitative Analysis**

The quantitative analysis aimed at answering the following research questions:

1. How are perceived effective assessment practices related to the demographic and IAT categories?
2. What is the relationship between implicit racial bias (IAT categories) and perception of clinician effectiveness and clinician characteristics?

The electronic survey was concerned with three types of quantitative information including demographic information, clinician self-reported effectiveness, and the IAT. The data were reported based on these three categories. It is noted that there were very few participants who completed the IAT. In order to identify participant implicit racial preference, the IAT requires completion of all activities. Some participants expressed to the researcher that they felt overwhelmed or anxious when taking the IAT and stopped as they wanted more time to focus. These participants were not scored as they did not finish the IAT. Other participants expressed, after the completion of the survey, that the IAT screen did not load properly, preventing them from completing the IAT. The quantitative results of this study only include the 43 participants who completed the IAT in its entirety.

### **Characteristics of the Participants**

The survey yielded data from 87 participants, 74 of whom met the minimum requirements to participate. Of the 74 participants who met the minimum requirements, not all answered every survey question. The participants also included students who although qualified, have not yet completed mental health assessments by themselves. Of the 74 participants, 25 agreed to participate in the interview, with 22 who provided contact information and four participants who met the identified goals for interview. Table 3 demonstrates the yield of participants by race and IAT score who also agreed to participate in an interview.

Table 3

#### *Interview Volunteers Yielded by Survey*

Identity by IAT Score	Preference for Black	Do not Prefer Black
White Participants	None Yielded	2 Interviews
Black Participants	1 Interview	None Yielded
Other Participants	None Yielded	1 Interviews

### Demographic Information

The participants in the Qualtrics survey included 57 (77.03%) female and 17 (22.97%) male participants for a total of 74. The age of the participants varied with a majority in the 22-34 age group at 51.39%, and the 35-44 age group next at 26.39%. The 18-24 and the 45-54 age groups each consisted of 6.94%, with the 65-74 age group following at 5.56% and the smallest age group being 55-64 consisting of only 2.78% of the group. Table 4 presents demographic information of the participant gender and age. Table 5 presents the ethnicities and highest completed degrees of the participants. The ethnicities with the most participants are White ( $n=27$ , 37.50%) and Hispanic/Latinx ( $n = 25$ , 34.72%). The degrees held most by participants are master's degrees ( $n=34$ , 47.22%) and bachelor's degrees ( $n = 24$ , 33.33%). Table 6 presents the participant professions and agency types. The profession with the highest frequency of participants are Counselor/Therapist ( $n = 53$ , 77.94%), and non-profit organizations ( $n = 27$ , 40.30%) have the highest frequency for agencies.

Table 4

#### *Frequencies and Percentages of Gender and Age*

Characteristic	Demographic	Frequency	Percent
Gender	Male	17	22.97
	Female	57	77.03
	Other (Please State)	0	
	Decline to State	0	
	Total	74	100.00
Age	18-24 years old	5	6.94
	25-34 years old	37	51.39
	35-44 years old	19	26.39
	45-54 years old	5	6.94
	55-64 years old	2	2.78
	65-74 years old	4	5.56
	75 years or older	0	0.00
	Total	72	100.00

Table 5

*Frequencies and Percentages of Ethnicity and Degree*

Characteristic	Demographic	Frequency	Percent
Ethnicity	White	27	37.50
	Hispanic or Latinx	25	34.72
	Black or African American	10	13.89
	Native American, Indigenous or Alaska Native	1	1.39
	Asian/Pacific Islander	5	6.94
	Multi-ethnic	4	5.56
	Total	72	100.00
Degree	Trade/technical/vocational training	0	0.00
	Associate Degree	1	1.39
	Bachelor's Degree	24	33.33
	Master's Degree	34	47.22
	Professional Degree	1	1.39
	Doctoral/Medical Degree	12	16.67
	Total	72	100.00

Table 6

*Frequencies and Percentages of Profession and Agency Type*

Characteristic	Demographic	Frequency	Percent
Profession/internship	Psychiatrist	0	0.00
	Psychologist	6	8.82
	Counselor/Therapist	53	77.94
	Social Worker	5	7.35
	Mental Health Nurse	3	4.41
	Substance Abuse Counselor	1	1.47
	Total	68	
Agency Type	County mental health	18	26.87
	Specialty mental health	2	2.99
	Non-profit organization	27	40.30
	Private practice	8	11.94
	Other	12	17.91
	Multiple	0	0.00
	Total	67	100.00

A total of 95.52% of participants provided direct mental health services to individuals. A large majority of the sample at 86.57% ( $n=67$ ) reported participating in a cultural competency training that included Black culture within the last year. The respondents were also asked if they completed Mental Health Assessments (MHA) over the course of multiple sessions to which 63.24% responded “Yes” and 36.76% responded “No.” A majority of participants (67.16%) reported they complete MHAs in 1 to 2 hours, while 23.88% complete the MHA in 2 to 3 hours and only 8.96% of the sample completing a MHA in less than an hour. Table 7 identifies the modes of payment of African American clients identified by respondents with Medicaid ( $n = 19$ , 32.76%) and Medicare ( $n = 12$ , 20.69%) having the highest frequencies.

Table 7

*Frequencies and Percentages of Payment Types of African American Clients*

Characteristic	Demographic	Frequency	Percent
Payment Types	Private Ins.	5	8.62
	Cash	5	8.62
	Medicaid	19	32.76
	Medicare	12	20.69
	Other	22	37.93
	Total	63	100.00

### **Perceived Effectiveness of Mental Health**

#### **Assessments**

The clinicians were asked to self-report perceived effectiveness in the following three domains: 1) MHA portion of treatment; 2) MHA with White clients and 3) MHA with Black clients. A 10-point Likert scale was used to measure explicit effectiveness for each domain. Table 8 presents the effectiveness variables associated with each domain of the MHA. The mean effectiveness for a

MHA was 8.02 with a standard deviation of 1.15. The mean effectiveness for a MHA with White clients was 7.66 with a standard deviation of 1.46. The mean effectiveness for a MHA with Black clients was 7.08 with a standard deviation of 1.59. Table 8 presents the overall means and standard deviations for perceived effectiveness of the MHA (MHA, MHA with White clients, MHA with Black clients) for all participants.

Table 8

*Means and Standard Deviations for Perceived Effectiveness of a MHA*

Variable	Mean	Standard Deviation
MHA	8.02	1.15
MHA with White Clients	7.66	1.46
MHA with Black Clients	7.08	1.59

### **IAT Levels and Condensing**

The IAT was conducted after the electronic survey was completed. Participants who did not fully complete the IAT were not able to be scored. A total of 43 participants completed the IAT successfully and were then given a score. Table 9 presents the full IAT categories and the missing data. Table 10 indicates the frequencies and percentages of the condensed IAT scores. Since there were so few IAT scores, they were condensed into categories that consist of preference for European Americans, no score/missing data and preference for African Americans. The condensed categorization assists in identifying relationships with other variables in the study and avoids the problems associated with empty cells and chi-square analyses (Marascuilo & McSweeney, 1977).

Table 9

*Frequencies and Percentages of full IAT Scores and Missing Data*

Categories	IAT Score	Frequency	Percent
Pref. for European Am.	Strong	6	7.2
	Moderate	17	20.5
	Slight	6	7.2
No Preference		6	7.2
Pref. for African Am.	Slight	1	1.2
	Moderate	5	6.0
	Strong	2	2.4
No score / Missing data		40	48.2
	Total	83	100

Table 10

*Frequencies and Percentages of Condensed IAT Scores and Missing Data*

IAT Score	Frequency	Percent
Preference for European Am.	29	34.9
No Preference	6	7.2
Preference for African Americans	8	9.6
No score/Missing data	40	48.2
Total	83	100

**Multivariate Analysis for Full IAT**

A Multivariate Analysis of Variance (MANOVA) was completed to test for differences among the effectiveness responses for each dependent variable (MHA, MHA with a White client, MHA with a Black client) and all levels of IAT scores. The seven levels included for the full IAT include (1) strong, (2) moderate, and (3) slight preferences for European Americans, (4) no preference, and (5) slight, (6) moderate, and (7) strong preferences for African Americans. Table 11 presents the means and standard deviations for self-reported perceived effectiveness by full IAT score. The MANOVA test for differences between IAT scores, on self-reported perceived effectiveness was not significant, Pillai's Trace=.446,  $F(18,99) = .961$ ,  $p=.509$ ,  $\eta^2 = .149$ ; Wilk's Lambda=.605,  $F(18,88) = .951$ ,  $p=.522$ ,  $\eta^2 =$

.154; Hotelling's Trace=.570,  $F(18,89)=.939$ ,  $p=.535$ ,  $\eta^2 = .160$ ; Roy's Largest Root=.387,  $F(6,33) =2.129$ ,  $33$ ,  $p=.076$ ,  $\eta^2=.279$ .

Table 11

*Means and Standard Deviations for self-reported effectiveness by IAT score*

Category	IAT Score	MHA		White MHA		Black MHA	
		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Prefer European Am.	Strong	6.40	.894	7.60	1.517	7.80	.837
	Moderate	6.71	1.312	7.94	1.144	8.18	1.131
	Slight	7.17	1.941	7.83	1.169	8.33	1.033
No Pref.	No Preference	7.60	1.817	7.00	3.536	8.40	1.140
	Slight	8.00		8.00		8.00	
Prefer African Am.	Moderate	8.00	1.414	7.00	.816	7.75	.500
	Strong	9.50	.707	9.00	1.414	9.00	1.414
	Total	7.15	1.528	7.73	1.601	8.18	1.010

### Univariate Results for Full IAT

The univariate results for the full IAT scores appear in Table 12. The univariate results for MHA were not significant ( $F(6,33) = 1.734$ ,  $p=.144$ , partial  $\eta^2 = .240$ ). The univariate results for MHA with White clients were not significant ( $F(6,33) = .544$ ,  $p=.771$ , partial  $\eta^2 = .090$ ). The univariate results for MHA with Black clients were not significant ( $F(6,30) = .485$ ,  $p = .815$ , partial  $\eta^2 = .081$ ).

Table 12

*Summary of Univariate Results*

Source	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>	Partial $\eta^2$
MHA	21.837	6, 33	3.640	1.734	.144	.240
Error	69.263		2.099			
White MHA	9.000	6, 33	1.500	.544	.771	.090
Error	90.975		2.757			
Black MHA	3.221	6, 30	.537	.485	.815	.081
Error	36.554		1.108			

### Multivariate Analysis by Condensed IAT

Due to the large amount of missing data a second series of analyses was run using the condensed IAT as the independent variable. Condensed IAT levels include Prefer European Americans, no preference, and Prefer African Americans. A Multivariate Analysis of Variance (MANOVA) was completed to test for differences among the effectiveness responses for each dependent variable (MHA, MHA with a White client, MHA with a Black client) and condensed levels of IAT scores. Table 13 presents the means and standard deviations for the condensed IAT scores by perceived effectiveness. The MANOVA test for differences between condensed IAT scores, on self-reported perceived effectiveness was significant, Pillai's Trace=.336,  $F(6,72) = 2.422$ ,  $p=.035$ ,  $\eta^2 = .168$ ; Wilk's Lambda=.684,  $F(6,70) 2.439$ ,  $p=.034$ ,  $\eta^2 = .173$ ; Hotelling's Trace=.433,  $F(6,68)=2.452$ ,  $p=.033$ ,  $\eta^2 = .178$ ; Roy's Largest Root= .349,  $F(3,36) =4.193$ , 36,  $p=.012$ ,  $\eta^2=.259$ .

Table 13

#### *Means and Standard Deviations for Condensed IAT Score by Perceived Effectiveness*

Category	IAT Score	MHA		White MHA		Black MHA	
		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Prefer	European	8.14	1.044	7.86	1.177	6.75	1.378
No	Preference	8.40	1.140	7.00	3.536	7.60	1.817
Prefer	African American	8.14	.900	7.71	1.254	8.43	1.272
	Total	8.18	1.010	7.73	1.601	7.15	1.528

### Univariate Results for Condensed IAT

Table 14 presents the means and standard deviations for MHA variables by condensed IAT levels. The univariate results for overall MHA were not significant ( $F(2,37) = .136$ ,  $p = .874$ , partial  $\eta^2 = .007$ ). The univariate results for MHA with

White clients were not significant ( $F(2,37) = .596, p = .556, \text{partial } \eta^2 = .031$ ). However, the univariate results for MHA with Black clients were significant ( $F(2,37) = 4.225, p = .022, \text{partial } \eta^2 = .186$ ) with the preference for African Americans group being the highest ( $M = 8.43$ ) and the preference for European Americans group being the lowest ( $M = 6.75$ ).

Table 14

*Summary of Univariate Results for Condensed IAT*

Source	Sum of Squares	df	Mean Square	F	p	Partial $\eta^2$
MHA	.289	2, 37	.145	.136	.874	.007
Error	39.486		1.067			
White MHA	3.118	2, 37	1.559	.596	.556	.031
Error	96.857		2.618			
Black MHA	16.936	2, 37	8.468	4.225	.022	.186
Error	74.164		2.004			

### Chi Square Results

All chi-square analyses were conducted with the condensed IAT levels to avoid problems due to too many empty cells (Marascuilo & McSweeney, 1977). The frequencies and percentages of condensed IAT scores and gender appear in Table 15. Gender is not dependent on condensed IAT score ( $\chi^2(2) = 3.070, p = .215$ ).

Table 15

*Frequencies and Percentages by Condensed IAT Score and Gender*

Gender	Number and Percent	Prefer			Total
		European Americans	No Preference	Prefer African Americans	
Female	N	21	4	8	33
	%	48.8%	9.3%	18.6%	76.7%
Male	N	8	2	0	10
	%	18.6%	4.7%	0.0%	23.3%
Total	N	29	6	8	43
	%	67.4%	14%	18.6%	100%

The frequencies and percentages of condensed IAT scores and age appear in Table 16. Age is not dependent on condensed IAT score ( $\chi^2(10) = 17.503$ ,  $p = .064$ ).

Table 16

*Frequencies and Percentages by Condensed IAT Score and Age Group*

Age Group	Number and %	Prefer Europeans	No Preference	Prefer African Americans	Total
18-24	N	1	0	0	1
	%	2.3%	0.0%	0.0%	2.3%
25-34	N	16	1	4	21
	%	37.2%	2.3%	9.3%	48.8%
35-44	N	9	2	3	14
	%	20.9%	4.7%	7.0%	32.6%
45-54	N	2	0	1	3
	%	4.7%	0.0%	2.3%	7.0%
55-64	N	1	1	0	2
	%	2.3%	2.3%	0.0%	4.7%
65-74	N	0	2	0	2
	%	0.0%	4.7%	0.0%	4.7%
Total	N	29	6	8	43
	%	67.4%	14.0%	18.6%	100.0%

The frequencies and percentages of condensed IAT scores and ethnicity appear in Table 17. Ethnicity is significantly dependent on condensed IAT score ( $\chi^2(10) = 25.451$ ,  $p = .005$ ). For this test, Asian/Pacific Islanders, Hispanic/Latinx, Multi-Ethnic and Whites prefer Europeans, while Blacks and Native American/Indigenous/ Alaskan Native prefer African American.

The frequencies and percentages of condensed IAT scores and degree appear in Table 18. Degree is not significantly dependent on condensed IAT score ( $\chi^2(8) = 14.420$ ,  $p = .071$ ).

Table 17

*Frequencies and Percentages of Condensed IAT Score and Ethnicity*

Ethnicity/IAT	Number and %	Prefer Europeans	No Preference	Prefer African Americans	Total
Asian/Pacific Islander	N	3	0	0	3
	%	7.0%	0.0%	0.0%	7.0%
Black or African American	N	0	1	4	5
	%	0.0%	2.3%	9.3%	11.6%
Hispanic/Latinx	N	9	1	3	13
	%	20.9%	2.3%	7.0%	30.2%
Multi-ethnic	N	2	1	0	3
	%	4.7%	2.3%	0.0%	7.0%
Native American/ Indigenous/ Alaskan Native	N	0	0	1	1
	%	0.0%	0.0%	2.3%	2.3%
White	N	15	3	0	18
	%	34.9%	7.0%	0.0%	41.9%
Total	N	29	6	8	43
	%	67.4%	14.0%	18.6%	100.0%

Table 18

*Frequencies and Percentages of Condensed IAT Score and Degree*

Degree	Number and %	Prefer Europeans	No Preference	Prefer African Americans	Total
Associate	N	1	0	0	1
	%	2.3%	0.0%	0.0%	2.3%
Bachelor's	N	4	1	2	7
	%	9.3%	2.3%	4.7%	16.3%
Doctoral/ Medical	N	2	2	3	7
	%	4.7%	4.7%	7.0%	16.3%
Master's	N	22	2	3	27
	%	51.2%	4.7%	7.0%	62.8%
Professional	N	0	1	0	1
	%	0.0%	2.3%	0.0%	2.3%
Total	N	29	6	8	43
	%	67.4%	14.0%	18.6%	100.0%

The frequencies and percentages of condensed IAT scores and profession are presented in Table 19. Profession is significantly dependent on condensed IAT score ( $\chi^2(8) = 17.529$ ,  $p = .025$ ). For this test, Counselors prefer Europeans while Psychologists, although their numbers are low, prefer African Americans.

The frequencies and percentages of condensed IAT scores and agency type are presented in Table 20. Agency type is not significantly dependent on condensed IAT score ( $\chi^2(8) = 10.636$ ,  $p = .223$ ).

Table 19

*Frequencies and Percentages of Condensed IAT Score and Profession*

Profession	Number and %	Prefer Europeans	No Preference	Prefer African Americans	Total
Counselor	N	24	5	4	33
	%	55.8%	11.6%	9.3%	76.7%
MH RN	N	1	1	0	2
	%	2.3%	2.3%	0.0%	4.7%
Psychologist	N	1	0	3	4
	%	2.3%	0.0%	7.0%	19.3%
Social Worker	N	3	0	0	3
	%	7.0%	0.0%	0.0%	7.0%
Unanswered	N	0	0	1	1
	%	0.0%	0.0%	2.3%	2.3%
Total	N	29	6	8	43
	%	67.4%	14.0%	18.6%	100.0%

Table 20

*Frequencies and Percentages of Condensed IAT Scores and Agency Type*

Agency	Number and %	Prefer Europeans	No Preference	Prefer African Americans	Total
County MH	N	12	2	0	14
	%	27.9%	4.7%	0.0%	32.6%
Non- Profit	N	11	1	3	15
	%	25.6%	2.3%	7.0%	34.9%
Other	N	3	1	3	7
	%	7.0%	2.3%	7.0%	16.3%
Private Practice	N	2	2	2	6
	%	4.7%	4.7%	4.7%	14.0%
Specialty MH	N	1	0	0	1
	%	2.3%	0.0%	0.0%	2.3%
Total	N	29	6	8	43
	%	67.4%	14.0%	18.6%	100.0%

The frequencies and percentages of condensed IAT scores and participation in a cultural competency training that discussed African American culture (yes/no) are presented in Table 21. Participation in a cultural competency training is not significantly dependent on condensed IAT score ( $\chi^2(2) = .750, p = .687$ ).

The frequencies and percentages of MHA completed over the course of multiple sessions and condensed IAT scores appear in Table 22. Completing a MHA over multiple sessions are not dependent on condensed IAT score ( $\chi^2(2) = 1.203, p = .548$ ).

Table 21

*Frequencies and Percentages of Condensed IAT Score and Completion of Training*

Condensed IAT / Training	Number and %	Prefer European American	No Preference	Prefer African American	Total
Yes	N	26	6	7	39
	%	60.5%	14.0%	16.3%	90.7%
No	N	3	0	1	4
	%	7.0%	0.0%	2.3%	9.3%
Total	N	29	6	8	43
	%	67.4%	14.0%	18.6%	100%

Table 22

*Frequencies and Percentages by Condensed IAT Score and MHA Completed Over Multiple Sessions*

Condensed IAT / MHA Multiple SSN	Number and %	Prefer European American	No Preference	Prefer African American	Total
Yes	N	16	3	6	25
	%	37.2%	7.0%	14.0%	58.1%
No	N	13	3	2	18
	%	30.2%	7.0%	4.7%	41.9%
Total	N	29	6	8	43
	%	67.4%	14.0%	18.6%	100%

The frequencies and percentages of condensed IAT scores and reported time needed to complete a MHA appear in Table 23. Time to complete MHA is not dependent on condensed IAT score ( $\chi^2(6) = 9.327, p = .156$ ).

The frequencies and percentages of MHA type of payments and condensed IAT scores appear in Table 24. Type of payments are not dependent on condensed IAT score ( $\chi^2(10) = 12.630, p = .245$ ).

Table 23

*Frequencies and Percentages by Condensed IAT Score and Hours for MHA*

Length of MHA	Number and %	Prefer European Americans	No Preference	Prefer African Americans	Total
1 to 2 hrs	N	19	5	4	28
	%	44.2	11.6%	9.3%	65.1
2 to 3 hrs	N	9	0	3	12
	%	20.9%	0.0%	7.0%	27.9%
<1 hr	N	1	1	0	2
	%	2.3%	2.3%	0.0%	4.7%
Total	N	29	6	8	43
	%	67.4%	14%	18.6%	100%

Table 24

*Frequencies and Percentages by Condensed IAT Score and Payment Type*

Payment Type	Number and %	Prefer European Americans	No Preference	Prefer African Americans	Total
Cash	N	2	1	1	4
	%	4.7%	2.3%	2.3%	9.3%
MediCaid	N	9	2	3	14
	%	20.9%	4.7%	7.0%	32.6%
MediCare	N	7	1	2	10
	%	16.3%	2.3%	4.7%	23.3%
Private	N	0	2	1	3
	%	0.0%	4.7%	2.3%	7.0%
Other	N	10	0	1	11
	%	23.3%	0.0%	2.3%	25.6%
Total	N	29	6	8	43
	%	67.4	14.0%	18.6%	100.0%

**Qualitative Analysis**

The qualitative analysis used an inductive approach focused on the following research question: *What do Clinicians perceive are effective MHA practices with Black clients?* This research question provides information about what is actually being applied to gain an understanding of what clinicians are

using with Black clients during the assessment portion of treatment. This question also provided a foundation for the coding process. The responses that were coded include the qualitative survey question and the interview responses. A constructivist grounded theory approach (Strauss & Corbin, 1998) was used to analyze the data from interviews and the qualitative survey question.

### **Survey Results**

The qualitative research prompt included in the survey was: *Describe a single effective mental health assessment with a Black client. (Be specific and provide details about why this assessment was effective. Possible things to consider: reason for referral, MHA tools used, diagnosis, why was it effective).*

The qualitative survey question responses were analyzed thoroughly using open, axial and selective coding to group the emergent themes. The themes that emerged were then categorized based on IAT score.

The inductive nature of the survey question brought up a variety of responses from participants. Participants identified specific practices that aided in effectiveness during the MHA with Black clients. These specific practices identified by participants were coded within a specific theme of Clinician Identified Effectiveness. Respondents also explained current practices with Black clients. The other main theme includes Clinician Practices. Table 25 identifies both themes and the sub-themes that emerged from each identified theme.

The coding themes and sub-themes emerged as many of the participants identified similar practices that occur during the MHA portion of treatments with Black clients. At times, respondents indicated dissonance between beliefs of effectiveness and current practices. Participant responses are organized under each theme and sub-theme to gain an understanding of the current practices believed to

Table 25

*Thematic Coding Matrix for Survey Question*

Themes	Subthemes
Clinician Identified Effectiveness	Dissimilarity Confrontation Use of Specific Interventions Awareness of Bias Explicitly inquiring about Cultural/Racial Info
Clinician Practices	Prioritization the MHA External Locus of Control Internal Locus of Control Deductive Approach Inductive Approach

be effective by mental health clinicians working with Black clients. Sample responses are organized by condensed IAT scores.

**Clinician identified effectiveness.** The research questions for this study focused on clinician perceived effectiveness. Participants identified many explanations of what worked with Black clients during the MHA. The main sub-themes that emerged were identified by clinicians include Dissimilarity Confrontation, Use of Specific Interventions, Awareness of Bias and Explicitly inquiring about Cultural/Racial Experiences. These sub-themes are explained further and demonstrated using the participants own words.

***Dissimilarity confrontation.*** Dissimilarity confrontation refers to the clinician addressing the cultural differences with a client from a differing culture (S. Sue & Zane, 1987). Many participants expressed addressing the cultural differences with Black clients aided in perceived effectiveness. Although clients did not explicitly state they used “dissimilarity confrontation” the responses indicate that this practice may be common among clinicians working with Black

clients. Participants of differing condensed IAT scores identified practicing dissimilarity confrontation.

*Preference for European Americans.* On the question of dissimilarity confrontation, one clinician with a preference for European Americans stated the following:

Having an open discussion about the cultural differences between us in the beginning dramatically improves the rapport building process. My usual starting line is, ‘So how is it sitting here with some weird-looking White dude getting all up in your personal and family business?’ That line hasn't failed me yet. :)

Another clinician said it was important to “hav[e] an open for invitation policy, letting the client know I am not an expert in their culture, but I'm more than willing to learn and ask about their experiences and would like for them to let me.”

*No preference.* Regarding dissimilarity confrontation, a clinician with no preference stated the following:

As a White male, I remember saying in a training that we need to openly discuss the privilege that is given me--not by my choosing--just because of my color and gender. An Afro-American (AA) friend said you are the first White guy to say it out loud. I commented that we need to do so.

*Preference for African Americans.* Another mention of dissimilarity confrontation is demonstrated by a clinician with a preference for African Americans:

Referral was initiated through Cal-Works program. Culture was discussed with ct in an effort to gain insight into Ct's personal perspective on cultural norms, influences of culture on bx and to increase my own awareness throughout assessment.

Participants expressed the use of dissimilarity confrontation along with using other interventions aided in the effectiveness of completing MHA's with Black clients across IAT categories.

*Use of specific interventions.* The participants reported the regular use of interventions including validity, empathy, and building rapport with Black clients. Participants also identified the use of specific tools depending on the clinician's goal for the MHA. For example, if a clinician expressed that a client was referred for depression, the use of some a depression scale was likely. This process will be discussed in more detail in the *Prioritization of the MHA* sub-theme. Some participants identified using bio/psycho/social approaches to aid in effectively understanding Black clients. The responses identify how participants from different condensed IAT scores use specific interventions.

*Preference for European Americans.* The use of specific interventions is demonstrated by the quote below from a participant with a preference for European Americans:

Use of radical genuineness, non-judgmental, probing questions to gain understanding, seeking feedback from the clt, use of DERS and BURNS scales, reflective listening and the use of validation and rapport building.

Another clinician stated "I use the genogram to assessment, clarify support system, coping skills, and trauma assessment measures."

*No preference.* Another participant with no racial preference identified the use of the specific interventions: "I use a biopsychosocial assessment. This assessment is effective because it provides detail information about the Client's family history, substance abuse, family of origin information."

*Preference for African Americans.* A participant with a preference for African Americans describes effectiveness within specific tools as identified below:

I completed a biopsychosocial based interview, identified the client's symptoms and diagnosis from self-report and collateral information. The client was diagnosed with Major Depressive Disorder, Tobacco Use

Disorder, and Stimulant Use Disorder, Amphetamine Type. The assessment was effective as I was able to identify all of the needs of the client who was receiving services in an acute psychiatric crisis center.

*Awareness of bias.* Many respondents identified having an awareness of inherent bias and this was effective in preventing countertransference with Black clients. This sub-theme easily emerged from the responses because of the nature of this study and research questions. Participants expressed value in acknowledging bias in order to prevent inherent assumptions from informing clinical decision making. In some instances, participants identified knowledge of a client's cultural and racial experiences assisted in preventing the clinician from making decisions based on assumptions. The responses of being aware of bias are reported according to participant condensed IAT score.

*Preference for European Americans.* On the question of awareness of inherent biases, one clinician with a preference for European Americans stated the following:

I conducted a MHA with a Black, adolescent client that I would describe as effective because I did not make any assumptions based on my own beliefs or biases, instead I gave him the opportunity to share his experience about the reason for referral and explored his personal reactions. I also inquired about any cultural factors that may impact treatment.

Another clinician with a preference for European Americans discussed that an awareness bias was something that aided effectiveness:

Joking about my White-ness at appropriate times has seemed to successfully (based on rapport over time) convey my openness to know my place and not assume I could ever truly understand their life experience. While I do not disclose this in assessment, and sometimes never, they often guess or become curious about how I "get" certain things not knowing that my long-term boyfriend is Black and grew up in a violent environment in the northeast. Due to the trauma or triggering the political climate has intensified, we talk about this thoroughly.

*No Preference.* A clinician with no preference identified the use of biopsychosocial assessment to assist in minimizing assumptions about a client's background: "I use a biopsychosocial assessment. This assessment is effective because it provides detail information about the Client's family history, substance abuse, family of origin information."

*Preference for African Americans.* Two clinicians with a preference for African Americans discuss preventing assumptions by explicitly asking client identity: "Provided psych education about assessment process and asked clt how he/she identified themselves in Race/Ethnicity and Gender. This prevented assumptions from the Clinician's side and allowed clt to be more willing to share information during assessment." The second clinician explained how they prevented assumptions: "Provided psych education about assessment process and asked clt how he/she identified themselves in Race/Ethnicity and Gender. This prevented assumptions from the Clinician's side and allowed clt to be more willing to share information during assessment."

***Explicitly discussing cultural/racial information.*** This sub-theme is identified under both themes. Under the theme of *Clinician Identified Effectiveness*, some participant responses in this sub-theme identified a suspicion that inquiring about race and culture is something that may aid in effectiveness with Black clients; however, it is not something that is practiced for one reason or another. This sub-theme identifies a disconnect between theory and practice. The respondents for this sub-theme under the theme of *Clinician Identified Effectiveness* are identified by condensed IAT scores and in one instance, a response from a participant who did not complete the IAT.

*Preference for European Americans.* Two clinicians with a preference for European Americans discuss explicitly asking about cultural/racial information. The first clinician explains how asking for cultural/racial information aids in effectiveness: “Now that you ask, I think it might be appropriate to ask about any experiences of racism contributing to presenting problems, but I've never asked that.” The second clinician with a preference for European Americans stated the following in regards to asking cultural/racial information: “The assessment form might not cover a situation or experience that the client feels is important. If it is important to a client, it should be important to you.”

*No preference.* There were not any clinicians with the no racial preference IAT score who identified explicitly asking about cultural/racial information. The lack of responses does not necessarily note significance.

*Preference for African Americans.* A clinician with a preference for African Americans identified being unable to collect specific information: “I only use the general assessments my organizations provide. I have not been able to go into a deeper assessment.”

*Missing IAT.* A clinician who did not complete the IAT identified a perception that tools that aid in collecting cultural/racial information as something that would aid in effectiveness: “Culturally specific tools not used per agency protocol, but clinician believes more sensitive tools would have given better information.” Participant responses explained managing the time during the MHA to prioritize client needs. It appears collecting racial and cultural information from Black clients was prioritized after ruling out crisis and referral needs. This transitions into the next theme of *Clinician Practices*, specifically the *Prioritizing the MHA* sub-theme.

**Clinician practices.** This theme collected the reported practices of participants beyond what was explicitly identified as being effective during the MHA with Black clients. Participants identified certain approaches or ideas of how they perceived effectiveness. This theme demonstrates how even the perception of effectiveness with Black clients is subject to a clinician's approach, goals for the MHA and even locus of control. The main sub-themes that emerged from the responses include Prioritization of the MHA, External Locus of Control, Internal Locus of Control, Deductive Approach, Inductive Approach, and Explicitly Inquiring about Cultural/Racial Info. These sub-themes are explained further and demonstrated using the participants own words.

***Prioritization of the MHA.*** The first emergent sub-theme, *Prioritization of the MHA* refers to the reported practice of deciding on the immediate needs of the client. Participants explained a rather subjective, yet goal directed practice of prioritizing the MHA with Black clients. A majority of participants identified first ruling out crisis, then identifying reason (and goal) for referral, identifying a diagnosis, then if there is enough time and if it seems appropriate for the presenting problem, collecting information related to culture and race. Table 26 identifies the sub sub-themes of the sub-theme prioritization of the MHA. These sub sub-themes will be explored in detail using participant responses. This prioritization of the MHA reported by participants appears to be a common practice that serves to manage the time effectively.

Table 26

***Prioritization of the MHA Sub-theme and Subsequent Sub-themes***

Sub-Theme	Sub Sub-themes
Prioritization the MHA	Ruling Out Crisis Reason for Referral Diagnosis Explicitly inquiring about cultural/racial info.

*Ruling out crisis.* Clinicians reported the priority of the MHA was to rule out any immediate crisis. Many of the respondents expressed ruling out that a client was an imminent danger to themselves (DTS), danger to others (DTO) or gravely disabled (GD) due to a mental illness. If a client met any of these crisis criteria, this would usually signify a client is appropriate for inpatient mental health (IPMH). If a client appears to be in crisis, it may not be appropriate to continue identifying a diagnosis, prognosis or develop a treatment plan with the client. Respondents identified the need to identify crisis, or at least rule out that a client is not currently in a crisis. The responses from this sub-theme are identified by condensed IAT score.

*Preference for European Americans.* In regard to ruling out crisis, one clinician with a preference for European Americans stated the following: “assess for DTS/DTO/GD, support system, employment and education hx, childhood upbringing, strengths, trauma hx, cultural issues (religious, racial, ethnic, SES, sexual orientation, gender, etc).”

*No preference.* Continuing the subject of ruling out crisis, one clinician with no preference stated the following: “I worked up an AA female at Fresno Co. where she was identified as being belligerent and loud--possibly a DTO.”

*Preference for African Americans.* Finally, the subject of ruling out crisis, is explained by a clinician with a preference for African Americans: “During that work-up conversation, I assessed no DTO, DTS or GD [...] Suicide assessment due to referral by mom. It was effective because there was ideations present, a safety plan was made, depression treatment started.”

*Reason for referral.* The next sub sub-theme includes reason for referral which was a regularly identified by respondents sharing how they prioritize the

MHA with Black clients. The reason for referral appeared to guide much of the MHA according to the responses. Many of the respondents identified clients that were referred by Child Protective Services (CPS) and were required to participate in OPMH in order to comply. A majority of the participants identified the Black clients they worked with were referred by CPS. The participants identifying CPS as a referral source all report similar behaviors from the Black clients.

*Preference for European Americans.* The first mention of reason for referral is demonstrated by a clinician with a preference for European Americans:

Client was referred in by CPS/DPHHS for failure to protect. Overall assessment was anxiety disorder and a lack of personal power that would allow her to intervene on her child's behalf. Assessment was effective because the client had buy in and was willing to look at ways to change. Client started out the session very defensive, answering questions in the shortest way possible. Client ended the session answering in full sentences and seeing me as an ally rather than another judge.

Another instance of reason for referral is demonstrated by another clinician with a preference for European Americans:

Black, female, adult. Reason for referral due to involvement with CPS. Kept culture in mind as I asked questions. Client was anxious, made no eye contact. Made open conversation with client and validated her experiences throughout the assessment. Validation and respect were most important to this client as she expressed feeling like most people judge her and her history and that this was the first time she had a different experience.

A second instance of reason for referral is identified by another clinician with a preference for European Americans:

She was referred by welfare and CPS, dx'd with MDD and a substance use disorder (hx of cocaine use). The assessment was successful because she was open and willing to participate in services. She may not have realized that she needed MH at that time, but was motivated to comply with CPS to get her children back.

The third and final instance of a clinician with a preference for European Americans follows:

Clt came in after being referred by CPS. Clt was resistant, provided short answers, and was forceful when speaking. Explained to the clt what I was there for. As clt spoke different actions were mentioned, instead of labeling the actions asked clt about her family history such as if these phrases she had heard from parents, grandparents. Gathered information about his environment growing up and currently. So instead of labeling actions as it being due to client being Black it was more abt clients actions being about the culture of his environment and being able to acknowledge that in such an environment any ethnicity would respond to or be left to engage in certain behaviors. In addition this information was looked at in diagnosing the client instead of the behaviors/symptoms on their own. Therefore the underlying issue was PTSD not that client had conduct D/O. I also went out to client's home and spoke with family members looked at what was happening surrounding the clt as well as expectations of the environmental culture.

Not all respondents who scored a preference for European Americans identified CPS as the referring agency. Some of the respondents identified Black clients who were self-referred or referred by another program. These referral sources did not appear to guide the MHA.

*Preference for European Americans.* A clinician with a preference for European Americans identified the referral source:

The client was self-referred to the clinic, but had received services at the clinic as a child. The client reported depression symptoms, so a Burns Depression Checklist was given to quantify a treatment goal. The client identified the differences between therapist (White) and the client (Black). The client was able describe how he grew up, family background, and racism experienced. I felt the assessment was effective due to being able to state our differences and the client being able to tell his story of how he grew up and depression's impact on him personally.

Continuing the theme of reason for referral, another clinician with a preference for European Americans stated the following:

Client was self-referred and eager for assistance. Client was dealing with Generalized Anxiety Disorder. I was able to develop rapport with this client by providing empathy and encouragement. Part of treatment included normalizing the client's experience. I used numerous mindfulness tools to increase the client's awareness and increase his distress tolerance.

Continuing the subject of reason for referral, another clinician with a preference for European Americans stated the following:

The student was self-referred to the clinic for support following a sexual assault. I took her history and asked specific questions to get a clear diagnostic picture. Having a working knowledge of potential diagnosis and how trauma influences psychological experiences assisted me in giving an accurate diagnosis and formulating an effective treatment plan.

*Preference for European Americans.* One participant with a preference for European Americans identified that clients forced to participate in OPMH is not an effective practice compared to those who are referred on their own. The participant stated When clients come to the therapy often time means they are ready. However, when I was working at Fresno Juvenile Justice Campus it was opposite from that because clients need to seek therapy. Then it was not as effective.

*No preference.* On the subject of reason for referral, a clinician with no racial preference stated the following:

I worked up an AA female at Fresno Co. where she was identified as being belligerent and loud--possibly a DTO. She was in her mid-30s, single, with children, high school graduate, and involved with CPS and a custody issue. I could hear her yelling in the lobby and I went out to see what was going on. I offered to take her to my office. Security followed me and her. We entered my office-security stayed outside out of view with the door open slightly. I explained who I was, what I did, and that I wanted to know how I could support her today. I started joining with her, validating how she had been treated by the reception staff, security and other clinical staff. As we continued to talk, she was calming down and giving more eye contact. At one point, she politely interrupted me saying, I know what you are doing. I responded curiously, asking, what am I doing? Client (C) You are calming me down, I am going to leave here feeling better, but I won't get what I need. Writer (W) You are right. I am trying to calm you down and I was going to eventually walk you out. I responded validating her and smiling at her insight. I asked then with empathy So what do you need? I have to get into mental health services and show my CPS worker that I have an appointment or I could lose my kids. I validated her noting that it is

hard to get an appointment, frustrating and can be a real hassle. Having CPS in your life is scary too. I told her, I can do that for you and proceeded to arrange an appointment with an intake clinician as I ran Metro Intake at the time. After getting the appointment, I asked for verbal permission to contact her CPS worker by e-mail to let her know that she has an appointment. She agreed to this. I did so, printed off a copy for her which she took, and put one in the paper chart attached to my workup note. I asked her if there was anything else I could do for her? She expressed satisfaction and appreciation. She asked if I could be her therapist and I explained that I would love to, but my other duties don't give me time to do therapy here.

Continuing the subject of reason for referral, another clinician with no racial preference stated the following:

Clt came in after being referred by CPS. Clt was resistant, provided short answers, and was forceful when speaking. Explained to the clt what I was there for. As clt spoke different actions were mentioned, instead of labeling the actions asked clt about her family history such as if these phrases she had heard from parents, grandparents. Gathered information about his environment growing up and currently. So instead of labeling actions as it being due to client being Black it was more abt clients actions being about the culture of his environment and being able to acknowledge that in such an environment any ethnicity would respond to or be left to engage in certain behaviors. In addition this information was looked at in diagnosing the client instead of the behaviors/symptoms on their own. Therefore the underlying issue was PTSD not that client had conduct D/O. I also went out to client's home and spoke with family members looked at what was happening surrounding the clt as well as expectations of the environmental culture.

*Preference for African Americans.* Closing the subject of reason for referral, a clinician with a preference for African Americans identified “Referral was initiated through Cal-Works program. Culture was discussed with ct in an effort to gain insight into the client’s personal perspective on cultural norms, influences of culture on bx and to increase my own awareness throughout assessment.”

*Diagnosis.* The next sub sub-theme of the *Prioritizing MHA* sub-theme included diagnosis. Diagnosis is identified as a diagnosable and billable mental illness specified by the ICD10 or DSMV (APA, 2015). In many settings, a diagnosis is required for treatment. A diagnosis serves to provide information about the presenting emotions and behaviors and assists clinicians with identifying effective treatments. Many of the participants identified diagnosis as the point of the MHA, even referring to the MHA as “Diagnostic assessment.” This indicates that some clinicians have the philosophical view that the purpose of the MHA is to identify a diagnosis, so effectiveness is connected to ability to place clients in a diagnostic category.

*Preference for European Americans.* In reference to diagnosis, one clinician with a preference for European Americans stated the following: “It was effective as I was able to gather enough information to give client an appropriate diagnosis and they were able to qualify for services.” Another with the same racial preference explains “She was referred by welfare and CPS, dx'd with MDD and a substance use disorder (hx of cocaine use).”

*No Preference.* Continuing the theme of diagnosis, a clinician with no racial preference reports: “Therefore the underlying issue was PTSD not that client had conduct D/O.”

*Preference for African Americans.* Finally, when considering diagnosis, a clinician with a preference for African Americans demonstrates clinical decision making “Diagnostic assessment to clarify PTSD diagnosis with African American man in 40s with history of childhood sexual abuse, incarceration for assault, and depression. Used PTSD symptom checklist, structured interview. Diagnosis was chronic PTSD.”

Of all of the diagnoses provided in the responses, mood disorders and substance abuse were the most common diagnoses reported for Black clients (15 references). Many of the respondents reported doing differential diagnosis to identify if a Black client would benefit from substance abuse treatment or mental health treatment. Looking for a diagnosis during the MHA is a deductive approach that is also a sub-theme that will be discussed at a later time.

*Explicitly inquiring about cultural/racial info.* After ruling out crisis and considering the reason for referral and appropriate diagnosis, cultural and racial information appears to be prioritized last by respondents. Cultural and racial experiences appear to be explored if it is believed to be relevant to the presenting problems by participants. Responses indicated that participants collect cultural experiences much more frequently than racial experiences, despite being asked specifically about Black clients. The clinicians who discussed culture often referred to religion, SES, and in some instances criminal justice. This indicated clinicians may be more comfortable discussing these experiences or there are clearer ways to identify how these groups inform on the client's experiences. The responses regarding the collection of cultural and racial experiences are reported by condensed IAT score. The preference to discuss culture rather than race is also reflected in the interviews.

*Preference for European Americans.* In regard to collecting cultural/racial information, one clinician with a preference for European Americans stated the following: "I have deep reverence for the daily (we are in the South) discrimination they may experience, so often ask what their experience has been with racism and discrimination - especially if they did not grow up here." Another clinician with a preference for European Americans explained "The client

identified the differences between therapist (White) and the client (Black). The client was able describe how he grew up, family background, and racism experienced.” A third mention of the theme by a clinician with a preference for European Americans points out “Plus asking about their cultural background during the assessment is a better way to understand how they identify and how important their culture is to them.” A final mention of inquiring about cultural/racial information states “Asking about their culture and using their beliefs while incorporating interventions.”

*No preference.* In regard to collecting cultural/racial information, one clinician with no preference stated the following:

Gathered information about his environment growing up and currently. So instead of labeling actions as it being due to client being Black it was more about client’s actions being about the culture of his environment and being able to acknowledge that in such an environment any ethnicity would respond to or be left to engage in certain behaviors.

*Preference for African Americans.* A clinician with a preference for African Americans stated the following about collecting cultural/racial information: “Provided psych education about assessment process and asked clt how he/she identified themselves in Race/Ethnicity and Gender.” Another stated “Referral was initiated through Cal-Works program. Culture was discussed with clt in an effort to gain insight into Clt’s personal perspective on cultural norms, influences of culture on bx and to increase my own awareness throughout assessment.”

*External Locus of Control.* Many clinicians perceived effectiveness as not within their control rather dependent on how the client responds to the interventions. This is referred to as an external locus of control. This sub-theme was identified using the CRT framework as a lens while keeping the research questions of the study in mind. Previous literature has identified (and blamed)

African Americans for their own poor outcomes in OPMH services. Subsequently, clinicians who perceive Black clients as controllers of the effectiveness of their own services potentially measure effectiveness based on a client being agreeable. When working with Black clients who are highly enculturated into African American culture, this intended measure of MHA effectiveness can inadvertently become a measure of acculturation and assimilation (Cokley & Helm, 2007; Rogers-Sirin, 2013; Rudmin, 2003). Respondents who demonstrated an external locus of control are identified by having a certain condensed IAT score. It is noted that there were only responses indicating an external locus of control from respondents who had a preference for European Americans. This does not mean that only participants with a preference for European Americans exhibit an external locus of control, rather this was the only group to yield responses that fit within this sub-theme.

*Preference for European Americans.* A clinician with a preference for European Americans demonstrated an external locus of control “I have met with Black clients and they tend to be receptive to my interventions, and they agree to follow through with plan”. Another clinician identified “the assessment was successful because she was open and willing to participate in services. She may not have realized that she needed MH at that time, but was motivated to comply with CPS to get her children back.” A third clinician demonstrated an external locus of control with the following quote:

Client was referred in by CPS/DPHHS for failure to protect. Overall assessment was anxiety disorder and a lack of personal power that would allow her to intervene on her child's behalf. Assessment was effective because the client had buy in and was willing to look at ways to change.

Another clinician with a preference for European Americans indicated an external locus of control:

I felt the assessment was effective due to participation from the family, ability to gather an extensive family history and mental health history, and participation from the client. It was effective as I was able to gather enough information to give client an appropriate diagnosis and they were able to qualify for services.

Another clinician with a preference for European Americans exhibited an external locus of control:

During the assessment, he disclosed that he was attempting to leave the facility for a medical reason to see his significant other. He was confronted as to why he would suddenly begin to hear voices at his age and state. This was effective because it became a teachable moment where he could be confronted in a non-judgmental manner, he was able to state what he really wanted, and there was no repercussions. His anxiety symptoms were legitimate and he was allowed to seek a renewal for his anxiety medications away from the facility.

*Internal Locus of Control.* Participants who had responses that emerged under this sub-theme perceived effectiveness within their control. This sub-theme was reflected in responses in which participants identified things they did during the MHA that participants perceived aided in MHA effectiveness. Participants who reported internal locus of control often identified ways in which they could adapt to clients to better meet their respective needs. Participants who explained effectiveness as within their control often identified effectiveness coming from a collaborative interaction with the client. Participants with internal locus of control also expressed client motivated approaches more often. Responses indicating an internal locus of control were identified by condensed IAT score.

*Preference for European Americans.* On the question of internal locus of control, one clinician with a preference for European Americans stated the following:

I think what is effective, is not so much the form, but the approach I took. I listen to what the family tells me is important to them. The assessment form

might not cover a situation or experience that the client feels is important. If it is important to a client, it should be important to you.

Another clinician with the same racial preference demonstrated an internal locus of control:

I would describe as effective because I did not make any assumptions based on my own beliefs or biases, instead I gave him the opportunity to share his experience about the reason for referral and explored his personal reactions. I also inquired about any cultural factors that may impact treatment.

A third clinician with a preference for European Americans exhibited an internal locus of control:

In one situation, I think I made more of an effort to validate. Validation and just being present and hearing the pain the clt was going through was what made the assessment effective. I wasn't searching for anything specific or trying to rush through, I just wanted to make sure that I was using all levels of validation and ensuring what I was hearing was correct by using reflective listening and asking for clarification. I also make no assumptions that I understand what is like to be them. Plus asking about their cultural background during the assessment is a better way to understand how they identify and how important their culture is to them.

*No Preference.* Concerning an internal locus of control, a clinician with no racial preference explains the “ability to include, validate and ingratiate the client’s faith, past drug use, and current mental health diagnosis into a care plan that addresses where she is at any given moment.”

*Preference for African Americans.* Regarding an internal locus of control, a clinician with a racial preference for African Americans explains the assessment “was effective because I built rapport with patient and actively listened to his concerns.”

***Deductive approach.*** The next sub-theme that emerged was that of a deductive approach. The deductive approach sub-theme was identified in the data by responses that expressed a hypothesis that was then followed by exploration of

finding data to support (or disprove) the hypothesis. This theme is relevant to the study and subsequent research questions as clinicians who perceive effectiveness in fulfilling specific goals (i.e., identifying diagnosis, fulfilling client legal obligations, etc.) are more likely to attempt to complete those goals. In many situations, the reason for referral appeared to serve as a clinician hypothesis. In situations where outside referrals are guiding the clinician, a deductive approach can guide the MHA. A deductive approach can be utilized to identify how cultural and racial experiences inform a client's worldview. Respondents in this study tended to hypothesize regarding a diagnosis. Responses that indicated a deductive approach are identified based on condensed IAT score.

*Preference for European Americans.* A clinician with a preference for European Americans demonstrated a deductive approach stating “During a mental health assessment with a Black client that was referred for possible depression or substance abuse... The determination was that the client was abusing prescription drugs and possibly other drugs.”

*No Preference.* A clinician with no racial preference alluded to a deductive approach:

55 yo female with panic disorder. Taken many medications over the years to little avail. Panic related to driving to work, especially on down-hill stretches of road. Has been treated by several psychiatrists and counselors over the years. With a little discovery, it was found that she was sexually abused by an uncle, repeatedly in her youth, down at the bottom of the hill.

*Preference for African Americans.* A clinician with no racial preference alluded to a deductive approach: “Diagnostic assessment to clarify PTSD diagnosis with African American man in 40s with history of childhood sexual abuse, incarceration for assault, and depression. Used PTSD symptom checklist, structured interview. Diagnosis was chronic PTSD.”

*Inductive approach.* The inductive approach sub-theme was identified by responses that expressed exploration of all information without a hypothesis of any kind. These responses typically indicated responding to things the client brings up during the MHA. Many of the respondents who appeared to have a more inductive approach expressed using a bio-psycho-social approach to complete the MHA. Responses that indicated an inductive approach are identified based on condensed IAT score.

*Preference for European Americans.* A clinician with a preference for European Americans explains the importance of using an inductive approach “I wasn't searching for anything specific or trying to rush through, I just wanted to make sure that I was using all levels of validation and ensuring what I was hearing was correct by using reflective listening and asking for clarification.”

Another clinician with a preference for European Americans identified an inductive approach as being effective:

The assessment was of an adolescent female who is a dependent of the court. The foster mom, who is also Black, was included and provided history on the client's family, with whom she had a long history. She was able to provide culturally relevant information, family history, foster care history, etc. No specific MHA tools were used, but the interview was extensive and took into consideration previous diagnoses, and current bxs.

*No Preference.* A clinician with no racial preference explains “I use a biopsychosocial assessment. This assessment is effective because it provides detail information about the Client's family history, substance abuse, family of origin information.”

*Preference for African Americans.* Demonstrating an inductive approach, a clinician with a preference for African Americans stated the following:

I completed a biopsychosocial based interview, identified the client's symptoms and diagnosis from self-report and collateral information. The

client was diagnosed with Major Depressive Disorder, Tobacco Use Disorder, and Stimulant Use Disorder, Amphetamine Type. The assessment was effective as I was able to identify all of the needs of the client who was receiving services in an acute psychiatric crisis center.

### **Survey Summary**

The qualitative survey question offered valuable insight into perceptions of effectiveness and current practices of clinicians working with Black clients. The responses provided explanation of the clinical decision making that occurs among mental health clinicians working with Black clients. It is noted that participants of all possible IAT scores identified no experience with a Black client. The lack of experience with a Black client was expected due to the low participation of African Americans in OPMH (SAMHSA, 2015). The information gathered from the qualitative survey question assists in identifying the beliefs of best practices with Black clients. Implications for future research sparked by the responses to the qualitative survey question are discussed in chapter 5.

### **Interviews**

The interview portion of this study aimed at answering the following research question: “What do clinicians perceive are effective MHA practices with Black Clients?” The interviews were conducted based on survey participants who agreed to participate in an interview and condensed IAT score by race. Table 27 presents the completed interview demographics. Two of the interviews (one White participant who did not have a preference for African Americans and one Black participant with a preference for African Americans) were completed over the phone while the other two interviews were completed in person.

Although the same constructivist grounded theory approach specified by Strauss and Corbin (1998) was used to code the interviews, the interviews were coded separately from the survey question as the questions utilized a more

Table 27

*Interview Yield by Ethnicity and IAT Category*

Identity by IAT Score	Preference for African American	Prefer European American
White Participants	None Yielded	2 Interviews
Black Participants	1 Interview	None Yielded
Other Participants	None Yielded	1 Interviews

deductive approach. It is noted the data collection stage focused on early returns for interview participants. As a result, three of the interview participants were employed with the researcher and were aware of the researcher's race. The researcher made changes to the research questions and decided to provide psychoeducation on the IAT prior to giving all participants their IAT score. This was done to minimize any possible distress of the employment relationships. The interviews were coded based on question and IAT score. The following questions guided the interview.

1. What do you see as the purpose of the assessment?
2. How do you establish support with your clients during assessment?
3. What makes an assessment successful?
4. How does your approach vary with clients of different ethnic groups?
5. How do you think you scored on the IAT?
6. (Psychoeducation on IAT/Informed of score) What do your IAT scores mean to you?
7. Did your IAT results change your perceived effectiveness? How so?
8. How do you work differently with Black clients?

9. Do you have any recommendations for other clinicians working with Black clients?

The interviews offered insight into how the clinical decision making occurred while considering IAT scores. Interview data yielded information about awareness of race, and racial experiences, how clinicians might collect race and cultural information, and ways in which effectiveness is perceived. The interview data also offered applicable recommendations on how to best work with Black clients who are presenting for mental health treatment.

### **Question and Demographics**

#### **Questions 1 and 2**

Questions 1 and 2 of the interviews focused on clinician perceptions of the purpose of the MHA. All of the clinicians who participated in the interview identified a similar purpose of the MHA in identifying the purpose of the MHA. This question served to identify the ways in which the MHA was perceived by participants. The main theme of this question was prioritizing the MHA. Some of the sub-themes that emerged from the theme *prioritizing the MHA* including *reason for referral* and *diagnosis*. Table 28 presents information and responses for how participants view the purpose of MHA.

Question 2 asked participants to share how they build rapport with clients during a MHA. This question served to identify the ways in which participants attempt to join with clients during the MHA. Building rapport was identified by participants as the way in which they attempt to build a level of comfort with a client during the MHA. The main theme identified in question 2 is reason the MHA was effective. Some of the sub-themes that came up for question 2 include or using specific interventions during the MHA. Table 29 presents sample responses of building rapport in the words of the participants.

Table 28

*MHA Purpose Responses by Ethnicity and IAT Score*

Ethnicity	Sample Response	Condensed IAT Score
Black	“In general, to understand what the person's needs are. In terms of their presenting issue, their history, any other confounding variables.”	Prefer African American
White	“Number one, the reasons why someone is coming in for service at this particular agency”	Prefer European American
White	“The purpose of the assessment for me is to find out what the immediate problem is because most of the assessments that I do are for the welfare department. It's also identifying what are the barriers or what are the potential mental health problems that are hindering the person from getting to work.”	Prefer European American
Multi-Ethnic	“To identify the strengths and needs of clients, and to gain a better understanding of what their struggles are, what their goals are for treatment, and how we can best help assist them in reaching those goals.”	Prefer European American

Table 29

*Rapport Building Sample Responses by Condensed IAT Score*

Ethnicity	Sample Response	Condensed IAT Score
Black	“I think by conveying that like, that you have a desire to be helpful to them, and also coming from a place of curiosity and genuinely wanting to get to know them; rather than just like, kind of robotically going through a structured list of questions.”	Prefer African American
White	“I normally start by introducing myself and kind of explaining the process of what we're gonna be going through and asking them if they have any questions about the process or myself before I get started.”	Prefer European American
White	“I think that we, I would start with some good listening and that depending on the culture, good eye contact and that kind of thing.”	Prefer European American
Multi-Ethnic	“I try to make sure to make eye contact, and I don't really focus on my computer. I make sure that I'm giving a feel that we are just a conversation-about what's going on, rather than it being like a kind of mechanical type of process. I try to validate as much as possible.”	Prefer European American

### Question 3

Question 3 specifically asked for ideas of effectiveness during the MHA. The main sub-themes that came up included an external locus of control. The main categories that were identified by the responses include collaboration and client motivated. The responses for question three were all very similar for ethnicity and condensed IAT score. Table 30 offers sample responses to question 3 by ethnicity and condensed IAT score.

Table 30

*Perceptions of Effectiveness Sample Responses by Ethnicity and Condensed IAT Score*

Ethnicity	Sample Response	Condensed IAT Score
Black	“I think a successful assessment is one where both the patient and like, myself as a clinician feel that that the patient feels that they've adequately kind of expressed whatever concern that they have.”	Prefer African American
White	“seeing where they're at because sometimes, people are super fearful of what they're getting themselves into and so I need to be able to match that, versus some people that are totally open and willing and have been waiting for this for a long time and, and are ready to dive in and so then, you know, that, that changes my approach.”	Prefer European American
White	“Well, I think it's successful when I feel like, two things that both of us are happy at the end of it.”	Prefer European American
Multi-Ethnic	“I ask for feedback at the end, as far as like, this is what I heard, or the issues, or what you're going through, do you feel like there's anything that I missed?”	Prefer European American

### Question 4

This question served to identify if a color-blind approach was being used by participants. A majority of the participants expressed they did not vary their

approach with clients of differing ethnicities. Some of the participants responded that although the approach did not vary, they were not necessarily using a color-blind approach as they asked all clients questions regarding ethnic identities. Some of the participants reported a client motivated approach was used to identify if ethnicity was relevant to the MHA. Table 31 presents some of the sample responses by ethnicity and condensed IAT score.

Table 31

*MHA with Differing Ethnicities Responses by Ethnicity and Condensed IAT Score*

Ethnicity	Sample Response	Condensed IAT Score
Black	“I don't think I've varied the approach. I tend to ask most people about their cultural and ethnic background, religious background; but I'll ask more follow-up questions if it's particularly salient to someone. Or, salient to their presenting concerns or family concerns.”	Prefer African American
White	“I don't, I don't really think that I do. And I ... I definitely ... The majority of the people I work with are Caucasian, I would say the next biggest group would be Hispanic.”	Prefer European American
White	“I might spend more time if I'm the less familiar I feel, comfortable the less I know about a certain, a person of a certain ethnicity as I spend more time and get the, and learn more myself.”	Prefer European American
Multi-Ethnic	“It does vary, but I feel like I ask that question as far as what's relevant to them as far as their culture at the beginning, so that I can kind of establish what the needs are in from that perspective I guess.”	Prefer European American

### Question 5

This interview question served to identify if dissonance occurred between clients explicit and implicit racial preferences. The respondents comments seem to express they do not want to be identified as having bias. All but the participant who identified as Black expressed that they were not sure how they scored on the IAT. Participants were made aware that they would be told how they scored on the IAT. An unintended result of this question was the discomfort that occurred with the respondent who identified as “other.” Table 32 presents some of the responses to question 5 by ethnicity and condensed IAT score. The response below describes the discomfort that was reported by the Multi-ethnic participant throughout the remainder of the interview:

I feel like even when I took the test, I definitely had this awareness of what I felt, 'cause you have this bias, right, of what is this testing me for, and I wanna make sure that ... I don't know. You- you tend to think like, ‘I can make sure that this is gonna go the way I want,’ even though you can't and the test was difficult and I found myself like stopping and like taking a deep breath, and sto- ... to stop thinking about it so much. So I'm interested. Slash nervous. (laughs)

Table 32

#### *IAT Guess Sample Responses by Ethnicity and Condensed IAT Score*

Ethnicity	Sample Response	Condensed IAT Score
Black	“I think like, the most recent time, I remember having like, a strong preference for African Americans, which is not surprising to me.”	Prefer African American
White	“No, I have no idea. (laughs)”	Prefer European American
White	“No. I don't know how I scored.”	Prefer European American
Multi-Ethnic	“I wanna say that I have like ... that I'm neutral, but I don't think that's true.”	Prefer European American

### Question 6

The purpose of this question was to identify how participants perceived the IAT score. Many participants offered explanations as to why they believed the IAT score may be appropriate. Table 33 presents the summation of responses to question 6.

Table 33

#### *IAT Meaning Sample Responses by Ethnicity and Condensed IAT Score*

Ethnicity	Sample Response	Condensed IAT Score
Black	“I mean I feel like, to some extent, my parents and the context of family and settings that I grew up I always have made me feel very proud of being Black, being African American, being Nigerian, specifically on my dad's side; and have, you know, helped me maintain that sense of pride in who I am and I feel very connected and find like, connection with other Black people very valuable...”	Prefer African American
White	“Well, I think it's exposure, not just in mental health and not just in assessment but just exposure in life. I mean, I have more exposure from the day-with White people”	Prefer European American
White	“nobody's going to come out perfect so you just have to know what your weaknesses are and then look for them and work against them	Prefer European American
Multi-Ethnic	“I'd like to think that I am less bias, but I feel like just the way we are, shapes and forms, and how I work, and my interactions, or lack of interactions might have caused that.”	Prefer European American

### Question 7

The purpose of question 7 was to see if knowledge of implicit racial preference as measured by IAT score changed the participant perceptions of effectiveness. The perception of effectiveness after learning IAT scores varied for

respondents. Table 34 presents the responses to question 7 by ethnicity and condensed IAT score.

Table 34

*Effectiveness After Learning IAT Sample Responses by Ethnicity and Condensed IAT Score*

Ethnicity	Sample Response	Condensed IAT Score
Black	“I probably have a lot of positive, mostly positive associations towards Black people; whereas like, when I think of like, White people, I generally think of like social privilege and like, just like historical precedence of what Whiteness represents to me.”	Prefer African American
White	“I don't think so but I think anything that's different from me, is very more, more difficult to assess, whether it's color of skin or any other factor”	Prefer European American
White	“No. I don't think so.”	Prefer European American
Multi-Ethnic	“Maybe I'm not doing as good a job as I think I am.”	Prefer European American

### Question 8

The purpose of question 8 was to identify the ways in which participants may have worked differently with Black clients with knowledge of how they scored on the IAT. Participants offered differing understandings of how they might work with Black clients. Table 35 presents the responses to question 8 by ethnicity and condensed IAT score.

Table 35

*Working with Black Clients Responses by Ethnicity and Condensed IAT Score*

Ethnicity	Sample Response	Condensed IAT Score
Black	<p>“I wouldn't say it's necessarily a conscious, intentional thing. But I feel like, especially with like, the type of work that I do, where I'm more relational, psychodynamic therapist. Like, the relationship between myself and the patient is always a factor in the room. And like, in both of our minds. It's also just like ... you can't necessarily be a blank screen, like for anyone; but also just like as someone with visible markers of your identity. It's just there and it would be, I think it would be a lot more harmful to ignore it, when someone sitting across from you is like, sharing these different cultural experiences that they know or that they assume that you share. So it's just a different feeling that might not always come across in what I say or the interventions I use but it's a different type of relationship.</p>	Prefer African American
White	<p>“I don't know that would be any, any more specifically different with with a Black client than, like I said, somebody from Kentucky where I just don't understand their context.”</p>	Prefer European American
White	<p>“You know, because I've worked with clients of all ethnicities and you know, I mean, sometimes you know, I'll go into it you know, I'll say, ‘Well, you have to do this you know, assessment and screening or even therapy.’ You know, I think, ‘Hm, African American teenage girl. What am I going to have in common. They're probably going to think...’ You know. And what are they going to think of me? You know, some old White guy. But I'm always surprised that by the end of it, I seem like I've been able to connect, I think and things have gone well.”</p>	Prefer European American
Multi-Ethnic	<p>“I feel like there's a ... we would ... I think every clinician, we go into this wanting to help, and I think that we do the best that we can to stay as neutral as possible, because that's what we're taught to do and we are trying to be empathetic with whomever is sitting in front of us but there is this bias and this thing happening in the back of our mind that we need to be made aware of so that we can fully understand and strive to be better. So if clinicians could know what they're score is, or how ... where their bias kind of lies, then you can become a better clinician.</p>	Prefer European American

### Question 9

This question served to identify any recommendations that respondents might have for other clinicians who may work with Black clients. This question sought to identify how clinicians perceived that assessments could improve for Black clients. All of the interview participants identified different recommendations for assessments with Black clients. Table 36 presents the responses for question 9 by ethnicity and condensed IAT score.

Table 36

*Recommendations on Working with Black Clients Responses by Ethnicity and Condensed IAT Score*

Ethnicity	Sample Response	Condensed IAT Score
Black	“The other thing that I think that a lot of people do is like, they only talk about culture if it's part of the presenting problem. And I think that sets up the framework where like, the like, only talk about it if it's related to that thing. But I feel like you should have therapeutic relationship where someone can talk about their Blackness in a way that's like, maybe is joyful or maybe they're celebrating something. Or like, other things. And just like, be a normal, nice person. Maybe not nice all the time, that's not a good word to use.”	Prefer African American
White	“I do think that tools like that would be very helpful for working with the client on an ongoing basis so that you can continually assess and and have time to talk about those things and explore.”	Prefer European American
White	“You better talk with somebody that knows what they're ... I'd refer them to ah, you know, someone that's probably done studies on these kind of things“	Prefer European American
Multi-Ethnic	“Cultural trainings, but even just training, 'cause I feel like I don't know about other people, but when I walked in I think I did ... I observed one assessment on how they do it here, and then I was just thrown into it.”	Prefer European American

### Summary of Chapter 4

This mixed methods study produced quantitative and qualitative data from an electronic survey with 87 participants and 43 of those who completed the IAT and were scored. The quantitative data revealed that some significant results related to IAT score. The MANOVA for the three MHA variables by Full IAT was not significant, but by Condensed IAT it was significant. No univariate ANOVAs by Full IAT were significant, but one was significant for the Condensed IAT. The MHA with Black clients was significant for Condensed IAT categories, with the highest mean for prefers African Americans. Only two of the Chi-square analyses for Condensed IAT categories by demographic variables was significant. These were for Condensed IAT by Ethnicity and for Condensed IAT by Profession.

The qualitative data revealed subjective approaches in how and when to collect racial and cultural information. The qualitative data yielded results that may conceal a hierarchy of clinical importance held by clinicians in which race and culture are at the bottom. The two main themes that emerged from the qualitative data include *Clinician Identified Effectiveness* and *Clinician Practices*. Sub-themes of *Clinician Identified Effectiveness* include four sub-themes including *Dissimilarity Confrontation*, *Use of Specific Interventions* *Awareness of Bias*, and *Explicitly inquiring about Cultural/Racial Info*. The five sub-themes of the theme *Clinician Practices* include *Prioritization the MHA*, *External Locus of Control*, *Internal Locus of Control*, *Deductive Approach*, and *Inductive Approach*. The sub-theme *Prioritization of MHA* has four subsequent sub-themes including *Ruling out crisis*, *Reason for referral*, *Diagnosis* and *Explicitly inquiring about culture*. The results for this mixed method, exploratory research study will

contribute to the existing body of literature focused as it provides a sample of applied practices among mental health clinicians.

## CHAPTER 5: DISCUSSION/SUMMARY/CONCLUSION

The purpose of this mixed method study was to explore the perceptions, beliefs and attitudes clinicians have when working with Black clients. Furthermore, this study sought to understand how clinician characteristics inform clinical perceptions of effective assessment practices. This study focused on clinician perceived effectiveness when working with Black clients during the mental health assessment portion of treatment. Previous literature focused on the outcomes of Black and African American clients seeking outpatient mental health (OPMH) treatment was deficit in nature and focused on how the clients interacted with services. This research aimed at identifying how mental health clinicians interact with and perceive Black clients both explicitly and implicitly. The results from this study identify current practices among mental health clinicians. The findings from this study can be used to identify ways to better accommodate Black clients participating in mental health treatment.

### **Summary of Results**

This mixed methods study produced results that were a summation of the implicit and explicit beliefs attitudes and practices of 74 mental health clinicians. After answering demographic and effectiveness questions, most participants completed the open-ended qualitative question. After completion of the electronic survey, participants were invited to participate in the interview. Interview volunteers were chosen based on ethnicity and IAT score in order to answer the research questions. Four participants with differing ethnicities and IAT scores participated in the open-ended interview. Both the quantitative and qualitative data answered the research questions below.

1. What do Clinicians perceive are effective MHA practices with Black clients?

2. How are perceived effective assessment practices related to the demographic and IAT variables?
3. What is the relationship between implicit racial bias (IAT categories) and perception of clinician effectiveness and clinician characteristics?

All three research questions were answered to some extent by both the qualitative survey question and the interviews. Question 1 was answered in the qualitative survey question and the interview questions. The two main themes that emerged from the qualitative data include *Clinician Identified Effectiveness* and *Clinician Practices*. Sub-themes of *Clinician Identified Effectiveness* include four sub-themes including *Dissimilarity Confrontation*, *Use of Specific Interventions*, *Awareness of Bias*, and *Explicitly inquiring about Cultural/Racial Info*. The five sub-themes of the theme *Clinician Practices* include *Prioritization the MHA*, *External Locus of Control*, *Internal Locus of Control*, *Deductive Approach*, and *Inductive Approach*. The sub-theme *Prioritization of MHA* has four subsequent sub-themes including *Ruling out crisis*, *Reason for referral*, *Diagnosis* and *Explicitly inquiring about culture* (see Table 37).

Table 37

*Themes, Sub-themes Coding Matrix*

Themes	Sub-themes	Sub Sub-themes
Clinician Identified Effectiveness	Dissimilarity Confrontation	
	Use of Specific Interventions	
	Awareness of Bias	
	Explicitly inquiring about Cultural/Racial Info	
Clinician Practices	Prioritization the MHA	<ul style="list-style-type: none"> <li>• Ruling Out Crisis</li> <li>• Reason for Referral</li> <li>• Diagnosis</li> <li>• Explicitly inquiring about cultural/racial info.</li> </ul>
	External Locus of Control	
	Internal Locus of Control	
	Deductive Approach	
	Inductive Approach	

### **Clinician Identified Effectiveness**

Participants described the use of a variety of approaches, interventions and practices that they believed were effective when working with Black clients. The sub-theme of *dissimilarity confrontation* was identified by multiple participants who reported effectiveness. The responses indicating the use of *dissimilarity confrontation* were different from those expressing *explicitly inquiring about cultural and racial information* in that clinicians using *dissimilarity confrontation* acknowledged the differences between themselves and the client. Participants who expressed *explicitly inquiring about cultural and racial information* only identified asking the client how their race or culture informed the client's worldview.

Some respondents identified suggestions for collecting racial experiences. These suggestions also appeared subjective and based on individual opinion and experiences. Respondents identified beliefs that racial power and privilege should be discussed with Black clients; however, differing perspectives of how or when this was appropriate was demonstrated in the responses. Some respondents suggested the belief that tools to assist in identifying racial experiences would aid in effectiveness during the MHA with Black clients. Other respondents expressed the belief that explicitly asking about racial experiences would be appropriate, although this was not the current practice.

Responses about the *use of specific interventions* identified how clinicians perceived the use interventions, including empathy and validation, that require them to check in with the client to affirm accuracy aided in effectiveness during the MHA with Black clients. Respondents also identified perceived effectiveness in the use of tools that aided in diagnosis (i.e., depression scales, PTSD checklists,

etc.). Not one response indicated the use of any cultural tools, including the use of the cultural tools available in the DSM (APA, 2015).

Although clinicians were asked to provide information related to an effective MHA with a Black client, some participants identified barriers that limited effectiveness. Some of the barriers identified by participants include agency protocols that prohibited the use of cultural tools, the fear of imposing assumptions or inherent biases on clients, and little to no experience working with Black clients. Many respondents expressed never working with Black clients at all, let alone during the MHA portion of treatment. These sub-themes and subsequent responses indicated that cultural assessment of Black clients is subjective in nature.

**Clinician practices.** Many of the participants in this study described decision making that occurs during the MHA with Black clients that attempts to identify the areas of greatest importance. The qualitative responses revealed that *prioritization of the MHA* is a common, albeit pragmatic practice, that may be connected to MHA effectiveness. Participants reported a loose, somewhat undefined and subjective taxonomy that may exist when prioritizing the needs of Black clients during the MHA. The top priority consists of ruling out crisis, with identifying the reason for referral closely behind, followed by identifying a qualifying diagnosis. At the bottom of this taxonomy, culture and race appear to be minimally explored when it appears to be relevant to the presenting problem. Clinicians, who do attempt to identify race and cultural information, do so in a manner that appears abstract at best and based on individual experience and comfort level.

Clinicians demonstrated differing perceptions of the locus of control related to effectiveness. Some clinicians measure effectiveness based on specific

interventions or approaches that they themselves have done during the MHA. The participants, who demonstrated an internal locus of control, explained that perceived effectiveness was completely within their control. Respondents, who indicated an internal locus of control, identified the ways in which they can adapt interventions to clients to aid in effectiveness.

Some respondents indicated an external locus of control that measured effectiveness in actions of the client. Participants who expressed an external locus of control attributed effectiveness to how the client interacted with them during the MHA. Respondents who measured effectiveness based on an external locus of control identified effectiveness based on the client's ability to be agreeable or comply within the parameters of the MHA. Participants who demonstrated an external locus of control also belonged to the group with an implicit racial preference for European Americans. Due to how few participants completed the IAT, no generalizations can be made about this relationship. An external locus of control that measures effectiveness as within control of the client exposes clients to risks, particularly paired with a referral from a legal entity. These risks include forced assimilation to avoid legal consequences. These risks are discussed in more detail later in this chapter. Respondents with external locus of control have the potential for blaming the client for successes and failures of the MHA, while participants with internal locus of control described the belief that changing the approach or intervention could change the effectiveness of the MHA.

The MHA practices used with Black clients that were identified by respondents included both inductive and deductive approaches. Some clinicians identified a hypothesis, most times identified during the prioritization of the MHA, and the MHA served as an opportunity to build data to either prove or disprove the hypothesis. Clinicians with a deductive approach reported the use of tools that

assisted in collecting information to support the hypotheses, (e.g., depression, scales, etc.) Other clinicians expressed a more inductive approach that does not search for anything specific during the MHA. Clinicians who expressed a more inductive approach identified the use of a bio/psycho/social model to guide the clinical interview. As a result of this approach, clinicians with a more inductive approach expressed seeking out cultural information more often than the individuals with the deductive approach. Participants who used a deductive approach appeared to only collect information to either refute or confirm whatever they are thinking.

Questions 2 and 3 were answered in the quantitative analysis. The Chi-square revealed a statistically significant relationship between Condensed IAT with ethnicity and profession as it relates to perceived effectiveness (see Table 38). It is worth noting the possibility of ethnicity being a confounding variable for profession as four of the eight participants who identified as Psychologists also identified as Black. Individuals who identify as Black or Native American are not only more likely to have an implicit preference for African Americans, but less likely to have an implicit preference for European Americans. This will be discussed in more detail later in this chapter. This study also revealed that perceived effective assessment practices with Black clients have a statistically significant difference by condensed implicit racial preference (measured by IAT score) (see Table 39 for MANOVA and univariate ANOVA results). Specifically for the univariate results, individuals with an implicit racial preference for African Americans perceive themselves as the most effective during a MHA with Black client. The MANOVA results for the Condensed IAT is also significant.

The qualitative data did not reveal any noted similarities among effective practices and other demographic information. Although no commonalities among

Table 38

*Chi-Square Results for Condensed IAT Categories by Demographic Variables*

Condensed IAT Categories by	Significance
Gender	NS
Age	NS
Ethnicity	Significant
Degree	NS
Profession	Significant
Agency Type	NS
Participation in Cultural Competency Training	NS
Completed MHA Session	NS
Hours for MHA	NS
Payment Type	NS

Table 39

*MANOVA and Univariate ANOVA Results for MHA Dependent Variable by IAT*

Statistical Test	Significance
MANOVA for Full IAT and 3 MHA Variables	NS
Univariate ANOVA for Full IAT and MHA	NS
Univariate ANOVA for Full IAT and MHA with Whites	NS
Univariate ANOVA for Full IAT and MHA with Blacks	NS
MANOVA for Condensed IAT and 3 MHA Variables	Significant
Univariate ANOVA for Condensed IAT and MHA	NS
Univariate ANOVA for Condensed IAT and MHA with Whites	NS
Univariate ANOVA for Condensed IAT and MHA with Blacks	Significant

qualitative survey responses and participant characteristics were noted, few participants reported discussing race explicitly during the MHA with Black clients. Many respondents chose to discuss “culture” rather than race. This suggests a subjective understanding (and assessment) among clinicians of when and how it is appropriate to identify racial and cultural experiences. Furthermore,

it appears some clinicians are much more comfortable discussing race than others. This will be discussed in more detail later in this chapter.

### **Results Related to the Literature Review**

Respondents identified the main source of Black clients participating in the MHA were referred by CPS and probation. In a literal sense, this means that Black individuals are expected to assimilate to the norms of the dominant culture to restore their families. Black individuals referred to OPMH as a means of getting their children back are then subjected to an assessment completed by a clinician who ultimately gets to decide what kind of mental illness the client has. Very few participants identified a decision that services were not appropriate for Black individuals referred by CPS, despite feedback from the client. Participant responses like the one identified below suggest clinicians know what was best for clients beyond the client's own expertise on their life: "She may not have realized that she needed MH at that time, but was motivated to comply with CPS to get her children back."

Furthermore, very little to no discussions of racial experiences or cultural experiences related to race during the MHA appear to be common practice, suggesting that clinicians are not exploring what is within normal limits of the client's race/culture, or the ways in which clients have learned from their culture of origin how to meet mental health needs. A color-blind measure of mental health acculturation is applied to Black individuals, who are expected to adhere to the dominant culture's views of health. A majority of the respondents expressed that the Black clients served were referred for OPMH services from some dimension of the legal system. This in itself may contribute to the stigma of mental health services within the Black or African American community (Copeland & Snyder, 2011; Hackett, 2014). Within the Black and African American community, mental

health services may not be viewed as a source of wellness, rather a punishment that is the result of some legal consequence.

The literature review discussed the ways in which Critical Race Theory (CRT) assists in conceptualizing the relationship between power and oppression as it relates to race. Chapter 2 explored the parallels between mental health and the legal system as it relates to race. The results of this study indicate further parallels related to mental health and the legal system that may be rooted in racial oppression. P.J. Williams (1997) purported that victims of systematic racism would attempt to counteract perceived prejudice, racism and discrimination. Responses indicate Black individuals who are forced to participate in OPMH services as a means of minimizing interactions from the legal system do not experience relief from societal pressures and stereotypes upon arrival to the OPMH agency.

The reason for referral is significant in this study focused on identifying the most appropriate services for African American clients participating in OPMH. Through CRT as a lens, American society has many racist norms (Delgado et al., 2001). Therefore, it is unlikely clients will be referred for the emotional and behavioral consequences of regularly dealing with systemic racism. This study revealed deductive approaches typically are not focused on identifying the ways in which Black clients perceive themselves as racial beings, and clinicians with external locus of control measure effectiveness based in how well Black clients “comply” without measuring resilience after involvement in the legal system (Rashid & Ostermann, 2009).

The results of this study indicated significant correlations with ethnicity and implicit racial preferences. Specifically, Black and Native American individuals were much more likely to not only have an implicit racial preference for African

Americans, but were also less likely to have an implicit racial preference for European Americans. Although there were not enough participants to generalize to the population, a discussion of the history of oppression and colonialism related to these two groups is warranted, specifically when discussing mental health outcomes. A systematic disconnect is suggested if successful outcomes are expected for clients who are members of these groups who may perceive mental health services as a product of colonialism, and are subsequently forced to participate as a result of poor interactions with the legal system.

These color-blind expectations were described in the responses from participants. One response explains the description of a Black woman required by CPS to participate in services: “she was identified as being belligerent and loud--possibly a DTO. She was in her mid-30s, single, with children, high school graduate, and involved with CPS and a custody issue.” This client, who was forced to participate in OPMH services, openly expressed her frustration with the system and as a result, her freedoms were further threatened as she was identified as a potential danger to others.

Crenshaw (1991) identified the ways in which individuals may inadvertently perpetuate racism. The respondent describing the event of the upset Black woman referred by CPS scored no preference for European or African Americans. This respondent expressed an understanding and awareness of the complex racial subtleties that the client was experiencing. Despite the client expressing her participation in OPMH services was only done in order to get her children back, the client was diagnosed and encouraged to return to participate in services.

The respondent expressed his experiences of working within the criminal justice system aided in his effectiveness with this client despite no identification of

this client ever being involved in the criminal justice system. Black/African American culture and the criminal justice culture are not synonymous, yet microaggressions like this not only appear to be common but are relevant for clinical decision making as it eliminates certain freedoms. Clients who are self-referred are motivated for treatment and can easily identify goals; however, clients who are referred by outside agencies who are motivated by threats of legal consequences may not benefit from services but are left with no other choice but to assimilate. The Epstein et al. (2017) study identified the prevalence of perceived stereotypes among professionals working with young Black women. The findings of the Epstein et al. (2016) study appear to be prevalent in this study and consequences have not yet been fully explored.

This possible forced assimilation exhibits parallels to the prison system for Black individuals living in the U.S. In order to minimize consequences from the legal system, Black individuals are forced to assimilate in aspects of the dominant culture that they may or may not have acculturated into. Delgado et al. (2001) explored the tradition of civil liberties only benefiting the White Americans it was created for. In some senses, mental health services appear to share these ideals. The subjective taxonomy that respondents use to prioritize immediate needs of Black individuals materializes the presenting problem as a characteristic separate from race unless explicitly stated. Participants did not offer an understanding of when they were able to identify clients as Black, and did not express any understanding of racial identity or race related issues including internalized oppression which Cross (1971) describes as a common occurrence within the Black community.

The potential consequences for the lack of a collection of racial or cultural experiences during the MHA can be reflected by the Agar et al. (2002) study. A

deductive approach inquiring about abuse was much more likely to identify histories of abuse. Clinicians explicitly inquiring about racial and cultural experiences will not only be able to identify the ways in which clients view themselves and others racially, but an understanding of mental health restoration learned from the culture of origin can minimize assimilation that can occur and set the client up for success.

Whaley (2001) found that of 154 Black clients recently admitted to an IPMH hospital, 72% believed that “people are more comfortable with clinicians of their own ethnic/racial group” (p. 254). This statistic can be compared to the 18.60% of participants, who completed the IAT, identified in this study to have an implicit racial preference for African Americans. When considering the activity required for completion and scoring of the IAT, 67.44% of participants who scored a preference of European Americans associate Black individuals with more negative connotations (Greenwald et al., 1998).

Participants in this study were different from previous articles discussing the diagnosis of Black clients. Unlike the Gara et al. (2012) study, respondents rarely identified diagnosing Black clients with psychotic disorders. A majority of clients identified by respondents were diagnosed with substance abuse and mood disorders. This may be due to the use of mood related tools during the MHA. It is worth noting, not one cultural tool was identified by any respondent.

The use of dissimilarity confrontation first studied by S. Sue and Zane (1987) was regularly discussed by respondents. It appears some clinicians are much more comfortable expressing any noticeable racial or cultural differences than others. The interviews completed in this study revealed some levels of discomfort and defensiveness that may occur when discussing race. This finding could be a result of the researcher’s apparent race and attempts by the respondents

to avoid offense. However, the discomfort experienced by clinicians in discussing race with a Black client warrants further research. Furthermore, for clinicians who are not comfortable with discussing race, racial experiences of a Black client can be minimized, ignored or conceptualized as the exception not the norm.

### **Implications for Practice**

The overarching question after the completion of this study changed from *how can mental health clinicians provide the most appropriate services to Black clients participating in OPMH services* to *what is the recourse for Black clients who are forced to participate in OPMH services (that may or may not agree with their cultural values) with threats of looming legal involvement?* This study identified the need for policy makers to explore the effectiveness of forced OPMH services. The SAMSHA (2015) report indicating high rates of African American involvement in IPMH may be attributed to how quickly removal of freedoms become an option for Black clients expressing their frustration with systems not working for them. Further research on this area is necessary.

This study identified the need for research and policies focused not only on CRT but also Critical Discourse Analysis (CDA). Previous studies that explored how Black clients interact with mental health services appear to blame Black clients for poor outcomes. This study identifies poor outcomes for Black clients referred to mental health services may be due to subjective and unclear prioritizations and a lack of best practices for Black clients referred from outside agencies. A need for exploration of the effectiveness of outcomes for clients referred by outside entities while considering intersectionality was identified by this study.

An unintended outcome of this study identified the need for more structured assessment practices among mental health clinicians. Many clinicians

expressed a disconnect from theory and practice, and identified deficits within agencies in identifying cultural information from the client. Current best practices indicate the collection of cultural experiences and understandings from clients (Foltz, 2012; Rogers-Sirin, 2013; Terrell & Terrell, 1981; Whaley, 2001; Whaley & Geller, 2007; Yakushko et al., 2009; Zhang & Burkard, 2008); however, responses indicate clinicians do not know how to do this or do not get the support to do so from their agency.

Previous literature that identified Black clients who were only interested in OPMH services provided by Black clinicians (Terrell & Terrell, 1984) appears to hold some validity. This exploratory study identified many areas in need of further exploration. Many of the clinicians who participated in this study identified previous trainings in Black culture. Before applicable practices can be established, further research is necessary to identify evidenced based applicable practices.

### **Recommendations**

One of the most notable findings of this study was that a majority of the participants identified participating in a training which included Black culture (86.57% of the total participants who completed the electronic survey). This suggests that cultural competency trainings do not do much for feelings of clinician effectiveness when working with Black clients. The participant who identified as Black with an implicit racial preference for African Americans reported the reasons she felt effective when working with Black clients: “I probably have a lot of positive, mostly positive associations towards Black people”. Beyond trainings, it is recommended that clinicians who want to become more effective when working with Black clients, have positive experiences with Black individuals. The best way to understand what is within normal limits of a culture is to be fully immersed in the culture. Many Black individuals living in the

U.S. do not have the opportunity to take breaks from the dominant culture and only surround themselves around people who identify alike culturally. This is however, something that White individuals have the opportunity to do within the U.S. Although it may be uncomfortable at times, seeking out positive experiences within the Black community may be an effective way to better understand (and therefore treat) Black clients.

The findings for this study although significant, are positive as feelings of effectiveness are dynamic variables that are subject to change. Clinicians interested in becoming more effective when working with Black clients are encouraged to seek out clinicians who feel more effective when working with Black clients. Clinicians are also encouraged to speak to individuals who identify as Black and practice becoming more comfortable openly discussing racial experiences specific to Black culture. Clinicians dealing with White fragility are encouraged to seek out their own counseling to identify and prevent any possible countertransference that may occur.

### **Suggestions for Future Research**

This exploratory study identified the need for further research that explores the complexities of race and implicit and explicit racial preferences as it relates to clinical decision making. The first suggestion for future research, however, aims at identifying the ways in which Black culture restores mental health. Many participants expressed that referrals for Black clients included referrals to churches and other religious sites. This is something that has been identified as an aspect within normal limits of Black culture (Terrell & Terrell, 1984); however, evidenced based practices regarding religion have not yet been identified a means of mental health outcomes for Black individuals. Identifying the ways in which mental health clinicians can use the norms of Black culture to restore their mental

health, can provide relevant information for best practices when working with individuals from the Black community.

The second suggestion for future research, based on the results of this study, include a regression model of the locus of control and implicit racial preferences. The combination of many factors found in the data appears to influence clinical decision making. A regression model of the approach and implicit racial preference is also suggested for future research. These clinician practices during the MHA with Black clients are hypothesized to have potential outcomes for forced assimilation.

The third suggestion for future research is to explore the ways in which clinician salient identities informs clinical decision making with clients. It is hypothesized that clinicians with racial salient identities are more likely to collect information regarding racial experiences and so on. Research regarding this clinical complexity could assist in identifying reasons for the subjectivity during the assessment. This could assist in identifying more objective ways to collect information during the assessment portion of treatment.

The final suggestion for future research is to explore the ways in which White fragility informs clinical decision making during the MHA portion of treatment with clients of color. This study suggested some clinicians are much more comfortable discussing race than others. The interview revealed that even discussing race can cause discomfort, defensiveness and an overall “bad” feeling in White clinicians. If clinicians are uncomfortable with discussions of race, explorations of how they collect racial experiences is warranted.

### **Summary**

This study identified that poor outcomes for African American clients participating in OPMH services may not be attributed to how the client works with

the services alone. The findings of this study identified validity in Black client's requests for Black clinicians as Black clinicians tend to be more likely to have an implicit racial preference for African Americans. The findings of this study suggest the potential for OPMH to not be a source of wellness for Black clients, but rather another system that perpetuates systematic racism.

On the other hand, many of the respondents expressed a genuine desire to meet the needs of Black clients. Perhaps OPMH can be an opportunity for Black clients to interact with individuals of other races who are focused on their well-being. In the same manner, OPMH can be an opportunity for non-Black clinicians to interact with Black clients focused on wellness and to learn about their life experiences from those Black clients. Finally, this study indicated a need for more structure and training in identifying when and how it is appropriate to collect racial information.

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## APPENDIX A: SURVEY

13. What is your gender?

- a. Female
- b. Male
- c. Other (Please State)
- d. Decline to State

14. What is your age

- a. 18-24 years old
- b. 25-34 years old
- c. 35-44 years old
- d. 45-54 years old
- e. 55-64 years old
- f. 65-74 years old
- g. 75 years or older

15. Your ethnicity (Pick one)

- a. White
- b. Hispanic or Latinx
- c. Black or African American
- d. Native American or American Indian
- e. Asian / Pacific Islander
- f. Multi-ethnic

16. What is the highest degree you have received?
- Trade/technical/vocational training
  - Associate degree
  - Bachelor's degree
  - Master's degree
  - Professional degree
  - Doctoral/medical degree
17. Which best describes your current profession or internship?
- Psychiatrist (e. g., M.D.)
  - Psychologist (e. g., Psy.D., Ph.D.)
  - Counselor/Therapist (e. g., LMFT, LPCC, MFTI, MFTT, MFCC)
  - Social Worker (e. g., LCSW, MSW)
  - Mental Health Nurse (Psychiatric nurse/tech, Nurse practitioner)
  - Substance Abuse Counselor (e. g., RAS)
18. At what kind(s) of Agency do you currently provide services? Pick One:
- County mental health
  - Specialty mental health,
  - Non-profit organization,

- d. Private practice
- e. Other (Specify)
- f. Multiple (Specify)

19. Do you complete the assessment over the course of multiple sessions? Yes/no
20. What is the average length of time it takes you to conduct a mental health assessment?
- a. Less than an hour
  - b. 1 to 2 hours
  - c. 2 to 3 hours
21. Approximately how many individual (not family, couples or group) clients did you provide services to last week?
22. Are you currently or in the past year have you provided direct mental health services to an individual client? Yes/No
23. Which entities do your African American clients bill to the most?
- a. Private Insurance
  - b. Cash
  - c. MediCaid
  - d. Medicare
  - e. Other (Please Specify)\_\_\_\_\_

24. Have you participated in any cultural competency training which included Black culture over the last 5 years (e. g., University courses, conferences, CEU's). Yes/no
25. On a scale of 1-10 how effective are you during Mental Health Assessments with Black Clients?  
1(not effective) 2 3 4 5 6 7 8 9 10 (highly effective)
26. On a scale of 1-10 how effective are you during Mental Health Assessments with White Clients?  
1(not effective) 2 3 4 5 6 7 8 9 10 (highly effective)
27. On a scale of 1-10 how effective are you during Mental Health Assessments?  
1(not effective) 2 3 4 5 6 7 8 9 10 (highly effective)
28. Open Ended Question: Describe a single effective mental health assessment with a Black client. (Be specific and provide details about why this assessment was effective. Possible things to consider: reason for referral, MHA tools used, diagnosis, why was it effective)
29. Would you be willing to complete an interview? Yes/No If yes, please provide contact information (phone/email)

## APPENDIX B: INTERVIEW QUESTIONS

1. What do you see as the purpose of the assessment?
2. How do you establish support with your clients during assessment?
3. What makes an assessment successful?
4. How does your approach vary with clients of different ethnic groups?
5. How do you think you scored on the IAT?
6. What do your IAT scores mean to you?
7. Did your IAT results change your perceived effectiveness? How so?
8. How do you work differently with Black clients?
9. Do you have any recommendations for other clinicians working with Black clients?

## APPENDIX C: CONSENT FORM FOR INTERVIEW

You are invited to participate in a research study about the clinical experiences of mental health professionals. You were selected as a possible participant in this study because you are a mental health professional who is currently or previously worked with individual clients in a clinical mental health setting. Your participation is voluntary and there are no known risks or costs. You are asked to complete a 20-minute questionnaire. **IN ORDER TO FULLY PARTICIPATE, A KEYBOARD IS NECESSARY.** The information collected may or may not benefit you by informing your practice with particular populations, and ideally will inform best practices. Any information obtained in connection you will remain confidential and will be disclosed only with your permission or as required by law. No one will be able to identify you or your answers, and no one will know whether you participated in the study. Individuals from the Institutional Review Board may inspect these records. Should the data be published, no individual will be disclosed.

In you have any questions about the study, please contact Tiffany White, tcw69945@mail.fresnostate.edu (559) 707-8721 or Susan Tracz, susant@csufresno.edu, (559) 278-0347. The California State University, Fresno (Fresno State) Review Board has reviewed my request to conduct this project. Questions regarding the rights of research subjects may be directed to Kris Clarke, Chair, CSU Fresno Committee on the Protection of Human Subjects, (559) 278-4468.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name Printed \_\_\_\_\_

Researcher Signature \_\_\_\_\_ Date \_\_\_\_\_

## APPENDIX D: CONSENT FORM FOR INTERVIEW

You are invited to participate in a research study about the clinical experiences of mental health professionals. This study is being conducted by Tiffany White from the Doctoral Program in Educational Leadership at California State University, Fresno (Fresno State), in fulfillment of the doctoral degree.

You were selected as a possible participant in this study because you are a mental health professional who is currently (or have previously) worked with individual clients in a clinical mental health setting. Your participation in this study is voluntary and there are no known risks if you decide to participate in this research study and there are no costs for your participation in this study. Your participation will consist of a scheduled 15-20 minute interview. The information collected may or may not benefit you directly by informing your practice with particular populations. Ideally the information collected in this study will inform best practices when working with specific populations.

Any information that is obtained in connection with this study that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. No one will be able to identify you or your answers, and no one will know whether you participated in the study. Individuals from the Institutional Review Board may inspect these records. Should the data be published, no individual will be disclosed.

In you have any questions about the study, please contact Tiffany White, [tcw69945@mail.fresnostate.edu](mailto:tcw69945@mail.fresnostate.edu) (559) 707-8721 or Susan Tracz, [susant@csufresno.edu](mailto:susant@csufresno.edu), (559) 278-0347.

The California State University, Fresno (Fresno State) Review Board has reviewed my request to conduct this project. Questions regarding the rights of research subjects may be directed to Kris Clarke, Chair, CSU Fresno Committee on the Protection of Human Subjects, (559) 278-4468.

I agree to be interviewed and audio taped.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name Printed \_\_\_\_\_

Researcher Signature \_\_\_\_\_ Date \_\_\_\_\_