

Treatment-Seeking Disparity Between African Americans and Whites: Attitudes Toward Treatment, Coping Resources, and Racism

Juleen K. Buser

African Americans seek mental health treatment at lower rates than Whites. This disparity has been attributed to African Americans' attitudes toward services, alternate coping, and differences in care. Research on microaggressions adds an important element to this literature. Including discussion of microaggressions in counseling training may illuminate subtle student biases.

Los individuos Afroamericanos buscan recibir tratamientos de salud mental en un índice menor que los Blancos. Esta disparidad ha sido atribuida a las actitudes de los Afroamericanos hacia los servicios, formas de afrontamiento alternativas, y a las diferencias en la asistencia. Las investigaciones sobre microagresiones añaden un elemento importante a esta documentación. Incluir la discusión sobre microagresiones en la formación de consejeros puede iluminar los sesgos sutiles de los estudiantes.

Despite studies indicating that African Americans struggle with mental illness and may deal with more persistent mental health issues than Whites (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005; Kessler et al., 1994; Robins & Regier, 1991), African Americans seek treatment at lower rates than Whites do (Angold et al., 2002; Kearney, Draper, & Baron, 2005; Song, Sands, & Wong, 2004). This treatment-seeking disparity is often explained through an emphasis on African Americans' attitudes toward mental health service, coping resources in the African American community, and forms of racial bias in mental health care (Breland-Noble, Bell, & Nicolas, 2006; Snowden, 2003). Much of the research on the treatment-seeking disparity does not emphasize subtle forms of racism in mental health treatment. However, literature has also focused on aversive racism—such as microaggressions—in mental health professions (e.g., Constantine & Sue, 2007; Sue et al., 2007; Sue, Nadal, et al., 2008). This research adds a crucial element in explaining African Americans' hesitancy to seek mental health care (Constantine, 2007).

In this review, I underscore literature on the stigma associated with seeking mental health services in the African American community, coping resources often used by African Americans, and racial differences in mental health care. Although it is imperative to consider these reasons, they alone cannot explain the discrepant treatment-seeking rates. I also review emerging research on microaggressions in the therapeutic encounter to explain African American

Juleen K. Buser, Department of Counseling and Human Services, Syracuse University. Portions of this article were presented at the 2008 American Counseling Association Convention in Honolulu, HI. Correspondence regarding this article should be addressed to Juleen K. Buser, Department of Counseling and Human Services, Syracuse University, 259 Huntington Hall, Syracuse, NY 13244 (e-mail: jkbuser@syr.edu).

© 2009 American Counseling Association. All rights reserved.

hesitancy to pursue care. Ultimately, these findings reveal the obvious and insidious ways in which racism continues to persist and present a call to counselors to address these realities in practice and training.

mental illness rates

Comparisons of physical disease among racial groups have garnered more research attention than investigations of mental illness differences (Breslau et al., 2005). However, a body of research has examined mental illness rates in the African American community (Breslau et al., 2005; Kessler et al., 1994; Robins & Regier, 1991).

The Epidemiologic Catchment Area Study was conducted in the 1980s and included 4,638 African American, 12,944 White, and 1,600 Hispanic samples taken from the general community and from institutions (Robins & Regier, 1991; U.S. Department of Health and Human Services, 2001). The Epidemiologic Catchment Area Study found that African Americans had a higher lifetime prevalence of mental disorders, but this difference disappeared after accounting for demographics and socioeconomic status (SES [Robins & Regier, 1991; U.S. Department of Health and Human Services, 2001]). However, African Americans were found to have twice the lifetime prevalence of agoraphobia and phobia when compared with Whites (Kessler et al., 1994; Robins & Regier, 1991).

The National Comorbidity Survey (NCS) was conducted in the early 1990s with a stratified sample of 8,098 U.S. citizens ranging in age from 15 to 54. The sample included 4,498 Whites, 666 African Americans, and 713 from other racial groups (Kessler et al., 1994; U.S. Department of Health and Human Services, 2001). These authors reported that African Americans had a lower lifetime prevalence of mental disorders than Whites had. Breslau et al. (2005) conducted an in-depth analysis of the NCS data and reported that after controlling for gender, age, and SES, African Americans displayed more persistent mental illness than Whites do. A *persistent mental disorder* was defined as one that presented 2 years or more prior to data collection and was also present during the year before the interview.

Research has typically reported a lower incidence of suicide among African Americans when compared with Whites and American Indian/Alaska Natives (Centers for Disease Control and Prevention [CDC], 2007b). Studies have found similar suicide rates among Asian American/Pacific Islanders, Hispanics, and African Americans (CDC, 2007b). However, suicide rates among African Americans may be underreported because of the misclassification of suicides as other causes of death, such as homicides and accidental deaths (Phillips & Ruth, 1993). In addition, certain age groups of African Americans may be at high risk for suicide. From 1980 to 1995, suicide rates among African American youths ages 10 to 19 increased at a faster pace than suicide rates of White youths (CDC, 1998).

Researchers have concluded that the evidence reveals similar rates of mental illness between African Americans and Whites (U.S. Department of Health and

Human Services, 2001). However, issues such as differences in recall among racial groups and bias in the survey items used to measure mental illness may affect results (Breslau et al., 2005). Authors have also noted that, as African Americans are overrepresented in high-need populations not measured by national surveys, an accurate picture of African American mental health may not be provided (Snowden, 2001).

treatment seeking

As documented above, African Americans deal with a variety of mental health concerns and may struggle with more persistent mental illness than Whites do, yet research has found that African Americans seek treatment for mental illness at lower rates than Whites do (Angold et al., 2002; Kearney et al., 2005; Song et al., 2004). This discrepancy persists when SES is controlled (Snowden, 2003). Authors have noted that the treatment-seeking difference may be related to a host of issues, including attitudes toward psychological services, a reliance on other coping mechanisms, and bias in mental health care (Breland-Noble et al., 2006; Snowden, 2003). The emerging literature on racial microaggressions in the therapeutic encounter (e.g., Constantine, 2007; Sue et al., 2007; Sue, Nadal, et al., 2008) adds crucial data to the discussion of African Americans' hesitancy to seek care.

STIGMA

Some literature has discussed the perception of stigma voiced by African Americans regarding mental illness (Breland-Noble, 2004). Lindsey et al. (2006) conducted a qualitative study of 18 African American male adolescents. A theme emerging in these interviews was a reluctance to seek mental health care because of a fear of mockery from their peers and a social perception of weakness. In another qualitative study with 70 participants, Matthews, Corrigan, Smith, and Aranda (2006) reported that African American participants identified disgrace, embarrassment, and isolation associated with mental illness as barriers to seeking services.

Although stigma in the family and community may play a role in dissuading some African Americans from seeking mental health care, researchers have reported conflicting evidence on the pervasiveness of this stigma. Diala et al. (2001) used data on 5,877 U.S. individuals from the NCS (Kessler et al., 1994) and found that African Americans reported minimal perception of stigma related to seeking mental health services. In fact, when adjusting for demographics, African American respondents indicated that they would be less likely than Whites to feel embarrassment about friends discovering that they were seeking treatment.

However, in Diala et al.'s (2001) study, mental health treatment was defined broadly as "professional help." Participants could have interpreted this term-

nology to include religious leaders and primary care physicians. Research has found that African Americans are more likely to seek mental health assistance from primary care physicians and religious leaders than from mental health professionals (Taylor, Chatters, & Levin, 2004). Diala et al. (2001) might have obtained different results if they had defined "professional help" specifically as mental health counseling.

Research by Schnittker, Freese, and Powell (2000) adds another important element to the literature on African American attitudes toward mental health care. These authors found no racial differences in attitudes toward mental health treatment after controlling for participants' beliefs about the cause of mental illness. Individuals who believed that the etiology of mental illness was rooted in genetic factors, family upbringing, or a chemical imbalance were more likely to endorse mental health services. On the other hand, individuals who believed that mental illness was due to God's will were less likely to express positive attitudes toward mental health treatment. Schnittker et al. (2000) found that African Americans were less likely than Whites were to believe that mental illness was caused by family upbringing or genetic factors. The authors also reported evidence that suggested African Americans might be somewhat more likely than Whites to attribute the cause of mental illness to God's will. Future research should continue this line of inquiry by examining African Americans' attitudes regarding seeking mental health services and their beliefs about the etiology of mental illness.

COPING MECHANISMS

African Americans may also be hesitant to seek mental health treatment because of a wealth of personal and cultural coping resources; these resources may serve as substitutes for professional mental health assistance and may proliferate social norms about the irrelevance of such service (Snowden, 2001).

John Henryism is one alternate coping method; this construct is based on the legend of an African American steel worker who won a physical challenge with a steam drill (Bennett et al., 2004; James, 1994). *John Henryism* has been defined as a form of active coping and purposeful striving against barriers and stressors (James, 1994).

John Henryism has been found to differentially affect African Americans based on SES. It has been linked to physical health benefits among high-SES male African Americans (Bonham, Sellers, & Neighbors, 2004) and has been associated with increased blood pressure in African American men with low educational attainment (Merritt, Bennett, Williams, Sollers, & Thayer, 2004). Authors have suggested that, for individuals who have access to a range of resources because of their education level (e.g., social networks, job prospects, knowledge of healthy behaviors), John Henryism is adaptive and beneficial; however, for individuals who lack access to resources, continual striving may lead to persistent strain on the cardiovascular system (James, 1994; Merritt et al., 2004).

Authors have hypothesized that a belief in the ability to overcome stressors through personal effort may be related to a disinclination to seek treatment. This belief, it is argued, supports a cultural norm of self-sufficiency (Breland-Noble et al., 2006; Snowden, 2001). In Lindsey et al.'s (2006) qualitative study mentioned earlier, African American male adolescents spoke about a tendency for males to rely on personal stamina and pride to overcome problems.

The importance of social support has been hypothesized to relate to African American treatment seeking (Snowden, 2001). Authors have posited that familial and social sources may serve as indirect sources of support; African Americans may rely on the encouragement of family and friends rather than directly asking them for assistance (Snowden, 1998). Research has documented the beneficial impact of social supports on the well-being of African Americans. For example, the use of collective coping styles among African Americans has been found to predict positive quality-of-life outcomes above traditional resiliency markers (Utsey, Bolden, Lanier, & Otis, 2007).

The role of faith in the lives of many African American families has been hypothesized to affect treatment-seeking behaviors (Breland-Noble et al., 2006). Research has found that African Americans report seeking assistance for personal problems from religious leaders to a greater degree than from mental health professionals (Taylor et al., 2004). Blank, Mahmood, Fox, and Guterbock (2002) found that African American churches provided more mental health and social services than White churches do. Neighbors, Musick, and Williams (1998) reported that African Americans who initially sought assistance from clergy for personal problems were less likely to seek mental health services than were Whites. Some research has supported the notion that faith may promote norms regarding the sufficiency of one's religion in dealing with mental illness; Matthews et al. (2006) found that religious community leaders and members reported negative views about mental health treatment, voicing opinions that use of medication would be tantamount to admitting a loss of faith in God.

Authors have also discussed the indirect nature of support African Americans may garner from their church community and spiritual beliefs (Snowden, 1998; Taylor et al., 2004). Utsey et al. (2007) reported that spiritual coping was predictive of quality of life above traditional resiliency markers. Bierman (2006) found that attending religious services protected African Americans from the negative mental health effects of discrimination.

RACIAL DISPARITIES IN MENTAL HEALTH TREATMENT

In addition to focusing on African Americans' coping and attitudes toward treatment, authors have also discussed a lack of African American trust in the medical profession (Breland-Noble et al., 2006; Freimuth et al., 2001; Matthews et al., 2006; Whaley, 2001). For example, in their qualitative exploration of 70 African Americans' attitudes, Matthews et al. (2006) found that many participants believed that mental illness was used as a negative, limiting label

on African American children. This mistrust has been linked, in part, to a historical instance of racism in health care (Breland-Noble et al., 2006).

The "Tuskegee Study of Untreated Syphilis in the Negro Male," from 1932 to 1972, has had a lasting impact on the African American community (Breland-Noble, 2004; CDC, 2007a). In this study, 399 African American men with syphilis and 201 controls were studied but not informed of the research—they were denied penicillin and other treatment, and ultimately 20 to 100 likely died because of syphilis (Freimuth et al., 2001).

Freimuth et al. (2001) conducted a focus group study with 60 African Americans in four major U.S. cities in 1997. In this qualitative analysis, Freimuth et al. found that a majority of the participants were aware of the Tuskegee Study, seeing it as representative of much current medical research. The authors reported a prevalent theme of mistrust of White researchers, and racism was often referred to as a reason for this mistrust. Participants also conveyed mistrust of the mental health care system. One woman asserted a sentiment that the prescription of psychotropic medication to African Americans was a plot to maintain insanity. Similarly, in Matthews et al.'s (2006) study, some participants believed that medication was addictive and worked to maintain mental illness.

The literature has documented disparate practices in mental health care, such as differences in diagnosis and prescription patterns (Snowden, 2003). These disparities may affect African Americans' mistrust of the mental health system. Research has shown that African Americans are more likely to be diagnosed with schizophrenia than Whites are (Snowden & Cheung, 1990). Authors have concluded that racial bias is a part of this diagnosis difference; clinicians may hold racial stereotypes about mental illness (Neighbors, Jackson, Campbell, & Williams, 1989). For example, Loring and Powell (1988) asked a sample of psychiatrists to provide a diagnosis for case studies differing only in client race and gender. Male African Americans were more likely to be diagnosed with paranoid schizophrenia, and African Americans of both genders were more likely to be diagnosed with a paranoid personality disorder. The authors noted that White psychiatrists exhibited this pattern to a greater degree.

The prescription of psychotropic medications has also been found to differ according to race. Zito et al. (1997) reported that during 1991 in Maryland, 1,331 Medicaid prescription claims were made for White children and adolescents and 836 claims were made for African American children and adolescents. This study found that African American children and adolescents were 2.6 times less likely to be given methylphenidate than White children and adolescents were.

Some of the difference in prescribing rates of psychotropic medication may be attributable to the tendency of African Americans to seek mental health care from primary care physicians rather than psychiatrists (Snowden & Pingitore, 2002). Research has found that primary care physicians may underdiagnose mental illness (Higgins, 1994). However, Snowden and Pingitore (2002) found that after controlling for demographics, primary care physicians prescribed fewer psychotropic medications to African Americans than to Whites.

Snowden and Pingitore (2002) noted that a range of issues could have influenced the differential prescription practice among physicians in their study, including African Americans' hesitancy to use psychotropic medications (Givens, Houston, Van Voorhees, Ford, & Cooper, 2007) and the fact that data suggest African Americans may metabolize some antipsychotic and antidepressant medications at a slower rate than Whites do (U.S. Department of Health and Human Services, 2001). Issues of biased care may also be an explanation for the disparate prescription rates (Snowden, 2003).

Other research has found that African Americans are less likely to receive more current psychotropic medications. Kuno and Rothbard (2002) studied 2,515 Medicaid clients with schizophrenia. These authors found that African American clients were less likely to receive atypical antipsychotics—which are believed to produce more beneficial effects—and were more likely to be given earlier-generation depot antipsychotics. These findings may be evidence of biased mental health treatment (Snowden, 2003). However, Kuno and Rothbard (2002) noted that although they did not measure clinical symptomatology differences between African Americans and Whites, such differences could explain these discrepant prescription practices.

The literature on the treatment-seeking disparity documents African American coping resources, attitudes toward the mental health profession, and differences in mental health care. Although these factors may contribute to the disparate rates of treatment seeking, they do not fully explain why such differences exist. The impact of unintentional and subtle forms of racism adds an important element to this literature.

MICROAGGRESSIONS

Differences in diagnostic and prescription practices suggest the possibility of racial bias in mental health care (Neighbors et al., 1989; Snowden, 2003). This potential bias is located in fairly obvious practices—not as overt as the practices of Jim Crow racism but more obvious than microaggressions, which often lie beyond the conscious awareness of the perpetrator (Sue et al., 2007). Microaggressions have been defined as “brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group” (Sue et al., 2007, p. 273). Two types of unintentional microaggressions have been identified: microinvalidations and microinsults (Sue et al., 2007; Sue, Nadal, et al., 2008).

These often unintended, yet damaging, microaggressions are usually the way in which racism is displayed today; Lawrence (1987) asserted that overt racism has become taboo, but society's collective unconscious continues to be embedded in racist assumptions. The counseling field is recognizing that the more obvious forms of discrimination—although still apparent—are not the only markers of racism in therapy (Constantine, 2007; Whaley, 1998). Counselors strive not to be intentionally biased, and training programs emphasize

cultural competencies, self-awareness, and recognition of one's racial identity (Roysircar, Arredondo, Fuertes, Ponterotto, & Toporek, 2003; Sue, Arredondo, & McDavis, 1992; Sue et al., 2007). By virtue of this training in counseling and the impetus to become a therapist in the first place, counselors may assume they are impervious to initiating microaggressions on clients (Constantine, 2007). This assumption, however, has been shown to be inaccurate; microaggressions do occur in therapy (Constantine, 2007). Yet, given the position of power clinicians hold in the therapy dyad, the often unintentional nature of this form of racism, and a counselor's conviction of being unprejudiced, microaggressions are likely to go undetected (Sue et al., 2007).

The emerging body of empirical and theoretical work in the counseling field examining racial microaggressions has identified several types of these subtle displays of racism in counseling. Constantine (2007) studied African American clients' perceptions of microaggressions initiated by their White therapists. Microaggressions that clients experienced included counselors avoiding discussion of cultural issues in session, denying the harboring of racial biases, accusing the client of being too sensitive about racial issues, being unaware of racial issues, communicating racial stereotypes, and using culturally inappropriate therapeutic assistance.

Constantine and Sue (2007) qualitatively examined microaggressions that occurred between Black supervisees, who were doctoral students in clinical or counseling psychology programs, and their White supervisors. Microaggressions inflicted by White supervisors included an invalidation of racial and cultural issues; biased beliefs about Black clients and Black supervisees; a failure to give a balanced evaluation of Black supervisees; a propensity to locate the source of mental problems in clients of color rather than in external forces, such as discrimination; and suggestions of treatment for clients of color that were not sensitive to the client's culture.

Researchers have also studied the impact of microaggressions. Constantine (2007) reported that African American clients' perception of racial microaggressions by their White counselor predicted a weaker therapeutic alliance. Research has reported that the therapeutic relationship is a strong predictor of mental health outcomes (Horvath & Symonds, 1991). A specific microaggression—color-blind racial attitudes (Sue et al., 2007; Sue, Nadal, et al., 2008)—has been found to be detrimental in counseling. Therapists with high levels of color-blind beliefs reported less empathy for clients and were more likely to believe that African American clients were responsible for the solution to their problems (Burkard & Knox, 2004).

In addition to examining the impact of microaggressions in therapy, researchers have also discussed the impact of microaggressions on those who are recipients of this subtle racism in everyday life (Sue et al., 2007). In a focus group study, Black participants reported several psychological consequences of microaggressions: feelings of powerlessness, a sense of invisibility, a sacrifice of personal integrity to meet White standards, and feeling forced to

represent one's racial group (Sue, Capodilupo, & Holder, 2008). Solórzano, Ceja, and Yosso (2000) reported that racial microaggressions affected African American college students through increasing exhaustion, discouragement, and negative academic performance.

conclusion

African Americans face mental health concerns, as evidenced by data on mental illness rates (Breslau et al., 2005; Kessler et al., 1994; Robins & Regier, 1991; U.S. Department of Health and Human Services, 2001). Yet research has documented the disparate rates of treatment seeking between African Americans and Whites (Angold et al., 2002; Kearney et al., 2005; Song et al., 2004). Authors have asserted that this treatment-seeking disparity may be related to issues such as African Americans' attitudes toward mental illness and services, cultural coping mechanisms, and biased practices in mental health care (Breland-Noble et al., 2006; Snowden, 2003). Although these issues are important, they do not offer a full account of the treatment-seeking discrepancy. The literature on microaggressions in mental health practice is also vital in understanding African American hesitancy to seek care for mental illness. The research on microaggressions points to subtle forms of racism that can go unnoticed and unacknowledged by counselors (Constantine, 2007; Sue et al., 2007; Sue, Nadal, et al., 2008).

The literature reviewed in this study has implications for counselors. Counselors need to commit to a multicultural counseling competency that includes awareness of the racism present in mental health treatment. This racism includes unintentional racist comments and actions that damage the therapeutic alliance. Including a discussion of microaggressions in counseling training programs is vital in order to bring students' unconscious racist beliefs into the open and to ultimately develop ethical, culturally competent practitioners (Constantine, 2007; Sue et al., 2007; Sue, Nadal, et al., 2008; Whaley, 1998).

references

- Angold, A., Erknali, A., Farmer, E., Fairbank, J., Burns, B. J., Keeler, G., & Costello, J. (2002). Psychiatric disorder, impairment, and service use in rural African American and White youth. *Archives of General Psychiatry*, *59*, 893-901.
- Bennett, G. F., Merritt, M. M., Sollers, J. J., Edwards, C. L., Whitefield, K. E., Brandon, D. T., & Tucker, R. D. (2004). Stress, coping, and health outcomes among African-Americans: A review of the John Henryism hypothesis. *Psychology and Health*, *19*(3), 369-383.
- Bierman, A. (2006). Does religion buffer the effects of discrimination on mental health? Differing effects by race. *Journal for the Scientific Study of Religion*, *45*(4), 551-565.
- Blank, M. B., Mahmood, M., Fox, J. C., & Guterbock, T. (2002). Alternative mental health services: The role of the Black church in the South. *American Journal of Public Health*, *92*, 1668-1672.
- Bonham, V. L., Sellers, S. L., & Neighbors, H. A. (2004). John Henryism and self-reported physical health among high-socioeconomic status African American men. *American Journal of Public Health*, *94*(5), 737-738.

- Breland-Noble, A. M. (2004). Mental healthcare disparities affect treatment of Black adolescents. *Psychiatric Annals*, *34*, 534-541.
- Breland-Noble, A. M., Bell, C., & Nicolas, G. (2006). Family first: The development of an evidence-based family intervention for increasing participation in psychiatric clinical care and research in depressed African American adolescents. *Family Process*, *45*(2), 153-169.
- Breslau, J., Kendler, K. S., Su, M., Gaxiola-Aguilar, S., & Kessler, R. C. (2005). Lifetime risk and persistence of psychiatric disorders across ethnic groups in the United States. *Psychological Medicine*, *35*, 317-327.
- Burkard, A. W., & Knox, S. (2004). Effect of therapist color-blindness on empathy and attributions in cross-cultural counseling. *Journal of Counseling Psychology*, *51*, 387-397.
- Centers for Disease Control and Prevention. (1998, March 20). Suicide among Black youths—United States, 1980-1995. *Morbidity and Mortality Weekly Report*. Retrieved October 15, 2008, from www.cdc.gov/mmwr/preview/mmwrhtml/00051591.htm
- Centers for Disease Control and Prevention. (2007a). *U.S. public health services syphilis study at Tuskegee: The Tuskegee timeline*. Retrieved May 15, 2007, from <http://www.cdc.gov/nchstp/od/tuskegee/time.htm>
- Centers for Disease Control and Prevention. (2007b). *WSIQARS injury mortality reports: 1999-2005*. Retrieved October 3, 2008, from http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html
- Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology*, *54*, 1-16.
- Constantine, M. G., & Sue, D. W. (2007). Perceptions of racial microaggressions among Black supervisees in cross-racial dyads. *Journal of Counseling Psychology*, *54*, 142-153.
- Diala, C. C., Muntaner, C., Walrath, C., Nickerson, K., LaVeist, T., & Leaf, P. (2001). Racial/ethnic differences in attitudes toward seeking professional mental health services. *American Journal of Public Health*, *91*(5), 805-807.
- Freimuth, V. S., Quinn, S. C., Thomas, S. B., Cole, G., Zook, E., & Duncan, T. (2001). African Americans' views on research and the Tuskegee Syphilis Study. *Social Science and Medicine*, *52*, 797-808.
- Givens, J. L., Houston, T. K., Van Voorhees, B. W., Ford, D. E., & Cooper, L. A. (2007). Ethnicity and preferences for depression treatment. *General Hospital Psychiatry*, *29*, 182-191.
- Higgins, E. S. (1994). A review of unrecognized mental illness in primary care: Prevalence, natural history and efforts to change the course. *Archives of Family Medicine*, *3*(10), 908-917.
- Horvath, A. O., & Symonds, B. D. (1991). Relationship between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, *38*, 139-149.
- James, S. A. (1994). John Henryism and the health of African-Americans. *Culture, Medicine, and Psychiatry*, *18*(2), 163-182.
- Kearney, L. K., Draper, M. D., & Baron, A. (2005). Counseling utilization by ethnic minority college students. *Cultural Diversity and Ethnic Minority Psychology*, *11*(3), 272-285.
- Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., et al. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Archives of General Psychiatry*, *51*, 8-19.
- Kuno, E., & Rothbard, A. B. (2002). Racial disparities in antipsychotic prescription patterns in patients with schizophrenia. *American Journal of Psychiatry*, *159*(4), 567-572.
- Lawrence, C. L. (1987). The id, the ego, and equal protection: Reckoning with unconscious racism. *Stanford Law Review*, *39*, 235-260.
- Lindsey, M. A., Korr, W. S., Broitman, M., Bone, L., Green, A., & Leaf, P. J. (2006). Help-seeking behaviors and depression among African American adolescent boys. *Social Work*, *51*(1), 49-58.
- Loring, M., & Powell, B. (1988). Gender, race, and DSM-III: A study of the objectivity of psychiatric diagnostic behavior. *Journal of Health and Social Behavior*, *29*, 1-22.
- Matthews, A. K., Corrigan, P. W., Smith, B. M., & Aranda, F. (2006). A qualitative exploration of African-Americans' attitudes toward mental illness and mental illness treatment seeking. *Rehabilitation Education*, *20*(4), 253-268.
- Merritt, M. M., Bennett, G. G., Williams, R. B., Sollers, J. J., & Thayer, J. F. (2004). Low educational attainment, John Henryism, and cardiovascular reactivity to and recovery from personally relevant stress. *Psychosomatic Medicine*, *66*, 49-55.
- Neighbors, H. W., Jackson, J. J., Campbell, D., & Williams, D. (1989). Racial influences on psychiatric diagnosis: A review and suggestions for research. *Community Mental Health Journal*, *25*(4), 301-311.

- Neighbors, H. W., Musick, M. A., & Williams, D. R. (1998). The African American minister as a source of help for serious personal crises: Bridge or barrier to mental health care? *Health Education and Behavior, 25*(6), 759–777.
- Phillips, D. P., & Ruth, T. E. (1993). Adequacy of official suicide statistics for scientific research and policy. *Suicide and Life-Threatening Behavior, 23*(4), 307–319.
- Robins, L. N., & Regier, D. A. (Eds.). (1991). *Psychiatric disorders in America: The Epidemiologic Catchment Area study*. New York: Free Press.
- Roysircar, G., Arredondo, P., Fuertes, J. N., Ponterotto, J. G., & Toporek, R. L. (2003). *Multicultural counseling competencies 2003: Association for Multicultural Counseling and Development*. Alexandria, VA: American Counseling Association.
- Schnittker, J., Freese, J., & Powell B. (2000). Nature, nurture, neither, nor: Black–White differences in beliefs about the causes and appropriate treatment of mental illness. *Social Forces, 78*(3), 1101–1130.
- Snowden, L. R. (1998). Racial differences in informal help seeking for mental health problems. *Journal of Community Psychology, 26*(5), 429–438.
- Snowden, L. R. (2001). Barriers to effective mental health services for African Americans. *Mental Health Services Research, 3*(4), 181–187.
- Snowden, L. R. (2003). Bias in mental health assessment and intervention: Theory and evidence. *American Journal of Public Health, 93*(2), 239–243.
- Snowden, L. R., & Cheung, F. K. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist, 45*, 347–355.
- Snowden, L. R., & Pingitore, D. (2002). Frequency and scope of mental health service delivery to African Americans in primary care. *Mental Health Services Research, 4*(3), 123–130.
- Solórzano, D., Ceja, M., & Yosso, T. (2000). Critical race theory, racial microaggressions, and the campus racial climate: The experiences of African American college students. *Journal of Negro Education, 69*(1-2), 60–73.
- Song, D., Sands, R. G., & Wong, Y. I. (2004). Utilization of mental health services by low-income pregnant and postpartum women on medical assistance. *Women and Health, 39*(1), 1–24.
- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies: A call to the profession. *Journal of Counseling & Development, 70*, 477–486.
- Sue, D. W., Capodilupo, C. M., & Holder, A. M. B. (2008). Racial microaggressions in the life experiences of Black Americans. *Professional Psychology: Research and Practice, 39*, 329–336.
- Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*, 271–286.
- Sue, D. W., Nadal, K. L., Capodilupo, C. M., Lin, A. I., Torino, G. C., & Rivera, D. P. (2008). Racial microaggressions against Black Americans: Implications for counseling. *Journal of Counseling & Development, 86*, 330–338.
- Taylor, R. J., Chatters, L. M., & Levin, J. L. (2004). *Religion in the lives of African Americans: Social, psychological, and health perspectives*. Thousand Oaks, CA: Sage.
- U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General*. Retrieved May 15, 2007, from <http://mentalhealth.samhsa.gov/cre/toc.asp>
- Utsey, S. O., Bolden, M. A., Lanier, Y., & Otis, W. (2007). Examining the role of culture-specific coping as a predictor of resilient outcomes in African Americans from high-risk urban communities. *Journal of Black Psychology, 33*(1), 75–93.
- Whaley, A. L. (1998). Racism in the provision of mental health services: A social-cognitive analysis. *American Journal of Orthopsychiatry, 68*(1), 47–57.
- Whaley, A. L. (2001). Cultural mistrust: An important psychological construct for diagnosis and treatment for African Americans. *Professional Psychology: Research and Practice, 32*, 555–562.
- Zito, J. M., Safer, D. J., dosReis, S., Pharm, B. S., Magder, L. S., & Riddle, M. A. (1997). Methylphenidate patterns among Medicaid youths. *Psychopharmacology Bulletin, 33*(1), 143–147.