2018

The Influence of Race and Gender on the Choice of a Mental Health Provider

Meghan Rackers

Abstract

Although the current mental health treatment model provides little opportunity for consumers of services to exert control of their mental health experiences (specifically when choosing a provider), the ability to select a service provider may aid in the formation of the therapeutic alliance. The abundance of research regarding the topic of racial and gender matching of clinicians and clients has focused on treatment outcomes and client retention, and less on client preference and how it relates to likelihood that they will seek out services. Previous studies have used face-valid surveys asking whether clients would prefer a clinician who is a member of their racial or gender in-group – a method that is susceptible to social desirability bias. The current study proposed a new method of assessing service provider preference that is less susceptible to social desirability bias: by providing participants with a hypothetical scenario asking if they will seek services from a given service provider in a confidential online survey setting. The results indicated that there was not a significant difference in the likelihood of an individual to seek services when they were presented with a race and gender match.

TABLE OF CONTENTS

Abstract…….……,……...…….iii
Table of Contents…….…….……...……..….iv
Chapter I: Review of the Current Literature…….…….....…….1
Chapter II: Methodology…… ……...….10
Chapter III: Analysis…….…....13
Chapter IV: Results…….……...….14
Chapter V: Discussion……...……...…..15
Appendix A: IRB Approval Letter……24
Appendix B: Informed Consent…….…....25
Appendix C: Demographic Questions…….……..27
Appendix D: Clinician Photos from the Chicago Faces Database……....28
Appendix E: Clinician Profile……...29
References…….…30

The Influence of Race and Gender on the Choice of a Mental Health Provider

Treatment in the mental health field is marked by intense, often intimate interpersonal interactions between clients and providers. These interactions can be affected by innumerable variables such as personality traits of client and clinician and the situation under which the interaction is occurring (voluntary treatment or institutionally-mandated). While client characteristics have been extensively studied (e.g., income level, race, access to services), most research focusing on the clinician has focused on how personality traits of the provider are affecting the therapeutic relationship. In contrast, the role of demographic characteristics – age, race, and sex of both the provider and client – have received relatively little attention. Previous research has relied on self-report measures to gather information about the impact demographics of the therapist has on the therapeutic interaction. This literature suggests that the demographic characteristics of the therapist were not relevant to therapeutic efficacy. However, social desirability bias may artificially deflate statistical results when socially sensitive topics (such as race) are being discussed. Ergo, demographic characteristics of the provider – in particular, the extent to which they are similar to those of a client – may be more important than previous research suggests.

Research on human interaction supports the theory that human beings prefer to associate with individuals who are like them, and therefore they will prefer to interact with someone who they perceive to be similar to themselves (Newcomb, 1961). This phenomenon is often referred to as "ingroup bias" (Taylor & Moriarty, 1987). For example, when differences between the groups are more salient, the bias against members of the outgroup is more blatant. Race and gender are two very obvious group attributes that are assessed immediately upon meeting someone, ergo, individuals are more likely to experience in group bias when confronted with

members who differ on these dimensions (Brewer, 1979). Further research by Wilder (1986) found that individuals will seek out information to identify the members of the in-group, even when the inclusion criteria are unimportant, such as preference for a certain artist's paintings. Thus, it is reasonable to assume that clients are using the same process as a heuristic to make judgments about possible providers – a decision with significant consequences not always seen in research on group biases.

The use of such a heuristic is not without justification: there is some direct evidence that the selection of an in-group mental health service provider can facilitate improved outcomes. For example, several studies provide evidence that when consumers are race-matched with a provider, positive treatment outcomes would be supported by a strong therapeutic alliance (Harrison, 1975; Sue, 1977). More recently, work with the lesbian population through focus groups has reported that lesbians openly report a preference for a gender-matched provider in both healthcare and mental health settings (Saulnier, 2002). Smith and Cabral (2011) suggest that these principles can be applied to the relationship between therapists and their clients.

Consumer and Provider Characteristics

A great deal of research has been done on the variety of personal characteristics of consumers (individuals *seeking* therapeutic services – as opposed to service *providers*) that make a person more or less likely to seek mental health services. Large bodies of literature have shown that roughly 30-50% of individuals will experience a mental disorder in their lifetime, with 15-30% experiencing a disorder within the past year (Mackenzie, Gekoski & Knox, 2006). Robb, Haley, Becker, Polivka and Chwa (2003) found that adolescents and young adults between the ages of 15-19 are more likely to seek mental health services than older adults. Robb and colleagues also found that perceived severity of mental health concerns impacted the likelihood

that an individual would seek services. For example, an individual who is experiencing occasional depressive symptoms would be less likely to consider these symptoms serious enough for intervention, whereas someone experiencing hallucinations, or psychomotor agitation would be me more inclined to seek professional help as a result of such extreme symptoms (Robb, et.al, 2003). When surveyed, older adults in particular were more likely to seek services for mental health symptoms such as suicidality and characteristic symptoms of schizophrenia. Robb's final surveyed topic involved asking participants what type of provider people would prefer to receive services from. Older adults were more likely to seek help from a provider who was affiliated with clergy, psychologists and psychiatrists and less likely to seek services from social workers, nurses or peer groups (Robb et. al, 2003). Marketing research has also discovered that men are less likely to seek therapeutic services than women, even though men respond similarly as women to psychotherapy (Brooks & Good, 2001). Together, these findings suggest that the individual's circumstance and characteristics combined with those of the provider impact the likelihood that a consumer will seek out mental health services.

Despite these findings, the most popular theory about client choice of mental health providers is that perceived attributes of a clinician matter most in terms of treatment efficacy. For example, previous research has focused on desirable personality characteristics such as honesty, trustworthiness and the ability to be non-judgmental (Lipscomb, Shelley & Root, 2010). Similarly, Kivlighan, Clements, Blake, Arnzen and Brady (1993) found that while the sex role orientation did not correlate to development of a working alliance, there was a significant, positive relationship between counselor flexibility and working alliance as reported by participants. Lipscomb et al. also identified that there was a pattern of preference among providers who exhibited positive therapeutic skills like openness, attentiveness and accessibility,

however he stated that demographics (e.g. ethnicity, gender, age) had no statistically significant impact on the participants' choice of provider.

Relevance to the current treatment model.

Given the assumption that demographic factors of the provider are unimportant, current treatment models do not incorporate matching on these factors into clinician and client pairings. Reviews from clinicians and health marketing conclude that the diversity of treatment delivery systems and theoretical orientations have been successful in helping a large variety of individuals. However, the community mental health system is under constant pressure to prove that it is necessary to devote both human and financial resources towards client acquisition and retention (Kirasuk & Sherman, 1968). Because of this significant amount of pressure to prove it's societal worth, the community mental health systems are forced to follow the regiment of what is most cost and time effective. Most mental health service providers associated with community mental health services do not actively engage the client in their choice of provider. In the model suggested by Wells, Astrachan, Tischler and Unutzer (1995), clients are not normally afforded the opportunity to choose their own provider from those available. When a potential consumer presents to a clinic they are often assigned to whichever clinician has room on their caseload. While this method appears to be effective for providers who are governed by insurance standards, contract requirements etc. (Sue & Sue, 1977), it may not necessarily lead to the most effective treatment interventions (Herdelin & Scott, 1999).

Early studies support the notion that allowing consumers to select their own service providers is beneficial. For example, Devine and Fernald (1973) found that individuals who were placed in the preferred treatment group (i.e., they were placed with the therapist they rated as having the preferred treatment technique) had a significantly better therapeutic outcome than

those in the control group than those matched with a therapist who demonstrated their non preferred treatment modality. It appears that having clients make treatment decisions about providers and types of treatment they want to receive has positive impacts on treatment outcomes.

Research comparing the public community mental health sector and private providers speaks to this point as well. For example, Schwartz et al. (1998) found that elderly consumers use fewer public services, females use more private services, and individuals with higher levels of education and income use more private services (which allows them to select their provider). Because many individuals are likely to seek services from a private provider, we would be remiss to ignore that a significant portion of mental consumers are choosing their own service provider.

Additionally, as mentioned earlier, individual's personal characteristics and situations will determine their likelihood of seeking services. These circumstances also influence provider selection. When compared to professional qualifications such as degree earned, years of experience and specialty area of practice, and practical factors including acceptance of insurance, location of office and privacy, personal characteristics of the mental health professional are relatively unimportant (Eells, 1999). These data suggests that individuals may be utilizing a two-step decision-making model for choosing their mental health provider. Large bodies of research across multiple disciplines have indicated that individuals are less likely to choose a mental health provider who is deemed to have subpar credentialing (Saulnier, 2002). Because of this, individuals create a filter that facilitates a relationship between what is perceived as the providers' capabilities as a professional and their accessibility.

Such circumstances are compounded by legislation. For example, the Mental Health Parity Act (Mental Health Parity and Addiction Equity Act, 2008) requires that health insurance companies provide coverage of mental health services alongside coverage for traditional (physical) conditions. Because of this, consumers are seeking services more readily and are able to exercise personal preference when choosing a mental health provider (Lipscomb, Shaffer and Shelley, 2004). However, research on racial minority groups seeking mental health services has shown that the number of providers identifying with a racial/ethnic minority is small: the majority of providers within the community mental health system identify as white, while 45% of consumers identify as non-white (Jerrell, 1995). It seems possible that if individuals were afforded the opportunity to choose their provider, they may be unable to find a qualified provider who is also demographically matched (and thus more likely to form a therapeutic alliance; see Wintersteen, Mensinger & Diamond, 2005).

This gap in cultural diversity in the mental health field has been the focus of many studies attempting to develop training strategies to increase the cultural sensitivity of clinicians. Recently, the field of mental health has seen an increased emphasis on "cultural competency," which attempts to provide clinicians with training in cultural responsiveness and sensitivity (Sue, Zane, Hall & Berger, 2009). This movement has become a widely accepted answer to the lack of quality mental health services accessible to minority populations. However, the cultural competency of the clinician may not be the only area impeding usage of services by minorities. These potential consumers may be in pursuit of a mental health professional that shares their racial identity; someone they can quantify as a member of their in-group.

Very few studies have examined the reason that individuals favor certain mental health providers over others. As discussed previously, social psychologists have conducted innumerable

studies on the theory that individuals surround themselves with like individuals and push away or separate from those who are dissimilar (e.g., subjects will choose to interact with individuals who share the same ethnicity, profession etc.). The current understanding of this social phenomenon is known as in-group bias (Brewer, 1999). On the basis of this theory it is reasonable to infer that people who are choosing a provider will gravitate toward clinicians who are members of their in-group. The cultural competency method and the in group bias are two sides of the same coin: on one side, educators are taking measures to train clinicians in cultural differences (Sue et. al, 2009); on the other, minority populations may be avoiding services due to a lack of provider options that meet their needs.

Cultural competency is a development on the part of the psychological community in response to the discrepancy of minority clinicians in relationship to minority service recipients. Clinicians are instructed in techniques for engaging in cultural sensitivity, thus allowing for a more effective therapeutic relationship between clinicians and clients who do not share an in-group (Sue et. al, 2009). Teaching future clinicians to engage in cultural literacy is a proactive resolution for the phenomenon that the proposed research seeks to investigate.

Research on provider selection suggests that personal characteristics of the provider such as race and gender do not meaningfully impact provider selection (Eels et. al, 1999). However, this area of research has been conducted using largely direct survey questions that are increasingly susceptible to various forms of response bias.

Influence of Social Desirability

The reliance of existing research on simple survey questions is a significant weakness of the provider-selection literature. Social psychologists have long known that when asked about socially sensitive topics, individuals will answer in a way that is socially acceptable. This

phenomenon is known as social desirability bias (Fisher, 1993).This becomes a problem in social psychology research because this systematic bias can directly affect the observed relationship between variables (Gove & Geerken, 1977). For example, as mentioned above, current research suggests that men are less likely to seek out mental health services than women, even though services appear to be equally as effective. The idea that seeking mental health treatment is less socially acceptable for men, may be distorting the gender comparison on psychiatric symptom self report measures. This was the basis for research conducted by Phillips and Segal that hypothesized that men systematically report fewer psychiatric symptoms than women because of this perceived social judgment, even when the data was collected anonymously (Gove & Geerken, 1977). With respect to healthcare, a significant portion of research reported data that are influenced by social desirability (Van de Mortel, 2008). Taking these findings into account, the importance of personal characteristics of mental health providers may be underrepresented in the current research. In order to appropriately measure the impact these factors have on a consumers' likelihood of seeking services, the way the question is asked needs to be altered so as to avoid social desirability bias.

The proposed research lies at the intersection between social psychological principles and clinical psychological interactions: does ingroup bias impact the selection of a mental health provider? To address this question, I use a novel experimental paradigm that is less subject to social desirability bias: by providing participants with a gender and race matched clinician, a gender OR race matched clinician, and a non-matched potential clinician and then asking them to rate their likelihood of working with each, I will assess participants' choice of a mental health provider. By providing participants with a decision making task rather than a face-valid survey,

participants will be less likely to adjust their response based on the potential for negative social evaluations (e.g., providing the socially acceptable answer even if it contradicts their beliefs).

Methodoloy

Participants

Participants of this study were individuals participating in research through Psychological Research on the Net – a forum for academic research projects (Krantz, 1998). Additional participants were collected from SONA. The participants were 18 years or older, and included both male and female participants. Individuals under the age of 18 were excluded due to ethical considerations. In order to provide the appropriate amount of statistical power, the minimum number of required participants was 100. Once the minimum number of participants was gathered, collection continued for 3 weeks after the posting date of the survey.

Materials

All materials and procedures were approved by the Murray State University Institutional Review Board (see Appendix A). In order to measure participant's preference for therapists in an unbiased and nonjudgmental atmosphere, the survey was presented in an online format. Demographic information including age, race and gender was gathered from each participant (see Appendix C). The online survey was randomized to feature pictures from the Chicago Face Database (see Appendix D). Each participant was shown one of three images. These images featured 1) a clinician who is matched on both race and gender, 2) a clinician who is matched on only one (randomly-selected) demographic criterion, or 3) a clinician who has no characteristics similar to the participant. The participants were sorted randomly into either group 1, 2 or 3 and shown a corresponding photo (see Appendix D). The photo the participant sees was chosen to correspond to the previously entered demographic information.

Beneath the image was a list of the clinician's age, gender, and professional credentials (see Appendix E). At the bottom of each image, a sliding scale with a corresponding question appears, asking the client to indicate how likely it would be that they would seek services from the individual pictured above. The question was identical for each of the three photos and read "If you were in need of individual psychological services, how likely would you be to choose this person to provide treatment?"

Procedure

Participants logged in at their convenience. They were provided with a digital informed consent sheet providing contact details of both the researcher and supervisor. After consenting to the research, the participants were directed to the survey. The survey's first demographic question appeared on the screen independently, requesting the participant enter their age. Individuals who endorsed their age as less than 18 years were directed to the exit page of the survey.

After inputting their age, the participants was asked to indicate which gender they most closely identify. Then they were asked to indicate using a drop down list, which category most accurately describes the race with which they identify; White, African American, Asian, or Hispanic. Additional options of "Two or More Races" and "None of the above" were also provided. These individuals were automatically assigned to the unmatched condition.

After the aforementioned demographic information has been gathered, participants were briefed on the instructions for the survey (see Appendix B). Each participant was shown one of three images. These images featured 1) a clinician who is matched on both race and gender, 2) a clinician who is matched on only one of the demographic criteria, or 3) a clinician who has no similar characteristics to the participant. The participants were sorted randomly into either group

1, 2 or 3 and shown the corresponding photo. The photo the participant sees was chosen to correspond to the previously entered demographic information.

Beneath the image was a list of the clinician's age, gender, ethnicity, and professional credentials (See Appendix D). At the bottom of each image, a sliding scale with a corresponding question appeared, asking the client to indicate how likely it would be that they would seek services from the individual pictured above. The question was identical for each of the three photos and read "If you were in need of one-on-one psychological services, how likely would you be to choose this person to provide treatment?"

After responding to the questions beneath the final photo, each participant was provided with a debriefing statement informing them of the purpose of the study and thanking them for their participation.

Analysis

I predict that individuals in the group that has both matched demographic factors will be more likely to seek services from the provided clinician than both the individuals who are only matched on one of the demographic factors, and individuals who are not demographically matched with the pictured provider.

An alpha level of .05 was used for all analyses. Data will be analyzed using an analysis of variance (ANOVA) in the data analysis program R. The independent variable was assignment to a group (1, 2 or 3; described above). The dependent variable was self-reported likelihood of seeking services. A simple linear regression was used to determine if Race had a significant impact on an individual's likelihood of seeking services.

Results

Participants were 555 individuals, 378 females and 177 males (M_{age}=20.17, SD=5.24). Four racial groups were represented, with 499 individuals identifying as white, 23 individuals identifying as black, 18 as Asian, and 15 as Hispanic.

A simple linear regression was calculated to evaluate if age had a significant impact on an individual's likelihood to seek services. This result was significant, b = -0.72, $F(1,553) = 10.73$, p=.001, R^2 = .019, indicating that younger individuals were more likely to seek services. Another regression analysis was conducted to evaluate the impact of gender on an individual's likelihood to seek services. Additional regression analysis found that gender also had a significant impact on the dependent variable, b = -7.1, F (1,553) = 8.307, p=.004, with an R^2 of .014, indicating that females were more likely to seek services compared to males. Finally, an ANOVA indicated that all racial groups were equally likely to seek services, F (*3, 551)* = .29, p = .83.

For the primary analysis, a one-way between subjects ANOVA was conducted to compare the effect of group (gender and race match, gender OR race match, and no match conditions) on likelihood of seeking services. Participants in the gender and race match condition (M = 58.91, SD = 26.55, n=182) were equally likely to seek services compared to those in the gender or race match group (M = 55.33, SD = 29.03, n=198), or the no match group (M = 58.21, SD = 25.82, n= 175), $F(2, 552) = .927$, p = .396. These results suggest that potential clients are not likely to choose a mental health provided based on ingroup preferences. No significant difference was found between the three groups, indicating that the participants did not endorse that they were any more or less likely than the others to seek services based on the degree of matching (Race and Gender Match, Race or Gender Match, or No Match).

Discussion

The present study began with an understanding that this topic has not been studied as much as other topics in social psychology. It was hypothesized that subjects would indicate a higher likelihood of seeking services when the potential provider displayed similar race and gender. The results of this study found that there was no significant difference in an individual's likelihood to seek mental health services among three conditions. Unfortunately it is difficult to accurately measure sensitive constructs such as race and gender preferences, which mean inherent limitations for this study. The online platform alluded to anonymity for the subjects, however the subject knows that the researcher or research team will be analyzing the data. Even though the responses are never linked to a name, the participant may still feel pressured to provide socially desirable answers. The nature of the question may have contributed to the results listed above.

Additionally, the idea of providing a realistic situation that is relatable for the participant is difficult in the online platform. Evaluating an individual's receptiveness to mental health services, their history with treatment or diagnosis, and their insightfulness about their own mental illness if present. A less than probable scenario, such as the one provided in this study, may have failed to imitate a real-world experience. The client may have been unable to imagine themselves in the situation presented, subsequently preventing from putting themselves in the shoes of someone who needed mental health services. In the future, including a measure about perception of mental health, history of mental health services, and possibly a generalized question about being diagnosed personally with any mental illness, would allow control of a seemingly impactful covariate.

The findings of this study, while not as predicted, provide important insights about trends in mental health perception and utilization. Our understanding of how group bias effects the way humans interact is ever evolving. While research in the late seventies to early nineties suggested that in-group individuals were inherently viewed as more favorable (Brewer, 1979, Mullen, Brown & Smith, 1992), pioneers in the social psychology community have found that we can manipulate these heuristic tendencies by something as simple as thinking about categorizing people differently (Hall and Crisp, 2005). It is a stretch to say that differences among groups is becoming less important; however it is reasonable to infer that increasing our investigation of social interactions has led to a better understanding of how humans decide with whom to congregate and engage in meaningful relationships.

Another factor that could potentially impact the current findings is the way the question was presented to the participants. Each participant was asked how "likely" they were to seek services from the individual pictured. This implies that the participant can put themselves in a situation where they would be needing therapy. Instead we could have asked "How efficacious do you think this person would be in providing therapy to someone like yourself?" or I could have given participants the opportunity to express how much they might benefit from the interaction, not just if they would engage in the interaction.

Limitations

In addition to the inherent limitations of the study including the nature of the questions and the inability to replicate a realistic situation in an artificial environment, concerns with the sample and the administration and collection of data may have influenced the results. First, the subject pool was extremely homogeneous, with the majority of participants being Caucasian females in their early 20s. The goal of this study was to understand how differences in race and

gender could be affecting likelihood of potential clients to seek out services. However, without data representative of other races, ages and genders, our results cannot be generalized to other populations. Unfortunately, the primarily Caucasian sample did not provide the appropriate data to answer our question. Another option for exploring this hypothesis could be to change the subject pool to include only minority participants, or oversampling minority participants.

As previously mentioned, accurately assessing sensitive topics including racial preference in mental health service providers is incredibly difficult because of social desirability bias (Fisher, 1993). While gathering data where the participant is given a stronger sense of anonymity through a web survey is helpful, it does not allow for truly open disclosure. While the participants know that they can't be seen, they remain aware that someone somewhere is going to be looking at their answers. It is extremely difficult to "turn off" the little voice in their head saying, "If I answer the way I really feel people are going to judge me personally".

There is not as definitive answer on which mode of data collection yields the most representative information (Kreuter, Presser, &Tourangeau, 2008). When you create a laboratory environment you lose authenticity because the participant knows they are being watched. Similarly when online, one can use a less face valid measure, but using a less transparent tool may not assess the topic as accurately. While the most convenient and effective data gathering option in the current study, the computerized survey method may not have been the best way to "tap into" the social construct of in group out group bias and how it effects choice of mental health provider.

While these sample specific and inherent limitations may be affecting the results of the study, we would be remiss to address the idea that cultural competency education has made a significant difference in how potential consumers address salient differences.

The Cultural Competency Development

As previously mentioned, cultural competency is a psychological concept that focuses on the cultural education of the providers. Sue and Sue's *Counseling the Culturally Diverse* (2010), starts off with a disclaimer, much like the beginning of graphic television programs, that is intended to prepare the readers for emotions they may feel as they dive into the material. It is made clear that emotions such as guilt, defensiveness, shame, and anger are acceptable and expected responses to this topic.

Sue and associates asserted through their research that cultural competency requires an intense reprogramming of clinicians through education. This education starts with the notion that the experience you are embarking upon is one of discomfort and introspection about your own personal biases. According to Sue, cultural competency is a matter of social justice, and reacting with defensiveness prevents a clinician from engaging their empathetic abilities.

Sue indicates that clinicians need to be intensely aware of their preconceived notions about behavior, make a conscious effort to understand individuals with cultural differences and research and actively implement culturally sensitive protocols during therapy (Sue & Sue, 2010). Through these three principles, a clinician should be able to overcome cultural differences in psychotherapy, however Sue also indicates that his notion of cultural competency is something the field must strive for continuously, not something that will ever be completely achieved.

Sue's approach brings the discomfort associated with the sensitive topic of race and brings it right to the surface, as if to say "It's ok to feel some or all of these feelings, but that does not mean you can dismiss this topic." In short he is preparing the clinicians for the discomfort that comes with discussing sensitive topics. This allows for the new clinicians to experience the uncomfortable emotions, sit with them, and then move into a space where they

can listen to disempowerment and feel comfortable saying “I can’t say I have experienced that, but I would really appreciate it if you could help me understand those feelings”. Including texts such as Sue’s Counseling the Culturally Diverse has contributed to a not only a new generation of clinicians with an arsenal of skills to successfully establish therapeutic alliances with culturally diverse clients, but has also begun to change the way the clients see the providers. The emphasis is moving from “I don’t think they could possibly understand me” to “These guys are trained to help me and I trust that they can, regardless of what they look like.”

Sue fleshes out the steps necessary to tear down clinicians and rebuild them to be competent. He highlights specific implications for cultural competency, and fifth on that list urges clinicians not to fear open an honest discussion about cultural differences. Contrary to Sue, I believe that this single step is the most important, and possibly the only necessary step.

In addition to Sue’s approach, three additional theories of how cultural differences impact psychotherapy have emerged over several years. First, the univeralist theory focuses on the qualities of the therapist negating the need to address cultural difference. Clinicians who adopt the universalist theory in their practice focus more on their innate abilities as the force necessary to overcome client/clinician barriers. For example, a universalist would assert that a clinician who is empathetic, understanding and open would be able use those qualities along with clinical training to move past perceived cultural barriers.

The particularist approach asserts that there is no overcoming the innate differences between individuals from different cultural backgrounds. A particularist clinician who interacts with clients who are culturally diverse would contend that focusing on these differences would be a moot point because they cannot be overcome. This isn’t to say that the clinician won’t be

helpful in treating their clients, but the barriers to treatment with clients of unique cultural backgrounds may be more salient.

The transcendent approach that emphasizes the ability of the therapist and the client to overcome the differences in order to engage in a meaningful therapeutic connection. (Roche & Maxime, 2003). The transcendent approach has become the most applied methodology, and does not narrow the application to cultural differences. Instead, transcendists believe that the differences that should be addressed are those that are most salient to the client. For example, Roche notes that for some clients, difference in race may not present a barrier to therapeutic intervention, but a difference in marital status might be a major concern for the client. For that client, the clinician should openly address the barrier providing the most resistance to progress, not only the barrier that seems most obvious.

The transcendists push to address differences openly and to the benefit of the client. Contrary to Sue's thorough re-education theory, the transcendist approach is targeted and direct, comparable to a laser that hones in on the barriers and addresses them to allow true progress for the client. It is accepted in the clinical community that cultural differences are a concern, however spending time aggressively educating future clinicians on how to completely override their understanding of differences, is unnecessary when the option to observe, address and overcome the differences is available.

The basis of Sue's cultural competency movement is that the preferences inherently exist and we can only react to those preferences. Contrarily, if the data is analyzed with the transcendist approach in mind, then it stands to reason that the individuals in our participant pool (primarily Caucasian) may not see race and gender as their salient barriers. More likely, it seems

the current subject pool points more to the notion that Caucasian individuals do not see race as a salient barrier when selecting a treatment provider.

Implications for Future Research

The results of the current study provide important insights into both research and data gathering techniques and how the psychological community assesses and interprets data. The current study predicted that individuals would be more likely to seek psychological services from a provider who shared the same race and gender as themselves. The current data set did not support this hypothesis, which can point to two conclusions. Either individuals truly show no preference for a given mental health provider based on superficial phenotypical attributes, or the individuals still felt pressured to provide socially desirable answers. If the participants did feel a preference, but were too concerned about perceived judgement, then the design of the study should be changed to more accurately assess the hypothesis.

A more parsimonious explanation for the results is that either the design of the current study didn't tap into the construct we intended or our participant pool was not representative enough of minority populations to provide sufficient power for us to find what we were looking for. It is clear that recruiting a sufficient number of non-Caucasian participants to complete this study is paramount. The lack of data representing the phenomenon in the study was a major obstacle in the current model. The hope of providing a remote, brief, non- face valid experiment was to reduce the impact of social desirability bias felt by the participants. If successful, it could be inferred that our results were an accurate representation of the population. Instead, it appears that the influence of social desirability may have been interfering with our ability to gather truly representative data.

Future studies addressing the questions posed in the present study should consider a number of issues. First, it is clearly necessary to introduce a control for social desirability. Adding a measure such as the Balanced Inventory for Desirable Responding (BIDR) (Lee & Bagger, 2007). Adding a measure like the BIDR would help to establish how much baseline social influence the participants are experiencing and help to flesh out how much of their answers are truly how they feel, and how much are their natural tendency to provide the socially acceptable response.

It may also be helpful to include a measure that assesses an individual's feelings and attitudes towards mental health services. While the current experiment was concise and direct (which helped the participant to actively engage in the scenario), the brevity sacrificed an ability to control for individual extraneous influences. Including a measure that evaluates current attitudes towards mental health services such as the Mental Help Seeking Attitudes Scale (MHSAS; Hammer, Parents, & Spiker, 2018) would allow for the participants to be classified based on the biases they have towards help seeking. A participant who expresses negative attitudes about help seeking may answer differently than someone who is willing to reach out for assistance with mental health concerns. Additionally, knowing if an individual has personal experience (either themselves or someone else) with a mental health concern is important to take into consideration when asking about a sensitive topic such as this.

In addition to further exploring gender identity and biological sex, it would be advantageous to separate the variables of gender and race within the study. This would allow researchers to tease apart the effects of gender matching and race matching separately without confounding results.

The design of the current study may have been successful in keeping the participant focused by remaining brief, but the ability to control for important covariates was lost. Future research designed should focus on ensuring that enough data points are gathered on each participant to get a thorough understanding of how their individual experiences may be affecting their answers.

Appendix A
IRB Approval

MURRAY STATE UNIVERSITY

Institutional Review Board

328 Wells Hall
Murray, KY 42071-3318
270-809-2916• msu.irb@murraystate.edu

TO: **Sean Rife**
Psychology

FROM: **Institutional Review Board**
Jonathan Baskin, IRB Coordinator

DATE: **4/12/2017**

RE: **Human Subjects Protocol I.D. – IRB # 17-138**

The IRB has completed its review of your student's Level 1 protocol entitled *Factors Influencing the Choice of a Mental Health Provider*. After review and consideration, the IRB has determined that the research, as described in the protocol form, will be conducted in compliance with Murray State University guidelines for the protection of human participants.

The forms and materials that have been approved for use in this research study are attached to the email containing this letter. These are the forms and materials that must be presented to the subjects. Use of any process or forms other than those approved by the IRB will be considered misconduct in research as stated in the MSU IRB Procedures and Guidelines section 20.3.

Your stated data collection period is from 4/4/2017 to 5/1/2017.

If data collection extends beyond this period, please submit an Amendment to an Approved Protocol form detailing the new data collection period and the reason for the change.

This Level 1 approval is valid until 4/11/2018.

If data collection and analysis extends beyond this date, the research project must be reviewed as a continuation project by the IRB prior to the end of the approval period, 4/11/2018. You must reapply for IRB approval by submitting a Project Update and Closure form (available at murraystate.edu/irb). You must allow ample time for IRB processing and decision prior to your expiration date, or your research must stop until such time that IRB approval is received. If the research project is completed by the end of the approval period, then a Project Update and Closure form must be submitted for IRB review so that your protocol may be closed. It is your responsibility to submit the appropriate paperwork in a timely manner.

The protocol is approved. You may begin data collection now.

Appendix B
Informed Consent

Project Title:
The Influence of Race and Gender on
the Choice of a Mental Health Provider

Investigators: Primary Investigator: Meghan Rackers and Dr. Sean Rife, Dept. of Psychology, Murray State University, Murray, KY 42071, (270) 809-4404.
You are being invited to participate in a research study conducted through Murray State University. You must be at least 18 years of age to participate. The investigator will explain to you in detail the purpose of the project, the procedures to be used, and the potential benefits and possible risks of participation. You may ask him/her any questions you have to help you understand the project. A basic explanation of the project is written below. Please read this explanation and discuss with the investigator any questions you may have. You will be given a copy of this form to keep.
Nature and Purpose of the Project: The purpose of this study is to gain information regarding attitudes toward mental health services.
Explanation of Procedures: Your participation in this study will require you to answer a brief set of questions. Your total participation should take no longer than 5 minutes.
Discomforts and Risks: The risks to you as a participant are minimal. Regardless, please know that you can quit participating at any time without penalty.
Benefits: There are no direct individual benefits to you beyond the opportunity to learn first-hand what it is like to participate in a research study and to learn about some of the methods involved in psychological research. A general benefit is that you will add to our knowledge of the research subject.
Confidentiality: Your responses and participation in all tasks will be completely anonymous; they will only be numerically coded and not recorded in any way that can be identified with you. Dr. Rife will keep all information related to this study secure for at least three years after completion of this study, after which all such documents will be destroyed.
Refusal/Withdrawal: Your participation in this study should be completely voluntary. Your refusal to participate will involve no penalty. In addition, you have the right to withdraw at any time during the study without penalty or prejudice from the researchers.
I acknowledge that the risks and benefits involved and the need for the research have been fully explained to me; that I have been informed that I may withdraw from participation at any time without prejudice or penalty; and the investigator has offered to answer any inquiries that I may make concerning the procedures to be followed or my rights as a participant, and has answered to my satisfaction any questions that I have. I voluntarily consent to participate in this research project.
THIS PROJECT HAS BEEN REVIEWED AND APPROVED BY THE MURRAY STATE UNIVERSITY INSTITUTIONAL REVIEW BOARD (IRB) FOR THE PROTECTION OF HUMAN SUBJECTS. ANY QUESTIONS PERTAINING TO YOUR RIGHTS AS A PARTICIPANT OR ACTIVITY-RELATED INJURY SHOULD BE BROUGHT TO THE ATTENTION OF THE IRB COORDINATOR AT (270) 809-2916. ANY QUESTIONS ABOUT THE CONDUCT OF THIS RESEARCH PROJECT SHOULD BE BROUGHT TO

THE ATTENTION OF DR. SEAN RIFE IN THE MSU PSYCHOLOGY DEPT., AT (270) 809-4404.

Appendix C

Demographic Questions

Please enter your chronological age using only numbers

Please indicate your biological sex: Male or Female

Please Indicate which option best describes your ethnicity: Black/African American, White/Caucasian, Hispanic, Asian, Two or more races, or None of the Above.

Appendix D

Clinician Photos from the Chicago Faces Database

Appendix E

Standard profile presented beneath each photo

Age: 28
Degree: B.A- Psychology from Scranton University, M.A- Clinical Psychology from William and Mary College
License: Licensed Professional Counselor (LPC)
Specialty: Individual Therapy

References

Barak, A., Hen, L., Boniel-Nissim, M., & Shapira, N. (2008). A Comprehensive Review and a Meta-Analysis of the Effectiveness of Internet-Based Psychotherapeutic Interventions. *Journal of Technology in Human Services, 26*(2-4), 109-160. doi:10.1080/15228830802094429

Brewer, M. B. (1979). In-group bias in the minimal intergroup situation: A cognitive-motivational analysis. *Psychological Bulletin, 86*(2), 307-324. doi:10.1037/0033-2909.86.2.307

Brooks, G. R., & Good, G. E. (2001). *The New handbook of psychotherapy and counseling with men: A comprehensive guide to settings, problems, and treatment approaches*. San Francisco, CA: Jossey-Bass.

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology, 58*(4), 537-554. doi:10.1037/a0025266

Devine, D. A., & Fernald, P. S. (1973). Outcome effects of receiving a preferred, randomly assigned, or nonpreferred therapy. *Journal of Consulting and Clinical Psychology, 41*(1), 104-107. doi:10.1037/h0035617

Dowling, M., & Rickwood, D. (2013). Online Counseling and Therapy for Mental Health Problems: A Systematic Review of Individual Synchronous Interventions Using Chat. *Journal of Technology in Human Services, 31*(1), 1-21. doi:10.1080/15228835.2012.728508

Eells, G. T. (1999). Factors In Clients Selection Of Mental Health Providers. *Psychological Reports, 85*(5), 249. doi:10.2466/pr0.85.5.249-254

Fisher, R. J. (1993). Social Desirability Bias and the Validity of Indirect Questioning. *Journal of Consumer Research, 20*(2), 303. doi:10.1086/209351

Gove, W. R., & Geerken, M. R. (1977). Response Bias in Surveys of Mental Health: An Empirical Investigation. *American Journal of Sociology, 82*(6), 1289-1317. doi:10.1086/226466

Hammer, J. H., Parent, M. C., & Spiker, D. A. (2018). Supplemental Material for Mental Help Seeking Attitudes Scale (MHSAS): Development, Reliability, Validity, and Comparison With the ATSPPH-SF and IASMHS-PO. *Journal of Counseling Psychology, 65*, 74-85. doi:10.1037/cou0000248.supp

Harrison, D. K. (1975). Race as a Counselor-Client Variable in Counseling and Psychotherapy: A Review of the Research. *The Counseling Psychologist, 5*(1), 124-133. doi:10.1177/001100007500500130

Herdelin, A. C., & Scott, D. L. (1999). Experimental Studies of the Program of Assertive Community Treatment (PACT). *Journal of Disability Policy Studies, 10*(1), 53-89. doi:10.1177/104420739901000105

Jerrell, J. M. (1995). The effects of client-therapist match on service use and costs. *Administration and Policy in Mental Health, 23*(2), 119-126. doi:10.1007/bf02106722

Kiresuk, T. J., & Sherman, R. E. (1968). Goal attainment scaling: A general method for evaluating comprehensive community mental health programs. *Community Mental Health Journal, 4*(6), 443-453. doi:10.1007/bf01530764

Kivlighan, D. M., Clements, L., Blake, C., Arnzen, A., & Brady, L. (1993). Counselor Sex Role Orientation, Flexibility, and Working Alliance Formation. *Journal of Counseling & Development, 72*(1), 95-100. doi:10.1002/j.1556-

6676.1993.tb02284.x
Kreuter, F., Presser, S., & Tourangeau, R. (2008). Social Desirability Bias in CATI, IVR, and Web Surveys: The Effects of Mode and Question Sensitivity. *Public Opinion Quarterly, 72*(5), 847-865. doi:10.1093/poq/nfn063
Li, A., & Bagger, J. (2007). The Balanced Inventory of Desirable Responding (BIDR): A Reliability Generalization. *Educational and Psychological Measurement, 67*(3), 525-544. doi:10.1037/e518612013-343
Lipscomb, T. J., Root, T., & Shelley, K. (2008). Strategies for seeking mental health services. *Services Marketing Quarterly, 25*(4), 1-12. doi:10.1300/J396v25n04_01
Lipscomb, T. J., Shelley, K., & Root, T. (2010). Selection Criteria for Choosing Mental Health Service Providers: A Pilot Study. *Health Marketing Quarterly, 27*(4), 321-333. doi:10.1080/07359683.2010.519988
Mackenzie, C. S., Gekoski, W. L., & Knox, V. J. (2006). Age, gender, and the underutilization of mental health services: The influence of help-seeking attitudes. *Aging & Mental Health, 10*(6), 574-582. doi:10.1080/13607860600641200
Mullen, B., Brown, R., & Smith, C. (1992). Ingroup bias as a function of salience, relevance, and status: An integration. *European Journal of Social Psychology, 22*(2), 103-122. doi:10.1002/ejsp.2420220202
Newcomb, T. M. (1961). *The acquaintance process*. New York: Holt, Rinehart and Winston.
Robb, C., Haley, W. E., Becker, M. A., Polivka, L. A., & Chwa, H. J. (2003). Attitudes towards mental health care in younger and older adults: Similarities and differences. *Aging & Mental Health, 7*(2), 142-152. doi:10.1080/1360786031000072321
Psychological Research on the Net (n.d.). Retrieved June 21, 2016, from http://psych.hanover.edu/research/exponnet.html
Roche, M. J., & Maxie, A. (2003). Ten considerations in addressing cultural differences in psychotherapy. *Professional Psychology: Research and Practice, 34*(2), 180-186. doi:10.1037/0735-7028.34.2.180
Saulnier, C. F. (2002). Deciding who to see: Lesbians discuss their preferences in health and mental health care providers. *Social Work, 47*(4), 355-365. doi:10.1093/sw/47.4.355
Schwartz, M. S., Wagner, H. R., Swanson, J. W., Burns, B. J., George, L. K., & Padgett, D. K. (1998). Comparing use of public and private mental health services: The enduring barriers of race and age. *Community Mental Health Journal, 34*(2), 133-144. doi:10.1023/A:1018736917761
Sommers-Flanagan, J., & Sommers-Flanagan, R. (2009). *Clinical interviewing*. Hoboken, NJ: John Wiley & Sons.
Storrie, K., Ahern, K., & Tuckett, A. (2010). A systematic review: Students with mental health problems-A growing problem. *International Journal of Nursing Practice, 16*(1), 1-6. doi:10.1111/j.1440-172x.2009.01813.x
Sue, D. W., & Sue, D. (1977). Barriers to effective cross-cultural counseling. *Journal of Counseling Psychology, 24*(5), 420-429. doi:10.1037//0022-0167.24.5.420
Sue, S., Zane, N., Hall, G. C., & Berger, L. K. (2009). The Case for Cultural Competency in Psychotherapeutic Interventions. *Annual Review of Psychology, 60*(1), 525-548. doi:10.1146/annurev.psych.60.110707.163651
Taylor, D. A., & Moriarty, B. F. (1987). Ingroup bias as a function of competition and race. *Journal of Conflict Resolution, 31*(1), 192-199.

doi:10.1177/0022002787031001011
The Mental Health Parity and Addiction Equity Act (MHPAEA) Factsheet. (2016, October 27). Retrieved June 21, 2016, from https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html
Van de Mortel, T. F. (2008). Faking it: Social desirability response bias in self-report research. *The Australian Journal of Advanced Nursing, 25*(4), 40-48.
Wells, K. B., Astrachan, B. M., Tischler, G. L., & Unützer, J. (1995). Issues and approaches in evaluating managed mental health care. *The Milbank Quarterly, 73*(1), 57-75. doi:10.2307/3350313
Wilder, D. A. (1986). Social categorization: Implications for creation and reduction of intergroup bias. *Advances in Experimental Social Psychology, 19*, 293-355. doi:10.1016/s0065-2601(08)60217-8
Wintersteen, M. B., Mensinger, J. L., & Diamond, G. S. (2005). Do gender and racial differences between patient and therapist affect therapeutic alliance and treatment retention in adolescents? *Professional Psychology: Research and Practice, 36*(4), 400-408. doi:10.1037/0735-7028.36.4.400