IMPLICATIONS OF CULTURAL MISTRUST ON DIAGNOSIS AND SERVICES FOR STUDENTS WITH ADHD

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CARMEN BROWN, MSW

DENTON, TEXAS

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ABSTRACT

CARMEN BROWN

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The purpose of this study was to investigate variables that impact parental agreement with a diagnosis and acceptance of related services for Attention Deficit/Hyperactivity Disorder (ADHD) for their child. Specifically, this study attempted to discern whether cultural mistrust, ethnicity, level of education, and SES affected agreement or acceptance. Ninety-three parents participated in completing survey questions to determine level of cultural mistrust and perceptions regarding the diagnosis of ADHD and services provided within the school setting. Multiple and Hierarchical regressions were completed investigating the impact of each of the aforementioned variables on agreement with a diagnosis and acceptance of services. Additionally, a one way ANOVA was conducted to determine differences in cultural mistrust between Caucasians and Minorities. Results showed that higher levels of education predicted more willingness to accept services related to ADHD in the school setting, while cultural mistrust, ethnicity, and SES did not have a predictive relationship with either agreement with a diagnosis or acceptance of services. These results provide information about parental cultural mistrust in relation to services that may be offered for ADHD in the

context of school. Furthermore, school psychologists can apply these results to guide interactions with parents of children diagnosed with ADHD when offering these services.

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CHAPTER I

INTRODUCTION

The proposed study will investigate how cultural mistrust affects the diagnosis and services provided to students with Attention Deficit/Hyperactivity Disorder (ADHD). Specifically, differing levels of a parent's mistrust of individuals of cultural, racial, or ethnic backgrounds other than their own will be examined in relationship to their willingness to agree with a diagnosis and consequently, to accept related services provided within the context of the school setting. In order to adequately interpret the results of the proposed study, it is important to first examine the history of cultural mistrust in the United States (U. S.), especially in relation to mental health services. This is important as it provides the foundation, as well as an explanation, for how individuals have developed cultural mistrust and how historical events have shaped this mistrust. Subsequently, previous research relevant to the variables of the proposed study will be reviewed in order to establish a theoretical framework for the proposed study.

Overview of Study Variables

One of the variables central to this study is ethnicity. While there has been vast research using the construct of race or ethnicity as a variable to compare differences amongst racial groups, recent literature demonstrates the importance of avoiding the overgeneralization of beliefs, cultures, customs, and behaviors to a particular group due to intragroup differences (Alba, Jimenez, & Marrow, 2014). For minority groups,

different experiences with oppression, racism, and discrimination lead to individual perspectives (Hunter, 2008). Therefore, for this study statements are based on extant literature and not meant to representative of any entire minority population.

The concept of cultural mistrust was developed to describe the tendency of African Americans to distrust Caucasians and Caucasian-established institutions (Terrell, Taylor, Menzise, & Barrett, 2009). This tendency has been researched and studied for decades in an attempt to understand how this mistrust was initiated, developed, and maintained. Additionally, several theories have been proposed to explain the cause and conceptualization of cultural mistrust. Early theorists, Taylor and Brown (1984), hypothesized that African Americans are not born with an inherent distrust of Caucasians, but rather this distrust was developed after negative interactions with Caucasians. This theory implicitly expresses that African Americans will inevitably be discriminated against by Caucasians and will therefore develop a mistrust of them (Terrell et al., 2009). This discrimination is experienced or witnessed in Caucasian individuals, organizations, or institutions, such as schools. Consequently, this apprehension may be developed in even very young African American children (Terrell et al., 2009). Another theoretical perspective utilized the *ecological model* to postulate that a continuing interaction between the effects of an individual's environment and the individual's response to situations in their environment account for cultural mistrust (Neville & Mobley, 2001). In this theory, African Americans experience such pervasive racism, that distrust of Caucasians should be considered a normal part of the African American culture.

The American Psychological Association (APA) suggests that "socioeconomic factors and social class are fundamental determinants of human functioning across the life span, including development, well-being, and physical and mental health" (American Psychological Association Task Force on Socioeconomic Status, 2007). Socioeconomic status (SES) has been identified as a significant barrier that inhibits minorities' access to mental health services. According to the U.S. Census Bureau the poverty rate for African Americans and Latinos is nearly three times that of Caucasians (DeNavas-Walt, Proctor, & Smith, 2012). Research has indicated that lower annual incomes found in minority groups has a limiting effect on ability to access mental health services (Chadiha & Brown, 2002; Kohn & Hudson, 2002). Studies have also linked lower SES with overall mental health. Individuals from low SES backgrounds are at higher risk for developing psychological problems (McGuire & Miranda, 2008). One result of lower incomes can be lack of or inadequate insurance coverage (Hines-Martin, Malone, Kim, & Brown-Piper, 2003). Not having adequate health care insurance puts individuals in low SES groups at a greater risk for not receiving appropriate mental health care (Gary, 2005). While it has been surmised that there are more significant differences in values and belief systems between upper and lower SES groups than can be found between different racial groups, research has not indicated that SES has a significant influence on levels of cultural mistrust (Duncan, 2003). In fact, studies with African American college students have found that even African American individuals of higher SES status report academic dissatisfaction due to negative attitudes toward the dominant culture (Irving & Hudley, 2008; Ogbu, 2003).

There has been a lack of research on how an individual's level of education directly impacts their level of cultural mistrust in the mental health field. However, higher levels of education have been posited to overcome unsophisticated, stereotypical thinking (Farley, 2000). Additionally, there has been research within the medical field that indicates that individuals with lower education levels have less trust. A study conducted with parents of child patients indicated that 74% of individuals with less than a high school education reported high levels of distrust in physicians, while 44% of college graduates reported high levels (Rajakumar, Thomas, Musa, Almario, & Garza, 2009). Another study conducted with adult patients examined racial/ethnic differences in distrust of physicians (Armstrong, Ravenell, McMurphy, & Putt, 2007). These authors found that higher education levels resulted in smaller racial differences in levels of distrust, therefore indicating that educational attainment may act as a moderator for negative experiences of minority patients. However, the research has also indicated that parents with lower levels of education had greater health-seeking behavior and greater level of trust (Harth & Thong, 1990). Moseley, Freed, Bullard, and Goold (2007) found that parents with more than a high school education had lower levels of trust, perhaps because parents with higher education may have higher expectations and more dissatisfaction if those expectations are not met. Inconsistencies within the literature suggest that the impact of level of education on degree of trust is complex and warrants further investigation.

There is a dearth of research regarding parents' willingness to accept a diagnosis of ADHD or willingness to accept related services for ADHD in a school setting. Related

services for ADHD could be offered through special education or Section 504 accommodations. Section 504 of the Rehabilitation Act of 1973 states "No otherwise qualified individual with a disability in the United States, as defined in section 706(8) of this title, shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance…". Although research has not specifically linked cultural mistrust to related services, it is well documented that minorities are overrepresented in special education (Artiles, Kozleski, Trent, Osher, & Ortiz, 2010; Donovan & Cross, 2002; Duran, 2008; Hosp & Reschly, 2003, 2004; McCall & Skrtic, 2009; Oswald, Coutinho, Best, & Singh, 1999; Skiba, Poloni-Staudinger, Gallini, Simmons, & Feggins-Azziz, R., 2006; Van Tassel-Baska, Feng, Chandler, Quek, & Swanson, 2009; Zhang & Katsiyannis, 2002). For example, data gathered from a 2008 study indicated that African American and Hispanic students were nearly or greater than twice as likely to be classified with an emotional or intellectual disability as compared to Caucasians (Rebora, 2011). While this indicates that minorities are receiving special education services, it does not give a clear understanding regarding specific services or provide insight into parental perceptions of these services. Bussing, Gary, Mills and Garvan (2007) found that while 87% of parents participating in a study on ADHD perceptions had some knowledge of the disorder, very few parents were aware of special education services. Given the discrepancy between research indicating that minority children are underdiagnosed with ADHD and research that shows disproportionate

representation of minorities in special education, one may postulate that minority children are primarily receiving services for disabilities other than ADHD in the school setting.

Purpose of the Study

The proposed study will examine the relationship between cultural mistrust and parents' willingness to accept both a diagnosis of and related services for ADHD for their child within the school setting. Additionally, SES and education level will be examined to determine if they serve as moderators for cultural mistrust. Over the past few decades, there has been an abundance of research conducted on the construct of cultural mistrust, particularly in the African American population. Research has linked cultural mistrust to negative attitudes towards mental health providers, and to a reluctance to seek out mental health services. However, there is little to no research investigating cultural mistrust in other racial populations. Furthermore, research in this area has focused primarily on mental health services in relation to oneself, not on how cultural mistrust can impact a parent's attitudes regarding a diagnosis and services for their child. According to the Centers for Disease Control ([CDC], 2011), although the number of children diagnosed with ADHD increased by two million between 2003 and 2011, approximately 17.5% of those diagnosed have never received any type of treatment or medication. Additionally, the CDC (2011) reports that while percentages of ADHD diagnoses have steadily increased across most demographics between 2007 and 2011, rates have actually decreased for children reported as multiracial and children of other races as compared to both African American and Caucasian children. One such barrier to diagnosis and treatment may be due to cultural mistrust. Gaining an understanding of the implications

of cultural mistrust on diagnoses and the acceptance of services for children with ADHD will hopefully provide insight into a significant barrier to helping children receive needed services. Furthermore, when more is understood about how cultural mistrust impacts the acceptance of services for children with ADHD, school psychologists and mental health practitioners can proceed with careful consideration of this construct in situations where children are assessed, and or receive services from a professional of a different cultural background. This is particularly relevant in the school setting where parents do not have a choice of the provider of these services and school psychology positions are predominately held by Caucasians (Curtis, Lopez, Batsche, & Smith, 2006).

Research Questions

The research questions underlying the proposed study are:

1) What is the effect of cultural mistrust on parents' willingness to agree with a diagnosis of ADHD for their child?
2) What is the effect of cultural mistrust on parents' willingness to accept services for their child in a school setting?
3) Which cultural group has the highest levels of mistrust?
4) Do SES and level of education change the effects of cultural mistrust on parents' acceptance of both a diagnosis and related services for ADHD for their child in a school setting?

Definition of Terms

African American: For this study, the definition of *African American* will use the National Alliance for Mental Illness' (NAMI) definition. "African American will be used to denote persons of African descent, which now include refugees and immigrants from Sudan, Nigeria, and other African countries" (National Alliance for Mental Illness, 2008, p. 3).

Asian American: "The generic term *Asian American* refers to persons with historical ties to China, Hong Kong, Taiwan, Korea, Vietnam, Cambodia, Laos, Philippines, Malaysia, India, or other Asian countries, as well as native Hawaiian and Pacific Islander persons (National Alliance for Mental Illness, 2008, p. 3).

Attention-Deficit/Hyperactivity Disorder: "A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development" (American Psychiatric Association, 2013, p. 59).

Binationals: A U.S. citizen who has parents of different nationalities at birth (Paxton & Wade, 2011).

Caucasian: For this study, Caucasian will be defined using the U.S. Office of Managements and Budgets (OMB) definition. "A person having origins in any of the original peoples of Europe, the Middle East, or North Africa such as Irish, German, Polish, Arab, Lebanese, Palestinian, Algerian, Moroccan, and Egyptian" (Humes, Jones, & Ramirez, 2010, p. 3).

Cultural mistrust: "the belief acquired by African Americans, due to past and ongoing mistreatment related to being a member of that ethnic group, that Whites cannot be trusted" (Neville, Tynes, & Utsey, 2009, p. 299).

Cultural paranoia: An adaptive defense mechanism that provided some African Americans a healthy psychological defense against racism (Grier & Cobbs, 1968).

Familism: A form of social structure in which the needs of the family as a group are more important than the needs of any individual family member (Bruhn, 2009).

Hispanic/Latino: "The term *Latino/Hispanic* encompasses multiple Spanish-speaking groups including Mexican, Puerto Rican, and Cuban" (National Alliance for Mental Illness, 2008, p. 3).

Involuntary minority: "Involuntary (nonimmigrant) minorities are people who have been conquered, colonized, or enslaved. Unlike immigrant minorities, the nonimmigrants have been made to be a part of the U.S. society permanently against their will. Two distinguishing features of involuntary minorities are that (1) they did not choose but were forced against their will to become a part of the United States, and (2) they themselves usually interpret their presence in the United States as forced on them by white people" (Ogbu & Simmons, 1998, p. 165).

Middle Eastern: For this study, *Middle Eastern* will be used to describe "individuals from a geographic region encompassing Northern Africa, Southwestern Asia, and part of Europe that include the 22 Arab league states" (Hilliard, Ernst, Gray, Saeed, & Cortina, 2012, p. 171).

Native American: "*Native American* captures the many tribes of American Indians as well as Alaska natives" (National Alliance for Mental Illness, 2008, p.3).

Refugees: "Refugees who were forced to come to the United States because of civil war or other crises in their places of origin. Examples of refugees in the United States are Cambodians, Ethiopians, Haitians, Hmong, and Vietnamese" (Ogbu & Simmons, 1998, p. 164-165).

Related services: "transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. Related services also include school health services and school nurse services, social work services in schools, and parent counseling and training" (Individuals with Disabilities Education Improvement Act, 2004).

Voluntary minority: "Voluntary (immigrant) minorities are those who have more or less willingly moved to the United States because they expect better opportunities (better jobs, more political or religious freedom) than they had in their homelands or places of origin" (Ogbu & Simmons, 1998, p.164).

CHAPTER II

LITERATURE REVIEW

The following review of the literature focuses on variables (i.e., cultural mistrust, ethnicity, socioeconomic status, and level of education) postulated to influence an individual's willingness to accept a diagnosis and related psychological services suggested for their child. In order to gain a thorough understanding of cultural mistrust, a review of the theoretical framework underlying the development of cultural mistrust will be presented. Additionally, this review will examine cultural mistrust across races and settings. Many of the variables of interest may overlap with one another. Therefore, topics are divided by research as it relates to the specific variable of interest.

Brief Overview of Differences in Diagnosis of ADHD across Cultures

Children with ADHD are characterized as having difficulties with sustaining attention, following directions, organization, restlessness, and impulsive behavior (American Psychiatric Association, 2013). ADHD is conceptualized as being a disorder that is manifested in childhood. Children with ADHD have an increased risk of negative outcomes such as poorer school performance, decreased overall quality of life, and increased rate of entering the juvenile justice system (Hinojosa et al., 2012). Although prevalence rates of ADHD appear to be approximately 5% of children across most cultures, research has indicated lower identification rates in African American and Latino American children in the United States (Froehlich et al., 2007; Kessler et al., 2006;

Miller, Nigg, & Miller, 2009). This discrepancy has been linked to cultural differences in informant and child symptom ratings (Mann, Ikeda, Mueller, & Takahashi, 1992; Miller et al., 2009) and cultural variations in help-seeking behaviors of parents (Bussing et al., 2007).

Cultural differences for reporting symptomatology of various mental health disorders, including ADHD, can be attributed to a number of variables. Research has indicated that individuals of minority groups have less access to and tend to seek mental health services much less than Caucasians (Hines-Martin et al., 2003). In addition, the literature has shown that attitudes and beliefs regarding the mental health system differ between cultural groups (Anglin, Alberti, Link, & Phelan, 2008). For example, African American parents have been shown to have less general knowledge regarding ADHD (Bussing et al., 2007; Bussing, Schoenberg, & Perwien, 1998), tend to attribute symptoms to willful misbehavior rather than a medical disorder (Bussing et al., 1998), and believe that sugar intake is directly related to ADHD symptoms (Bussing et al., 2007). Lower levels of knowledge among African American parents has been posited to be due to concerns related to ADHD symptoms being of lower concern than competing parental concerns and needs such as economic deprivation, exposure to violence or drugs, or incarceration (Bussing et al., 2007). Lower knowledge levels in parents of children in lower socioeconomic backgrounds indicate that current ADHD resources and psychoeducation may not be culturally relevant or appropriate (Bussing et al., 2007).

In addition to lower knowledge levels regarding the disorder itself, African American parents were significantly less likely than Caucasian parents to be aware of

special education services available for students with ADHD (Bussing et al., 2007). Due to disproportionate representation of minorities in special education, particularly for intellectual disabilities (Coutinho & Oswald, 2000), parents of minority children may be reluctant to receive these services for fear of stigmatization.

Additionally, researchers found that African American parents found lack of access to services, no perceived need for treatment, and negative outcome expectations as barriers to seeking treatment for their children (Bussing, Gary, Mills, Garvan, & Wilson, 2003). Furthermore, it has been posited that socially constructed views such as distrust of the educational system, perceived lack of cultural awareness of the provider, concern over social stigma, fear of addiction related to stimulant medication, and political pressure all have an impact on diagnosis and treatment seeking behavior in the African American population (Davison & Ford, 2001).

Although Latinos must deal with many of the barriers that are common amongst ethnic minority groups in the United States (e.g., lack of health insurance, lack of reliable transportation, and lower education levels), they face additional barriers that hinder seeking services (Gerdes, Lawton, Haak, & Hurtado, 2013). Latinos also contend with immigration issues, language barriers, lack of knowledge and mistrust of the mental health field, and lack of culturally sensitive providers (Callejas, Hernandez, Nesman, & Mowery, 2010; Flores et al., 2002; Hinojosa et al., 2012). Overall, Latino parents, like African American parents, may not identify ADHD symptoms, do not understand that problematic behaviors may have a biopsychosocial etiology, and do not feel that the problematic behaviors require mental health treatment (Gerdes et al., 2013). The cultural

values of familism and traditional gender roles have been linked to sociological and spiritual beliefs regarding the etiology of ADHD (Lawton, Gerdes, Haak, & Schneider, 2014). Additionally, in the Latino population, the role of caregivers and perceptions regarding the duty to provide care for family members may also impact seeking mental health services. Latinos tend to report a greater sense of duty and typically engage in more informal means of treating illnesses and disorders in the family (Clark & Huttlinger, 1998; Mausbach, et al., 2004).

There is relatively little research focusing on Asian American children and adolescents in regard to mental health. Existing research indicates that attention concerns are less prevalent in Asian Americans when compared to other ethnic minority groups (Mak & Rosenblatt, 2002; Serafica, 1997; Yao, Solanto & Wender, 1988). As noted with the above mentioned minority groups, Asian Americans are underrepresented in mental health services (Nguyen, et al., 2004). Reasons for this underrepresentation are consistent with other groups, such as lack of linguistically and culturally appropriate mental health services (Nguyen et al., 2004).

Among other minority groups, there is a paucity of research that investigates parental perceptions of ADHD. For example, while there have been studies that examined mental health related concerns in the Native American/American Indian population (Dickerson & Johnson, 2012; Mignon & Holmes, 2013), there are no studies that specifically focus on ADHD in this population. However, research indicates that Native Americans value a connection between mind, body, and spirit (Barnard, 2007) and therefore it can be postulated that they may struggle with identifying the symptoms

associated with ADHD as a disorder rather than an imbalance in this connection. Similarly, there is research regarding Muslim immigrants and attitudes towards mental health, but not specific to ADHD. Research on mental health in the Muslim community indicates that Muslims feel that mental health issues can be attributed to lack of faith, spirit possession, or bad karma (Amri &Bemak, 2012). Muslims, along with various other cultures, feel that having a mental health issue is a sign of weakness, therefore individuals feel a sense of shame in admitting that they experience mental health problems. This is particularly felt within the Muslim community where it is felt that Islam should be the source of strength and healing (Ali, Milstein, & Marzuk, 2005; Ghaffari & Çiftçi, 2010). Individuals that struggle with mental health issues are viewed as having lost their faith in God (Erikson & El-Tamimi, 2001; Vogel, Wade, & Hackler, 2007). Due to stigma, Muslims prefer to address mental health concerns within their family or community, as this is viewed as more socially acceptable (Ali et al., 2005; Ali, Liu, & Humedian, 2004; Al-Krenawi & Graham, 2000; Carolan, Bagherinia, Juhari, Himelright, & Mouton-Sanders, 2002). Additionally, Muslims are encouraged to handle mental illness by being mentally stronger and tougher (Cauce et al., 2002).

Historical Background of Cultural Mistrust

The concept of cultural mistrust is defined as "the belief acquired by African Americans, due to past and ongoing mistreatment related to being a member of that ethnic group, that Whites cannot be trusted" (Neville et al., 2009, p. 299). Cultural mistrust is rooted in a long history of maltreatment and egregious acts beginning with the capturing, transporting, and enslavement of individuals of African descent. In the 1680s,

the practice of importing slaves from Africa began to become widespread (Fields, 1990). In the 1860's many individuals in the mental health field justified slavery with the belief that the concept of freedom was a source of pathology for African Americans and the act of physical bondage was the cure (Hughes, 1992). Some scholars viewed African Americans as savages that were incapable of changing their ways to the demands of living in the Western culture and as a result became mentally unstable (Summers, 2010).

From the time that African Americans were brought to the United States, differences from the Caucasians were highlighted and studied. In 1879, Ales Hrdlicka, a curator from the Smithsonian Institution began to attempt to standardize the measurement and observation of human characteristics (Guthrie, 2004). He used color selection cards to compare skin color. From there, many other characteristics of humans began to be measured, such as hair texture (as cited in Guthrie, 2004) and thickness of lips (as cited in Guthrie, 2004). The purpose for the intense interest in measuring these differences was an effort to gain evidence that there were two distinct human species.

Research Attempts to Prove Racial Inequality

As the field of psychology was emerging, the study of intellectual, behavioral, and mental differences between races also became a focus. This allowed scholars to place not only negative physical characteristics onto African Americans, but deficient mental characteristics as well (Guthrie, 2004). Psychological testing, such as intellectual tests, were used to compare races. In 1881, the earliest documented attempt by an American researcher to examine psychological traits in different races was recorded when C.S. Meyers tested the reaction times of Japanese subjects and compared them to

those of Europeans (Guthrie, 2004). This study was followed by additional attempts to establish that Caucasians were superior and all other races were inferior. In 1895, R.M. Bache entreated Lightner Witmer to conduct experiments to test the reaction times of Caucasians, African Americans, and Native Americans (Benjamin, 2009). Witmer found that Native Americans had the fastest reaction time, while Caucasians had the slowest. In an attempt to explain the slower reaction of Caucasians while still supporting the belief that Caucasians were superior, Bache hypothesized that this was indicative of Caucasians being contemplative rather than responding in an automatic, reflexive manner as the Native Americans and African Americans did (Benjamin, 2009). At the 1904 St. Louis World Fair, a group of psychologists were convened to administer and compare psychological tests on Filipino, Malaysian, Singhalese, American Indian, and Pygmy individuals (Guthrie, 2004). Test batteries included auditory, visual, motor control, reaction times, and intelligence tests. The psychologists concluded that some of the racial groups exhibited inferior intelligence, like that of individuals with mental deficiencies, due to making stupid errors and taking an inordinate amount of time to complete the tasks (Guthrie, 2004). One of the individuals being assessed was Ota Benga, a pygmy from the Belgian Congo. After the fair, Benga was placed in a large monkey cage and put on exhibit at the zoo in New York. Over the next couple of decades, numerous studies were carried out to examine African Americans. Topics ranged from the inferiority of the African American, to immorality, to the expression of emotions (Guthrie, 2004). Between 1912 and 1915, several studies were conducted on children to assess intellectual differences between African Americans and Caucasians.

The results of these studies were used to suggest that African Americans had intellectual deficits that warranted separate educational programs and that African Americans should only be trained to be manual laborers (Guthrie, 2004). At the time, these studies were considered to be a scientific justification for segregation in the educational system. Erstwhile, the only evidence to support this segregation was based on philosophical opinions, such as that of G. Stanley Hall, the founding father of the American Psychological Association (Guthrie, 2004). Hall suggested that:

> No two races in history, taken as a whole, differ so much in their traits, both physical and psychic, as the Caucasian and the African. The color of the skin and the crookedness of the hair are only the outward signs of the many far deeper differences, including cranial and thoracic capacity, proportions of body, nervous system, glands, and secretions, vita sexualis, food, temperament, disposition, character, longevity, instincts, customs, emotional traits, and diseases. All these differences as they are coming to be better understood, are seen to be so great as to qualify if not imperil every inference from one race to another, whether theoretical or practical, so that what is true and good for one is often false and bad for the other. (as cited in Guthrie, 2004, p.65)

With the onset of World War I, intelligence testing shifted from children to adults. The Army used a special committee of the American Psychological Association to administer intelligence testing to all drafted soldiers. There were two tests, the Army Alpha and the Army Beta, that were used to measure mental ability (Miller, McIntire, & Lovler, 2012). The Army Alpha was utilized to assess literate individuals and was considered a valid

representation of mental ability, despite the test being culturally loaded (Guthrie, 2004). The Army Beta was used to measure the mental abilities of illiterate or non-English speaking individuals. The Beta was considered the non-verbal equivalent to the Alpha (Guthrie, 2004). A large number of African American recruits were administered the Beta, despite information that the Beta was not an adequate measure for African American intelligence. The test scores were thought to be used to determine opportunities for advancement in the Army; however, the Army had no intention of training African Americans for any jobs other than manual labor (Miller et al., 2012). During the 1930s, perspectives begin to shift and by the 1940s a number of psychologists had rejected beliefs in inherent racial differences and began to look at social factors, such as prejudice and bias, as the cause of these differences (Benjamin, 2009). The German Nazi's treatment of Jewish individuals proved to be the catalyst for people to question the validity of racial inequality (Guthrie, 2004).

Racial and Ethnic Identity Development

Identity formation is described as a complex process by which individuals develop a distinct personality (Erikson, 1968). As part of the process of identity formation, individuals identify with certain characteristics, values, and beliefs from a variety of aspects of life, such as culture, race, religious affiliation, gender, and sexuality. Historically, there has been disagreement within the social psychology field regarding the definitions of race and ethnicity (Ponterotto & Park-Taylor, 2007). Therefore, it has been difficult for individuals who attempt to conduct research in this area (Nishina, Bellmore, Witkow, & Nylund-Gibson, 2010). According to the Center for Disease Control (2011),

30% of the United States population belongs to a racial or ethnic minority group (Center for Disease Control, 2011). Due to rapid increase and the diversity within the minority population, it is becoming of paramount importance for psychologists to understand how one develops an ethnic or racial identity.

The distinction between racial identity and ethnic identity is sometimes overlooked and these terms have been used interchangeably in the literature. Some scholars illustrate the differences by describing the development of an ethnic identity to involve self-identification as a member of a specific group, adopting attitudes about the group and of one's self in relation to that group, and adopting attitudes about other members of the group (Negy, Shreve, Jensen, & Uddin, 2003). Additionally, ethnic identity represents a dedication to practices, beliefs, and behaviors shared by a group of individuals with similar ancestry or geographic location (Phinney, 1992). Conversely, racial identity "reflects endorsement of membership in a group defined by physically identifiable characteristics" (Irving & Hudley, 2008, p. 678). Although efforts have been made to differentiate between ethnicity, race, and culture, these terms continue to be highly conflated.

Early theories shaped our understanding of race and ethnicity, culminating into models of racial or ethnic identity development. One highly noted theory is Phinney's model of ethnic identity development (1996). According to Phinney (1996), for most minorities, "Identity formation has to do with developing and understanding and acceptance of one's own group in the face of lower status and prestige in society and the presence of stereotypes and racism" (p. 144). Phinney's model has not only been used to

describe the ethnic identity development of African Americans, but can be applied to any ethnic minority (Negy et al., 2003). To date there has been a plethora of literature focusing on the construct of ethnic/racial/cultural identity development (Carter, 1995; Cross, 1971; Cross, Smith, & Payne, 2002; Helms, 1990; Phinney, 1989, 1992; Ruiz, 1990). "Racial identification is a dynamic construct influenced by individual, political, and social constructions in the United States" (Stokes-Brown, 2012, p. 310).

Although there are differences across the different models and theories, all share the underlying assumption that individuals from minority cultures start at a place of unawareness of cultural differences or admiration of the dominant culture's values. This is followed by a critical experience or encounter with the dominant culture group that leads to questioning of these values. At which time, the minority individual begins to reject the dominant culture and embrace their own ethnic/racial/cultural group's values. After a period of introspection and reflection, an individual is led to an awareness that both cultures have positive and negative attributions and thereby commits to seeking equality and justice for all individuals regardless of their ethnic/racial/cultural background (Yi, 2014). Racial Identity Theory can be used to explicate the relationship between race and distrust of individuals from another cultural background. Therefore, a brief summation of racial or ethnic identity across cultures would be beneficial to the current literature review.

Black racial identity theory. Helms' Black Racial Identity Theory (1990) is a model used to describe the degree to which African American individuals reject the negative portrayals of their race within society and conversely identify with their own

race. According to Helms (1990) the initial stage is *Pre-Encounter* stage. In the Pre-Encounter stage individuals hold the Caucasian dominant culture in high regard, thus rejecting values and beliefs associated with the African American race. This stage is characterized by internalized racism, negative self-esteem, and an adoption of Caucasian cultural values (Helms, 1990). The second stage in this model is the *Post-Encounter* stage, wherein African Americans experience a shift in perspective, anger, and guilt due to a critical encounter that leads to doubting the value of the dominant Caucasian culture and devalue of the African American culture (Helms, 1990). The next stage, *Immersion*, involves rejection of the Caucasian culture and strong alignment with the African American culture (Helms, 1990). Conversely, *Emmersion*, occurs when the individual integrates their former identity with a newfound appreciation for their own African American culture (Helms, 1990). Lastly, *Internalization* entails a positive connection with the African American culture and thus, a commitment to pursue social justice (Helms, 1990).

Hispanic/Latino racial identity theory. Latinos in the United States are faced with a unique position of having a decision of which racial identity with which to ascribe. In the United States, the predominant racial paradigm is either Caucasian or African American (Stokes-Brown, 2012). Additionally, the decision by the United States government to differentiate between race and ethnicity places Latinos are in a situation where they must choose an identity aligned with one or the other.

The racial group Latino is a heterogeneous group comprised of numerous subgroups dependent on country of origin. These subgroups differ in history, particularly

in the social formations that impact age, gender, and class relationships and differing waves of migration and how migrants were accepted into the United States culture (Guarnaccia, Martinez, & Acosta, 2005). These features have created intracultural variations. Despite this fact, social sciences, society, literature, and politics endorse the belief of Latino unity in the framework of racial groups (Ferdman & Gallegos, 2001). Racial categorization in the United States has perpetuated the inability to distinguish Latinos from varying countries (Ferdman & Gallegos, 2001).

With the complex nuances of the racial classification of Latino in mind, Ferdman and Gallegos (2001) constructed a Latino identity model to describe different types of orientation toward a Latino identity. This model describes orientations rather than a stage-like model that one progresses through. *Latino-integrated* are individuals who can fully identify not only with the Latino group, but also the specific subgroup to which they belong. These individuals are able to accept both positive and negative aspects of the Latino culture (Ferdman & Gallegos, 2001). Additionally, individuals with this orientation are comfortable with all types of Latinos. *Latino-identified* individuals view Latinos as a distinct racial category that encompasses all Latinos groups regardless of subgroups (Ferdman & Gallegos, 2001). These individuals view Caucasians, African Americans, and other groups in rigid categorical terms. *Subgroup identified* includes individuals that identify with their own ethnic or national-origin subgroup, but not with the Latino group as a whole (Ferdman & Gallegos, 2001). While these individuals view themselves as different from the Caucasian racial group, they do not necessarily identify with the Latino group either. Individuals with this orientation view their own subgroup

as positive and hold more negative views towards other Latino groups (Ferdman & Gallegos, 2001). The *Latino as "Other"* orientation includes individuals that are not cognizant of their specific Latino background, history, or culture but do identify as a minority or "person of color" due to phenotype, racial constructions, and other factors (Ferdman & Gallegos, 2001). These individuals do not ascribe to Latino values or social norms, but they also do not identify with Caucasian values. Additionally, they view race as polarized to Caucasian or not Caucasian (Other) and identify race through color of skin, thus aligning with other people of color as a whole (Ferdman & Gallegos, 2001). Individuals with the *Undifferentiated* orientation espouse views that do not connect them with any group, rather they prefer to look at individuals instead of racial classifications (Ferdman & Gallegos, 2001). Individuals with this orientation typically accept the norms of the dominant culture without questioning it, and justify any barriers as a result of individual attributes instead of intergroup dynamics (Ferdman & Gallegos, 2001). Lastly, the *White Identified* orientation includes individuals that view themselves as White or Caucasian (Ferdman & Gallegos, 2001). These individuals prefer Caucasian culture, view Latinos as inferior, and see race as only "White or Black". Individuals that ascribe to this orientation often use the term *mejorar la raza* to indicate that "marrying Whites as a way of improving Latinos, while marrying Blacks or Browns diminishes the group" (Ferdman & Gallegos, 2001, p. 54).

Asian American racial identity theory. Literature regarding the development of Asian Americans' racial identity has suggested that individuals with Asian ancestry often feel caught between two opposing cultures resulting in both positive and negative

feelings concerning their ethnicity (Akiyama, 2008). Many models have been developed (Chun, 2000; Kim, 2001; Phinney, 1992; Sue, 1981; Uba, 2003) to describe the process of Asian American identity development. Kim (2001) conceptualized a model that proposed that Asian Americans move through stages throughout their development. The first stage is the *Ethnic Awareness* stage that begins early in life, around the ages of 3-4. During this stage, an individual's sense of ethnic identity is derived from family members (Kim, 2001). Individuals typically experience positive or neutral feelings about their ethnicity dependent upon the messages that are conveyed within the feeling. As children get older and start school, the *White Identification* stage begins (Kim, 2001). In this stage children begin to realize that they are different from the dominant Caucasian culture and, due to racial prejudices, begin to develop feelings of negativity towards themselves and their ethnicity. In an effort to identify with the Caucasian culture, they begin to reject their own ethnic heritage (Kim, 2001). The *Awakening to Social Political Consciousness* stage is developed through an increased awareness and new perspectives as a result of significant political events. As this awareness builds, individuals begin to abandon their identification with Caucasian culture and develop an understanding of oppression (Kim, 2001). The next stage, *Redirection*, marks a renewed appreciation for the Asian culture and heritage. Concurrently, the realization that Caucasian oppression is at the root of their negative experiences leads to anger towards Caucasian culture and reinvigorated Asian pride (Kim, 2001). Lastly, the *Incorporation* stage, is the most highly evolved stage during which an individual is able to maintain strong identification with Asian cultural values and beliefs, while integrating a respect for other cultures as well (Kim,

2001). In this stage individuals no longer feel compelled to hold either a positive or negative view of Caucasian culture.

Native American /American Indian racial identity theory. Native Americans have the unique experience of living in two distinct, cultural environments simultaneously. This situation leads to the development of a bicultural ethnic identity (Brown & Smirles, 2003). While Native Americans have adopted many of the customs and ways of the dominant Caucasian culture, they continue to hold steadfast to their ancestry (Horse, 2005). This dichotomous self-identification is eloquently summarized by Horse (2005):

> Be that as it may, we are still the original Native people of North America. We are Kiowa, Navajo, Comanche, Apache, Wichita, and so on down the list of five hundred or more Indian tribes. We cling to that distinction consciously and unconsciously. That realization, that consciousness, is where Native American identity begins. As Native American people we inherit an innate sensibility about the world that originated far back in our ancestral past. That consciousness, that psychology if you will, developed separately and apart from the experience of other peoples who were not indigenous to this land. It is a worldview that is inherent in Native American tribal traditions, most of which were handed down orally in the tribal languages (Horse, 2005, p. 61).

Unlike other racial identity models, Horse (2005) describes issues and elements that intermingle to create a highly individualized Native American racial identity. One such issue that is an integral component of this identity is ethnic nomenclature. The terms

American Indian and Native American have been used interchangeably. However, each term was originated in different contexts. Although the meaning of the two terms is arbitrary, Horse (2005) argues that anyone born in America can also be called a Native American. Another element that must be considered is racial attitudes. The concept of race and privilege in American society is based on the dominance of one cultural group over another cultural group or groups. How an individual views their own race and other racial groups influences their own identity. If Native Americans accept that they are a marginalized, oppressed group of people, then they indirectly accept that they belong to a subordinate group (Horse, 2005). This creates further dissonance in the identity development of Native Americans. Horse (2005) posits that the most distinct factor that sets Native Americans apart from the rest of the American population is their legal and political status. Native American tribes are afforded the right to maintain sovereign tribal governments through the Commerce clause of the U.S Constitution. Each tribal government has the sole right to determine who is a citizen of that tribe (Horse, 2005). Therefore, if an individual requests to become legally recognized as Native American or American Indian, then they must obtain a specific tribal recognition (Horse, 2005). Thus, most Native Americans identify first with their tribal nation, and secondly as a Native American. An important point that Horse (2005) highlights is that tribal governments, not individuals, determine a person's legal status as an American Indian. Another component of Native American identity development resides in the concept of cultural change. What comprises "real" Native American culture is an ever changing concept. The redefinition of the Native Americans has been constructed in part due to reactions to

the Caucasian culture and White privilege (Horse, 2005). The last component mentioned by Horse (2005) is Personal Sensibility. Although Horse (2005) describes five influences that contribute to a Native American's identity, he describes an individual's personal feelings and experiences as the primary factor in identity development.

Caucasian racial identity theory. The concept of a Caucasian identity theory was introduced by Helms (1990) as the White racial identity model. In Helms' theory Caucasians, as well as other races, experience a process where they come to realize their own racial identity. In the first stage, *Contact*, individuals are unaware of cultural and institutional racism and their own White privilege (Helms, 1990). They vacillate between curiosity and fear of people from other racial groups based on stereotypes imbued by friends, family, and the media. Caucasians who directly or indirectly limit their interactions with people from other races may remain in this stage indefinitely. The next stage, *Disintegration*, is marked by cognitive dissonance regarding the aforementioned lack of awareness that is replaced by the uncomfortable feelings of guilt, shame, and sometimes anger at the recognition of their own advantages of being Caucasian (Helms, 1990). Additionally, Caucasians are faced with the realization and acknowledgement of the role of Caucasians in the maintenance of a racist system. In an attempt to reduce discomfort, Caucasians may experience denial (convincing themselves that racism no longer exists, or if it does, than it is warranted based on acts of the individual), avoidance of people of other races or discussions related to racism, and may attempt to change others' attitudes towards a more positive view of people of other races. This attempt is typically met with rejection from other Caucasians. The next stage, *Reintegration*, occurs

when individuals succumb to societal pressure to accept racism in order to gain acceptance by their own racial group (Helms, 1990). Reconstituted anger and fear are directed again to people of other racial groups, who become targeted as the source of this discomfort. In the *Pseudo-Independent* stage, Caucasians begin the process of self-examination seeking information about people of color and racism, and begin to question their previous conception of Whiteness and the justifiability of racism (Helms, 1990). Caucasians begin to abandon their beliefs in White superiority, but may continue to engage in behaviors that unintentionally perpetuate racism. At this stage Caucasians try to connect with people of other races in an attempt to understand racism by denying their own Whiteness and active affiliation with people of other races. This creates a sense of alienation from other Caucasians while experiencing rejection from persons of other races who may be suspicious of their motives (Helms, 1995). Individuals that move into the *Immersion/Emersion* stage are uncomfortable with their Whiteness, but are unable to fit into any other racial category. In turn, they begin to explore new, more comfortable ways to identify as a Caucasian. Much like individuals from other racial groups who seek to redefine their perception into more positive views through immersion in accurate information about their own culture and history, Caucasian individuals seek to replace racially related myths and stereotypes with accurate information about what it means to be Caucasian in the United States society. Individuals may embark on learning about positive examples of Caucasians that have been role models for fighting against racism and discrimination (Helms, 1990). Lastly, the *Autonomy* stage entails the internalization of a newly constructed Caucasian identity with positive feelings towards individuals from

other races, as well as active efforts to confront racism and oppression in their daily lives (Helms, 1990). Because their antiracist behaviors and attitudes are more consistently expressed, Caucasians in this stage are met with more acceptance and alliance with people of other races.

Middle Eastern American ethnic identity theory. Although there has been some research in the area of identity development in individuals considered to be from the Middle Eastern cultural group, there has not been a solidified, specific model proposed to describe this construct. Literature in this area has focused on the many aspects that must be taken into consideration when thinking about the identity development of this group of people. Due to media depictions, people from the Middle East are identified primarily in terms of religious identity as Muslims (Abu-Lughod, 2004). However, like other racial groups, individuals from the Middle East define themselves in a multitude of ways. Like other minority racial groups in the United States, people of Middle Eastern background have experienced significant discrimination. Discrimination and prejudice became increasingly heightened after the terrorist attacks in New York on September 11, 2001. These experiences have shaped and changed the identity development of Middle Eastern Americans.

In the beginning of the twentieth century, the federal courts rendered decisions regarding the prerequisite/naturalization laws to determine the "whiteness" of certain ethnic groups such as Lebanese, Turkish, Syrian, and Armenian (Tehranian, 2008). At that time, these groups were considered white by law. It wasn't until the late 1940s and 1950s that the term Middle Eastern was used to describe this group of people, prior to

this the term Middle East was used to describe a geographic region (Tehranian, 2008). Prior generations of people from Middle Eastern descent more closely matched the social construction of whiteness. They were predominately Christian, they came from a place perceived to be exotic but friendly, and they easily blended into the white category (Tehranian, 2008). However, when the Middle East region began to take on political and economic significance, it became necessary to racialize this group of people. "Race comes into existence only when a group grows sufficiently large, in terms of both numbers and power, to become a threat" (Tehranian, 2008, p.12). As perceptions have shifted, Middle Eastern Americans are now primarily viewed as Muslims, from an unfriendly foreign land filled with terrorists and anti-American sentiment (Tehranian, 2008). This paradigm shift has created a popular notion that Middle Eastern Americans are less able to assimilate and therefore are to be considered an enemy race in America.

Tehranian (2008) suggests that this paradigm shift has resulted in differing perceptions based on how an individual's actions are viewed. When an individual from Middle Eastern descent is viewed as being a good person, such as several famous singers and actresses, and their contributions to society are viewed as positive, then they are likely to be viewed as white or other rather than Middle Eastern (Tehranian, 2008). In contrast, when individuals engage in negative actions or wrongdoing, then they are racialized as Middle Eastern. Due to less prominent racial phenotypes in many people from the Middle Eastern region, many engage in covering, a social construct describing an individual's attempt to conceal disfavored aspects of their identity in order to assimilate (Yoshina, 2002). Many Middle Eastern Americans have engaged in covering

in response to discrimination they have faced. Unlike most other racial groups, Middle Eastern Americans must contend with society's intermingling of religious affiliation and national origin with racial identification (Tehranian, 2008).

Development of the Construct Cultural Mistrust

At some point in their racial and ethnic identity development, all individuals are faced with having to examine discrimination, racism, and prejudices and the negative outcomes associated with it. As a result of this examination, many individuals develop a strong distrust for people from other racial backgrounds. This phenomenon has been investigated across several populations. However, this mistrust of people from other racial backgrounds has developed through differing experiences and the causes may vary across races. It is important to examine these differences to better understand how this mistrust affects various racial groups.

In 1968, Grier and Cobbs began examining the concept of African Americans developing mistrust of the dominant Caucasian society due to being exposed to prejudice and racism (Biafora, Taylor, Warheit, Zimmerman, & Vega, 1993). Grier and Cobbs (1968) initially called this phenomena cultural paranoia, using terminology indicating a disorder. However, often times African Americans' mistrust of Whites was based on factual experiences, both direct and indirect (Neville et al., 2009). Ridley (1984) used the term healthy cultural paranoia to describe an African American individual who was psychologically healthy, but guarded against racism. Grier and Cobbs (1968) indicated that this paranoia was an adaptive defense mechanism that provided some African Americans a healthy psychological defense against racism. Early researchers rejected

such terminology in favor of more positive terms. Triandis, Ferdman, Weldon, and Harvey (1975) explained this mistrust as *ecosystem distrust* that is defined as having less trust in people, being more suspicious of the motives of others, rejection of authority figures and institutions, and seeing the environment as malevolent.

Research on this topic began to accelerate in the 70s and 80s when Terrell and Terrell (1981) formalized the definition and created an inventory to measure the specific characteristics of cultural mistrust amongst African Americans. Conversely, Thompson, Neville, Weathers, and Poston (1990) used the term *racism reaction* to represent a more neutral inference. The authors felt that a more neutral term should be used if these beliefs and perceptions were to be viewed as healthy reactions to feelings of being threatened.

In addition to direct or indirect experiences, it can be inferred that this mistrust is further supported and developed in both the home and school settings. All children receive early messages in the home regarding how society works and their place in it. African American children often receive messages from their parents and other family members that being African American in a predominately Caucasian society comes with strict parameters and a high degree of caution (Erikson, 1968). Additionally, this may be reinforced by experiences of unfair and biased education in the public educational system.

Awareness of the history of African Americans in the United States provides a foundation for comprehending the construct of cultural mistrust. The lasting effects of capturing and enslaving African individuals for centuries fostered feelings of acrimony towards Caucasian Americans. In addition, although slaves were granted freedom with

the fourteenth amendment in 1868, continued acts of abuse, prejudice, segregation, and racism denied African Americans equality in the United States (Chase, 2000). African Americans continued to be subjected to mistreatment that was upheld by the government and society. Consequently, African Americans have been circuitously taught to fear, disbelieve, and be suspicious of the ulterior motives of Caucasians (Chase, 2000).

Cultural Mistrust across Racial Groups

Although the vast majority of research to date on cultural mistrust has focused on African Americans, the concept has been studied in other minority populations (Biafora et al., 1993). One of the main components of research focused on cultural mistrust across different racial groups discusses differences based on whether these groups came to the United States as a voluntary or involuntary minority group.

According to Ogbu and Simmons (1998), minority status is not based upon a numerical percentage, rather it is based upon the power differential. "A population is a minority if it occupies some form of subordinate power position in relation to another population within the same country or society" (p.162). These authors categorize minorities into one of three groups based upon the circumstances surrounding their immigration to the United States. 1) Voluntary minorities include individuals that made a decision to move to the United States on their own free will for a variety of reasons. 2) Refugees, migrant workers, undocumented workers, and binationals comprise individuals that do not fit into either of the other groups. These individuals may not have made a specific plan or chosen to come to the United States, but did not come here against their will. 3) And lastly, involuntary minorities are individuals that were colonized,

conquered, or enslaved. These individuals were forced to either move or become a part of the United States. Ogbu and Simmons (1998) indicate that groups that came to the United States as an involuntary group have higher levels of mistrust, suspicion, and assimilation than voluntary groups.

Cultural Mistrust in the Hispanic/Latino Population

Relatively little research with cultural mistrust has focused on the Hispanic/Latino population. However, one study compared levels of cultural mistrust amongst African Americans, Hispanics, Native Americans, and Asian Americans (Ahluwalia, 1991). Results of this study indicated that there was not a strong association between cultural mistrust and dissatisfaction and unwillingness to seek mental health service in Hispanic Americans. Another study attempted to dispel the belief that Mexican Americans lacked trust in American institutions (Weaver, 2003). Mexican Americans were surveyed regarding their level of trust in thirteen institutions (i.e. education, organized religion, major companies, organized labor, banks and financial institutions, the press, television, the executive branch of the federal government, Congress, the U.S. Supreme Court, the military, medicine, and the scientific community) and found that Mexican Americans had no higher of distrust in institutions when compared to Caucasians (Weaver, 2003).

One of the explanations for findings in the research may be that Hispanics are a group that is considered to be a voluntary minority. Therefore, one could postulate that Hispanics likely do not harbor the same level of cultural mistrust for Caucasians based on their experiences. However, there has not been enough research regarding cultural

mistrust in the Hispanic population to make wide assumptions without further investigation.

Cultural Mistrust in the Asian Population

There is a paucity of research focusing specifically on the development and effects of cultural mistrust in the Asian population. While research has consistently indicated that Asian Americans access mental health services at a rate of approximately one third of what could be expected for the size of the population (for a review of the literature see Abe-Kim et al, 2007; Tewari, 2009; Yang & Worpat-Boria, 2007), However, additional research has identified that this underutilization of mental health services is not due to racial differences in prevalence for mental illnesses (David, 2010). Due to this disparity, there has been a great deal of recent research investigating possible factors that are impacting health seeking behaviors in Asian Americans (David, 2010). In the past few years, researchers have attempted to examine the relationship between cultural mistrust and mental health seeking behaviors in this population. David (2010) found that among Filipinos/Filipino Americans the development of cultural mistrust follows a similar pattern as seen in African Americans. In his study, David (2010) found that Filipinos had experienced oppression and racist events. The historical migration of Filipino workers into the western United States during the 1900s set the stage for discrimination and prejudice. During this time, Filipinos were considered U.S. nationals, but they were not American citizens and therefore were not protected under U.S. laws, which led to maltreatment (Bulosan, 2002). The results of this study found that higher levels of cultural mistrust were linked to lower levels of mental health-seeking behaviors

in Filipino Americans (David, 2010). Conversely, when looking at Asian Americans as a whole, research has indicated that Asians did not exhibit high levels of cultural mistrust for Caucasians (Ahluwalia, 1991).

Cultural Mistrust in the Native American Population

Another identified gap in the research on cultural mistrust is in the Native American population. Native Americans, also considered an involuntary minority group, have demonstrated that cultural mistrust of Caucasians impedes willingness to seek out mental health services (Ahluwalia, 1991). Native American or American Indian people have endured oppression in a way that no other racial group in the United States shares. Native Americans were forcibly removed from their land and resettled in areas that were unfamiliar to them (Pacheco et al., 2013). Their native languages, cultural rituals, and use of traditional healing practices were banned. Native American children were removed from their homes and sent to federal Indian boarding schools where they were taught in an educational program that was designed to eradicate Indian culture (Pacheco et al.). In 1976, the General Accounting Office (GAO) investigated the Indian Health Services and found that in a three year period (1973-1976) 3,406 Native American women were involuntarily sterilized (Pacheco et al., 2013). These and countless other examples of atrocities waged against Native American people culminated in a disdain and distrust for Caucasians and Caucasian-run institutions. This is evidenced by research indicating that Native Americans have a distrust for educators in a school system due to the typical ethnocentric cultural view perpetuated in schools (Cockrell, 1992).

Cultural Mistrust in Other Populations

The scarcity of literature that examines cultural mistrust in racial groups other than African Americans necessitates the generalization of research findings to other racial groups. While cultural mistrust by nature of the definition is used to describe a healthy defense mechanism against experiences of discrimination, racism, and oppression, it can be posited that all racial groups, including Caucasians, are subject to a mistrust of individuals of another race. While cultural mistrust in the traditional sense cannot be attributed to Caucasians, one can hypothesize that Caucasians can indeed develop a mistrust of individuals of another race based solely on their own perceived feelings of being prejudged as being racist, discriminatory, and prejudiced against other groups of people.

Cultural Mistrust across Settings

Cultural mistrust has been studied in a variety of settings including health care, mental health, education, and employment. A review of the literature indicates the impact of cultural mistrust is far reaching and can affect a multitude of areas in an individual's life. The following section delineates studies that highlight the effects of cultural mistrust across settings.

Cultural Mistrust in the Health Care Setting

The dishonorable and unethical treatment of racially diverse individuals has a long history within the medical field. One of the most widely known cases of unethical treatment is the Tuskegee syphilis experiment. In an attempt to reduce the prevalence of sexually transmitted diseases among African Americans (the reported prevalence rate at

the time was six times that of Caucasians [Sharma, 2010]), the American Social Hygiene Association (ASHA) created the Negro Project. For a span of 40 years, 1932 to 1972, an experiment originally titled "The Effects of Untreated Syphilis in Negro Males," was conducted to examine the effects of untreated syphilis disease (Sharma, 2010). The study included 600 black men, 399 had the disease, and the remaining 201 were part of the control group (Baker, Brawley, & Marks, 2005). The assumption at that time was that syphilis was untreatable in African American men; therefore, not offering treatment was not viewed as problematic (Sharma, 2010). Subjects were deceived and told they were being treated for bad blood. The majority of the subjects were illiterate and therefore were easily taken advantage of in egregious ways. Participants were not explained the risks associated with participation in the study (Sharma, 2010). This case became known as the Tuskegee syphilis experiment. The heinous maltreatment of African American individuals in this project was cornerstone to the establishment of ethical standards and guidelines for the use of human subjects in research today.

Another example that illustrates early negative viewpoints in the medical field was Dr. Benjamin Rush, signatory of the Declaration of Independence, believed that African Americans suffered from negritude, which he believed to be a form of leprosy (Feinstein, 1971). Rush also considered Blacks to be a deviation of nature for which he attempted to find a cure. Although a remedy for "blackness" was never found, Rush's writings perpetuated the pathologizing of African Americans as well as continued to give false credence to the hypothesis of inferiority (Feinstein, 1971).

Cultural Mistrust in the Mental Health Setting

A plethora of studies in this area focus on the implication of cultural mistrust on the relationships and delivery of mental health services. Since the inception of psychology, racist theories have been entrenched in the field. In the 18th century, debate began over speculation as to whether African Americans were more prone to insanity than Caucasians (Fernando, 2012). Using admission rates to insane asylums across the country, scholars determined that African Americans did not exhibit mental illness while being enslaved, but developed various mental disorders upon becoming free (Fernando, 2012). This and other related theories were used to justify slavery.

Of all the studies done on cultural mistrust, the majority have been regarding the relationship between cultural mistrust and African Americans relationships in counseling (Whaley, 2001). Results of these studies indicate that African Americans with higher levels of cultural mistrust espouse more negative thoughts and opinions of Caucasian mental health providers (Grant-Thompson & Atkinson, 1997; Nickerson, Helms, & Terrell, 1994; Poston, Craine, & Atkinson, 1991; Terrell & Terrell, 1984; Thompson, Worthington, & Atkinson, 1994; Watkins & Terrell, 1988; Watkins, Terrell, Miller, & Terrell, 1989). Additionally, research on cultural mistrust in the African American population has indicated that African Americans with higher levels of cultural mistrust have a higher preference for African American clinicians (Townes, Chavez-Korell, & Cunningham, 2009), hold more negative views towards seeking professional mental health help (Duncan, 2003), and often have premature termination from therapy (Terrell & Terrell, 1984).

Research indicates that high levels of cultural mistrust can be manifested as paranoia (Whaley, 2001). Whaley's (2001) review of the literature confirmed that cultural mistrust is an important factor in understanding the perspective of African American clients in counseling. Therefore, clinicians should attempt to understand and validate this mistrust.

Scott, McCoy, Munson, Snowden, and McMillen (2011) conducted research with African American males that were transitioning out of foster care. This study examined how individuals transitioning from foster care experience cultural mistrust towards mental health professionals. Results of this study indicated that level of satisfaction with child welfare services was a moderator on cultural mistrust. Individuals reported moderate levels of mistrust, and those with greater dissatisfaction with child welfare services had higher levels of cultural mistrust (Scott et al., 2011).

An additional consideration of reasons that African Americans seek mental health services less frequently than Caucasians is a difference of opinions regarding mental illness. African Americans are reported to hold more negative views of individuals with mental illness, feel that mental health patients are inferior, and hold less kind attitudes towards individuals with mental illness than Caucasians (Silva de Crane & Spielberger, 1981). However, Nickerson et al. (1994) found that cultural mistrust was the most consistent and powerful predictor of African Americans attitudes towards seeking mental health services.

Cultural Mistrust in the Employment Setting

Research in the area of cultural mistrust in the employment setting has been sparse. However, studies of African American youth have suggested that those with higher levels of cultural mistrust tend to have lower expectations regarding prospective employment (Terrell, Terrell, & Miller, 1993). Additionally, Whaley and Smyer (1998) found that cultural mistrust was related to decreases in African American adolescent's perceptions of job competence and overall self-worth, which compounded negative thoughts that education would not improve their chances of securing a job.

Bullock-Yowell, Andrews, and Buzzetta (2011) conducted a study to examine career decision-making self-efficacy (i.e., an individual's beliefs regarding his or her ability to perform tasks associated with the career decision-making process). As a part of the study, the authors were interested in how cultural mistrust may affect African American student's decision-making process in regards to future careers. They found that while cultural mistrust was related to career decision-making self-efficacy, career thoughts and personality better explained their career decision-making self-efficacy (Bullock-Yowell et al., 2011).

Cultural Mistrust in the Educational Setting

Cultural mistrust has also been researched in the context of implications in the educational setting. Early studies looking at cultural mistrust suggested African American children learn to mistrust Caucasians through contact with teachers in the educational system because it is unlikely they have had any direct experience with other institutions where cultural mistrust is fostered such as the legal system, business, or

politics (Terrell, 1980; Terrell & Terrell, 1981). Studies have shown that African American students have poorer performance on IQ tests when administered by a Caucasian than by an African American (Terrell & Terrell, 1984; Terrell, Terrell, & Taylor, 1981). Researchers posited that students may underperform on IQ tests, as well as in school, in order to stay within the boundaries of Caucasian teachers' expectations.

Irving and Hudley (2008) suggested that prior research has demonstrated a negative relationship between employment opportunities and cultural mistrust, as well as increased levels of self-report of deviant behavior (Taylor, Biafora, & Warheit, 1994). Irving and Hudley (2008) studied African American high school students to determine the relationship between cultural mistrust, academic achievement values, and academic outcomes. They found that high cultural mistrust was associated with low expectations and values. The authors suggested that African American students do not have high expectations for positive outcomes and therefore do not strive to achieve academically for fear of feeling incompetent. Additionally, due to perceived racial barriers, African American students do not feel that academic achievements will lead to an in increase in personal benefits.

Purpose of the Study

The purpose of this study is to examine the relationship between cultural mistrust and parents' willingness to accept both a diagnosis of and related services for Attention-Deficit/Hyperactivity Disorder (ADHD) for their child within the school setting. In addition, variables thought to influence cultural mistrust, such as SES and education level, will be used to determine if they serve as moderators for cultural mistrust. A

plethora of research has been conducted over the past few decades to explore the construct of cultural mistrust, particularly in the African American population. Research has linked cultural mistrust to negative attitudes towards mental health providers, and to a reluctance to seek out mental health services. However, there is a scarcity of research investigating cultural mistrust in other racial populations. Furthermore, research in this area has focused primarily on mental health services in relation to oneself, not on how cultural mistrust can impact a parent's attitudes regarding a diagnosis and services for their child. Numerous variables have been cited as barriers to a parent seeking mental health services for their child. One such barrier to diagnosis and treatment may be due to cultural mistrust. It is hoped that a thorough understanding of the implications of cultural mistrust on diagnoses and the delivery of services for children with ADHD will provide insight into a significant barrier to helping children receive needed services. Consequently, when more is understood about how cultural mistrust impacts the delivery of services for children with ADHD, school psychologists and mental health practitioners can proceed with careful consideration of this construct in situations where children are assessed, and or receive services from a professional of a different cultural background. This is particularly relevant in the school setting where parents do not have a choice of the provider of these services and school psychology positions are predominately held by Caucasians (Curtis et al., 2006).

Research Question and Design

The research questions underlying the proposed study are:

1) What is the effect of cultural mistrust on parents' willingness to agree with a diagnosis of ADHD for their child? The hypothesis stemming from this research question is: Higher levels of parental cultural mistrust, regardless of ethnicity, have a predictive effect on agreement with a diagnosis of ADHD for their children.
2) What is the effect of cultural mistrust on parents' willingness to accept services for their child in a school setting? The hypothesis stemming from this research question is: Higher levels of parental cultural mistrust, regardless of ethnicity, have a predictive effect on acceptance of services related to ADHD in the school setting.
3) Which cultural group has the highest levels of mistrust? The hypothesis stemming from this research question is: Minorities will have higher overall levels of cultural mistrust when compared to Caucasians.
4) Do income and level of education change the effects of cultural mistrust on parents' agreement with a diagnosis and acceptance of related services for ADHD for their child in a school setting? The hypothesis stemming from this research question is: When combined, higher levels of cultural mistrust, level of education, and SES will have a predictive effect on a parent's agreement with a diagnosis of ADHD for their child and acceptance of services related to ADHD in a school setting.

These hypotheses will be analyzed via hierarchical regressions followed by any necessary post hoc analyses to provide additional information.

CHAPTER III

METHOD

The purpose of this section is to describe the methodology for this study. Details of the original study, from which the present study gathered archival data, will be reviewed such as participant selection, survey design and structure, and the study procedures. Finally, the statistical analyses for the study will be discussed.

Participant Selection

This study was conducted through reviewing the archival data of a study completed by the Department of Psychology and Philosophy at Texas Woman's University (TWU) in Denton, Texas from Spring 2014 through the beginning of Summer 2014. The participants for this study were recruited through various online media including, but not limited to, ADHD blogs and journals, national and local organizations supporting families with children with ADHD, support groups, practitioner networks, and publishers. Each of these organizations and publications notified their readerships and members of the survey using email mailing lists, newsletters, message board postings, and social networking sites. Additionally, research team members sent notices to families they knew that have a child with ADHD and asked them to pass the information about the study on to other families. Participants were encouraged to share the information with others they knew who meet the criteria for participation.

Characteristics

Ninety-three participants completed the study. Levels of education were scattered across categories with participants reporting to have a Bachelors degree (32.3%) with the most participants, and those reporting to have some high school, but no diploma (1.1%) as the smallest category. Additionally, participants were asked questions that indicated their placement in numerous income level categories; how due to the scattered representation across the categories, the categories were collapsed into Low, Medium, and High. The participants income level was represented as Low (< 49,999), Medium (50,000-99,999), and High (> 100,000). The majority reported Medium income level (47.3), while 34.5% reported High income, and 18.2% reported Low income.

Approximately half of the participants fell between the ages of 35-44 (50.5), with the age groups of 25-34 (22.6%) and 45-54 (21.5%) being reported almost equally. Only 5.4% of the participants were within the 55-64 age group. The majority identified as Caucasian (79.6%), while 9.7% identified as African American, 8.6% identified as Hispanic, 1.1% identified as Asian, and 1.1% identified as Native American or American Indian. The majority of participants were female (82.8%) and 17.2% identified as male. See Table 1 for descriptive statistics of the categorical demographic variables and characteristics.

Table 1

Descriptive Statistics for Sample Demographics: Categorical Variables

Variable	Frequency	Percentage
Gender		
Male	16	17.2
Female	77	82.8
SES- Income		
Low	17	18.2
Medium	44	47.3
High	32	34.5
Education Level		
Some high School, no diploma	1	1.1
High school diploma/GED	7	7.5
Some College credit, no degree	13	14.0
Trade/Vocational/Technical	5	5.4
Associate degree	11	11.8
Bachelors degree	30	32.3
Masters degree	18	19.4
Doctorate degree	8	8.6
Race/Ethnicity		
Caucasian	74	79.6
African American	9	9.7
Hispanic/Latino	8	8.6
Asian	1	1.1
Native American/American Indian	1	1.1
Parental Age		
25-34	21	22.6
35-44	47	50.5
45-54	20	21.5
55-64	5	5.4

n =93

Measures

Two surveys were created, one with wording to ask questions regarding minorities' mistrust of Caucasians and the other with wording to ask questions regarding Caucasians mistrust of minorities. Each survey has the same questions with the

exception of the wording changes to depict the different racial group. Both surveys consist of 41 questions.

The order of the Likert scale answer choices, as well as the choices themselves, are the same and in the same order. The six points on one of the Likert scales ranges from strongly agree to strongly disagree and on another Likert scale ranges from very unwilling to very willing. The Likert scale is one of the most widely used instruments for measuring preference, attitude, and opinion (Leung, 2011). While there is much debate over the appropriate number of points to use on a Likert scale, it has been found that more choices increase sensitivity (Leung, 2011). Therefore, the Likert items on this survey were based on a six-point Likert scale rather than four-point.

The first set of questions answered by respondents involved demographic information and included country location of participant, gender, ethnicity, age, level of education, income, child's age, age of child at diagnosis, and ethnicity of professional that diagnosed child. Subsequently, respondents answered questions about their beliefs regarding the diagnosis given to their child and how much they agree with this diagnosis. Respondents then completed questions about the services that their child receives for this disability in the school setting and their level of willingness to accept these services. The complete minority survey can be found in Appendix A and the Caucasian survey is in Appendix B.

Cultural Mistrust Inventory

Imbedded within each survey is the Cultural Mistrust Inventory (CMI). The CMI is a questionnaire designed to obtain a score of an individual's overall level of cultural

mistrust (Terrell & Terrell, 1981). This measure has been used in a wide range of studies, particularly with African American individuals. Terrell and Terrell (1981) reported the scale has a two-week test-retest reliability (.86), has adequate internal consistency (Cronbach's alpha = .89), and criterion-related validity was established by examining the CMI and the Racial Discrimination Index. They indicate that a high score on the CMI is consistent with a high level of cultural mistrust, while a low score on the CMI is consistent with a low level of cultural mistrust (Terrell & Terrell, 1981).

Terrell and Terrell (1981) described the classification of each question on the survey as falling into the following domains: political/law (PL), education/training (ET), business/work (BW), and interpersonal relations (IR). Inter-correlations of the four subscales ranged from .11 to .23 which suggests independence of each scale. Furthermore, Ponterotto and Casas (1991) reported that, because there is weak correlation between the subscales, it is appropriate to use the subscales independently. Therefore, for the purpose of the current study, only the twenty items included in the ET and IR subscales were used. This instrument was selected for the study because of validity and ease of use.

The response options on the survey followed a six-point Likert scale ranging from "strongly disagree" (1) to "strongly agree" (6). The original CMI was based on a seven-point Likert scale; the neutral response of "neither agree nor disagree" was eliminated. Research has indicated that eliminating neutral mid-point choice can decrease the effect of social desirability bias that respondents may have in order to avoid giving what they perceive to be a socially unacceptable response and does not change the qualitative

results when eliminated (Garland, 1991; Nowlis, Kahn, & Dahr, 2002). Higher scores on the CMI indicate high levels of cultural mistrust. The CMI can be found at the end of the complete survey in Appendixes A and B.

Procedure

The Institutional Review Board (IRB) at TWU approved the original study, from which the archival data for the present study was obtained. As stated previously, participants were recruited via various online media and practitioner networks. The survey was administered online via the PsychData website. Participants were first presented with a consent form describing the study and risks involved in participating. Contact information was provided for the principal investigators. At the end of the consent form, participants were asked to select a button indicating whether they wanted to either proceed with the survey (indicating informed consent) or to end their participation and close the survey. Those participants who elected to proceed were directed to the survey. Upon answering the question regarding their own race or ethnicity, respondents were then assigned to one of two surveys: minority survey or Caucasian survey. While the consent form delineated the risks involved in participating in the study, such as the possible loss of confidentiality inherent in all Internet transactions, the research team did not collect any identifiable information from the participants in order to increase participants' anonymity.

Each participant answered basic demographic questions (e.g., country of participant, gender, ethnicity, age, level of education, income, child's age, age of child at diagnosis, and ethnicity of professional that diagnosed child). Following the

demographic questions, participants answered the remaining questions, including the CMI scale. For the current study, a subsequent IRB application was submitted and approved to allow the data from the original study to be analyzed.

Statistical Analyses

Prior to running the major statistical analyses, descriptive statistics were gathered for the demographic variables. Based on responses on the CMI, individual scores were derived for each participant by adding up the score for each response and dividing the total by the number of questions on the scale to comprise a CMI average score. The scores can range from 1 to 6, with reverse scoring for negatively worded questions. The sample was be divided into three groups—Low, Moderate and High. The groups are based on previous research utilizing the seven-item educational portion of the Cultural Mistrust Inventory with children and then adjusted for use in the current study (Taylor et al., 1994; Terrell & Terrell, 1984; Whaley & Smyer, 1998). The following ranges will be used to determine placement of participants into groups: Low - 1.00-2.50; Moderate = 2.51-4.00; and High = 4.01-6.00.

According to Petrocelli (2003), the best statistical method to use for analyzing the data from a relational survey study, such as the present study, is multiple regression. Multiple regression allows for the examination of more than one predictor against the outcome variable:

> Multiple regression is typically used when the introduction of additional predictor variables can lead to an increased prediction to the outcome variable to be used when they are trying to predict some outcome or criterion variable. Hierarchical

> regression is used to evaluate the relationship between a set of independent variables and the dependent variable, controlling for or taking into account the impact of a different set of independent variables on the dependent variable (Petrocelli, 2003, p.10).

Therefore, a series of multiple regressions was conducted to analyze hypothesis one and hypothesis two. The independent variables were level of cultural mistrust and ethnicity. The dependent variables were agreement with diagnosis and willingness to accept services. Then a one way ANOVA was conducted to analyze hypothesis three. The independent variable was ethnicity and the dependent variable was level of cultural mistrust. Finally, two hierarchical multiple regressions were conducted to analyze hypothesis four. The independent variables were level of education, SES, level of cultural mistrust, and ethnicity. The dependent variables were agreement with diagnosis and willingness to accept services.

In order to conduct hierarchical regressions, the independent variables were divided into three steps. The first step included entering the demographic variable, ethnicity. The second step involved the variables that may be moderators, specifically, level of education and SES in order to determine if level of education and SES were predictors over and above that of ethnicity. The final step included level of cultural mistrust, which is the primary predictor variable. As previously mentioned, the CMI provides an overall score for level of cultural mistrust that was be used in this stage.

Hypothesis	Analysis
1. Higher levels of cultural mistrust, regardless of ethnicity, have a predictive effect on agreement with a diagnosis of ADHD for their children.	1. A multiple regression with agreement with diagnosis of ADHD as the dependent variable and cultural mistrust and ethnicity as the independent variables.
Hypothesis	Analysis
2. Higher levels of cultural mistrust, regardless of ethnicity, have a predictive effect on acceptance of services related to ADHD in the school setting.	2. A multiple regression with acceptance of services as the dependent variable and cultural mistrust and ethnicity as the independent variables.
Hypothesis	Analysis
3. Minorities will have higher overall levels of cultural mistrust when compared to Caucasians.	3. An ANOVA with cultural mistrust as the dependent variable and ethnicity as the independent variable.
Hypothesis	Analysis
4. When combined, higher levels of cultural mistrust, level of education, and SES will have a predictive effect on a parent's agreement with a diagnosis of ADHD for their child and acceptance of services related to ADHD in a school	4. A hierarchical regression with agreement with diagnosis as the dependent variable and ethnicity, level of education, SES, and level of cultural mistrust as the independent variable.

setting.	Step 1: demographic factor (ethnicity). Step 2: level of education and SES. Step 3: Level of cultural mistrust.

CHAPTER IV

RESULTS

As stated in Chapter 1, the purpose of this study is to examine the effect of cultural mistrust and parents' willingness to agree with a diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD) and to accept related services for ADHD for their child within the school setting. This study also seeks to determine if SES and education level have a predictive relationship beyond that of cultural mistrust. This chapter begins with a description of the demographic characteristics of the parents that participated in the study. Study findings related to ethnicity, SES, level of education, cultural mistrust, and parental agreement with a diagnosis of ADHD for their child, as well as, acceptance of services related to ADHD in the school setting are described. Details of the multiple regressions for the first and second hypotheses are reviewed. Subsequently, details of the ANOVA for the third hypothesis are reviewed. Finally, the hierarchical regression for the fourth hypothesis and the analyses for each of the separate dependent variables are delineated.

Preliminary Analyses

Descriptive Statistics

Means, standard deviations, and ranges were calculated for all of the continuous variables measured in this study. See Table 2 for the descriptive data for dependent variables and Table 3 for the descriptive data for the non-demographic independent variables. Scores on the dependent variable, agreement with diagnosis, reflect negative to positive perspectives, with high scores (6 being the highest) indicating more agreement from the participants. Scores on the dependent variable, willingness to accept services, reflect negative to positive perspectives, with high scores (7 being the highest) indicating more willingness from participants.

Table 2

Descriptive Data for Dependent Variables

Variable	Mean	Range	*SD*
Agreement with Diagnosis of ADHD	4.77	1.00 – 6.00	1.70
Willingness to Accept Services in a School Setting	5.62	1.00-7.00	1.56

The scores for the Cultural Mistrust Inventory (CMI) reflect the degree to which the participants have cultural mistrust of another cultural or ethnic group, with higher scores reflecting higher levels of cultural mistrust. Overall, respondents reported a mean of 2.73, which is a moderate level of cultural mistrust (see Table 3).

Table 3

Descriptive Data for Non-Demographic Independent Variables

Variable	Mean	Range	*SD*
CMI	2.73	1.00-6.00	.26

Analyses of Hypothesis One

A multiple regression was completed to determine if cultural mistrust across ethnicities had a significant effect on parents' agreement with a diagnosis of ADHD. In the first hypothesis, the researcher predicted that parents with higher levels of cultural mistrust would be in less agreement with a diagnosis of ADHD for their children. The results of the multiple regression indicated that neither parents' level of cultural mistrust nor ethnicity predict agreement with an ADHD diagnosis for their child. The overall contribution between the predictors and the criterion was not significant in the first regression analysis (see Table 4). The R was .143, R^2 = .020, F (2, 90) = .93, and p = .397. As presented in Table 4, the regression coefficients or beta weights for independent variables resulted in the following: Cultural mistrust β = -.13 and Ethnicity β = -.07 indicating both had negative relationships with parental agreement with an ADHD diagnosis. This suggests that the degree of relationship between the predictors (cultural mistrust, ethnicity) and parental agreement with an ADHD diagnosis was not significantly greater than zero. The results are summarized in Table 4.

Table 4

Summary of the Multiple Regression of Parents' Agreement with Diagnosis of ADHD with CMI

Variables	*B*	*SE*	ß	T	*Sig.*
CMI	-.86	.69	-.13	-1.27	.21
Ethnicity	-.28	.44	-.07	-.641	.52

*Note. R = .143, R^2 = .020, Adj. R^2 = -.001, F (2, 90) = .93, p = .397

Analyses of Hypothesis Two

A multiple regression was completed to determine if cultural mistrust across ethnicities had a significant effect on parents' willingness to accept services in the school setting. In the second hypothesis, the researcher predicted that parents with higher levels of cultural mistrust would be less likely to accept services related to ADHD for their children in a school setting. The results of the multiple regression indicated that neither parents' level of cultural mistrust nor ethnicity predict acceptance of services related to ADHD for their children in a school setting. The overall contribution between the predictors and the criterion was not significant in the second regression analysis (see Table 5). The R was .122, R^2 = .015, F (2, 90) = .68, and p = .509. As presented in Table 5, the regression coefficients or beta weights for independent variables resulted in the following: Cultural mistrust β = -.19 had a negative relationship, while Ethnicity β = .44 had a positive relationship with acceptance of services. This suggests that the degree of relationship between the predictors (cultural mistrust, ethnicity) and parental acceptance of services related to ADHD in the school setting was not significantly greater than zero. The results are summarized in Table 5.

Table 5

Summary of the Multiple Regression of Parents' Acceptance of Services with CMI

Variables	*B*	*SE*	ß	T	*Sig.*
CMI	-.19	.63	-.032	-.301	.76
Ethnicity	.44	.41	.114	1.08	.28

*Note. R = .122, R^2 = .015, Adj.R^2 = -.007, F (2, 90) = .68, p = .509

Analyses of Hypothesis Three

A one-way ANOVA was conducted to determine if African Americans had the highest level of cultural mistrust when compared to all other racial groups. Due to small sample sizes in all of the minority groups, participants were collapsed into two groups: Caucasian (n = 74) and Minorities (n = 19). After testing for outliers, as assessed by box plot, an outlier with a value of 3.94 for CMI was discovered. In order to help remove the negative effect of the outlier, the outlier's value was reduced to just larger than the second largest value of 3.30; the data were normally distributed for each group, as assessed by the Shapiro-Wilk test ($p > .05$); and there was homogeneity of variances, as assessed by Levene's test of homogeneity of variances ($p = .682$). Data is presented as mean ± standard deviations. The CMI score ranged from the Caucasian (2.7 ± 0.2) to the Minority (2.8 ± 0.3) cultural ethnicity groups, but the differences between these cultural ethnicity groups was not statistically significant, F (1, 91) = 1.915, p = .170.

Table 6

Means and Standard Deviations for CMI by Ethnicity

Ethnicity	Mean	*SD*
Caucasian	2.7	.20
Minority	2.8	.31

Table 7

Summary of the ANOVA for the Relationship Between CMI and Ethnicity

Source	Df	SS	MS	F	*P*
Ethnicity	1	.104	.104	1.915	.170

Analyses of Hypothesis Four

Two hierarchical multiple regressions were completed to determine if adding variables, specifically ethnicity, SES, education, and level of cultural mistrust had a significant effect on parents' agreement with a diagnosis of ADHD, as well as, willingness to accept services in the school setting. In the fourth hypothesis, the researcher predicted that when combined, higher levels of cultural mistrust, level of education, and SES would have a significant effect on a parent's agreement with a diagnosis of ADHD for their child and acceptance of services related to ADHD in a school setting. The results of the first hierarchical multiple regression indicated that agreement with a diagnosis of ADHD was not significantly predicted by any of the independent variables: F (4, 88) = .851, p = .497, R^2 = .037. As presented in Table 8, the regression coefficients or beta weights for independent variables resulted in the following: Ethnicity β = -.323, SES β = -.071, and CMI β = -1.32 had a negative relationship with agreement with diagnosis, while Education β = .041 had a positive relationship with agreement of diagnosis. Additionally, this suggests that the degree of relationship between the predictors (ethnicity, education, SES, and cultural mistrust) and parental agreement with a diagnosis of ADHD for their children was not significantly greater than zero. The results are summarized in Table 8.

Table 8

Overall Agreement with Diagnosis Hierarchical Regression Summary

Predictors	R^2	*B*	*SE*	ß	*t*-value
Final Step	.037				
Ethnicity		-.323	.44	-.08	-.727
Education		.041	.11	.04	.378
SES		-.071	.10	-.08	-.69

CMI	-1.32	.78	-.18	-1.69

** $p < .01$, * $p < .05$

The results of the second hierarchical multiple regression indicated that the overall model for acceptance of services related to ADHD in the school setting was not significant. However, acceptance of services was significantly predicted by one of the independent variables: F (2, 90) = 2.94, p = .054, R^2 = .075. Level of education was the only variable that predicted more acceptance of services from respondents. In this regression, only the second step was significant but the first and third were not. As presented in Table 9, the regression coefficients or beta weights for independent variables resulted in the following: Ethnicity β = .11, Income β = .03, and Education β = .23 had a positive relationship with acceptance of services, while CMI β = -.005 had a negative relationship with acceptance of services. These results are summarized in Table 9.

Table 9

Overall Acceptance of Services Hierarchical Regression Summary

Predictors	R^2	*B*	*SE*	ß	*t*-value
Step Two	.075*				
Ethnicity		.437	.40	.11	1.097
Education		.203	.09	.23	2.13*
SES		.066	.24	.03	.273
CMI		-.022	.71	-.005	-.047

** $p < .01$, * $p < .05$

CHAPTER V

DISCUSSION

The purpose of the study was to examine if cultural mistrust had a predictive role in a parent agreeing with a diagnosis of ADHD and their willingness to accept services that are offered in a school setting. It is important to explore if cultural mistrust influences the identification and interventions that may be provided in a school setting for a child with ADHD. It was the author's belief that there are differences between minority groups and Caucasians concerning parental agreement with a mental health diagnosis, including ADHD. Therefore, it was posited that if a parent does not agree with a diagnosis, then they are less likely to accept services that may be offered for a related diagnosis. This chapter discusses the research findings of the study. The chapter has six main sections. The first section presents an overview of the rationales behind the study. The second section addresses the results of the research study, while the third and fourth sections discuss the limitations and contributions of the study. The fifth section offers

recommendations for future research on cultural mistrust and the diagnosis of ADHD in the school setting. The final section offers concluding thoughts about the study.

Overview of the Study

According to the Centers for Disease Control (CDC), although the number of children diagnosed with ADHD increased by two million between 2003 and 2011, approximately 17.5% of those diagnosed have never received any type of treatment or medication (Center for Disease Control, 2011). Additionally, the CDC (2011) reports that while percentages of ADHD diagnosis have steadily increased across most demographics between 2007 and 2011, rates have actually decreased for children reported as multiracial and children of other races as compared to both African American and Caucasian children. One such barrier to diagnosis and treatment may be cultural mistrust. A considerable amount of research has been conducted in an effort to explore factors influencing cultural mistrust. However, the majority of research has only focused on the African American population, while there is a paucity of research investigating cultural mistrust in other racial populations. A review of the literature found that cultural mistrust has been linked to negative attitudes towards mental health providers, as well as, dissatisfaction with and a reluctance to seek out mental health services leading to an underutilization of mental health services within minority populations (Ahluwalia, 1991; David, 2010; Grant-Thompson, & Atkinson, 1997; Nickerson et al., 1994; Poston et al., 1991; Terrell & Terrell, 1984; Thompson et al., 1994; Watkins & Terrell, 1988; Watkins et al., 1989). Additionally, research has indicated that having a low income has a limiting effect on ability to access mental health services (Chadiha & Brown, 2002; Kohn &

Hudson, 2002). In contrast, studies with an African American population found that even individuals of higher SES report negative attitudes toward the dominant culture, therefore limiting utilization of mental health services (Irving & Hudley, 2008; Ogbu, 2003). Furthermore, Rajakumar et al. (2009) found that individuals with lower education levels have less trust. Conflicting data and lack of research conducted on various racial groups, particularly Caucasians, suggests the need to examine the current trends for cultural mistrust across ethnicities and how this may influence parental behavior regarding a diagnosis of ADHD and receiving services to ameliorate difficulties in the school setting.

This research study aimed to determine if parents' level of cultural mistrust predicted their agreement with a diagnosis of ADHD and their acceptance of related services in the school setting. Given the evidence for education and SES to impact levels of trust and mental health seeking behaviors, level of education as measured by specific categories and SES as measured by income levels of low, medium, and high income were chosen as moderating variables in the study. It was hypothesized that higher levels of cultural mistrust predicted parental agreement of a diagnosis of ADHD and acceptance of related services. Furthermore, it was hypothesized that when combined, higher education, SES, and cultural mistrust will predict both agreement and acceptance. In addition, it was hypothesized that African Americans had higher levels of cultural mistrust when compared to other racial groups. However, due to small sample size in all minority groups, this variable was collapsed into two groups, Caucasian and Minority.

Discussion of Results

Scales of the CMI and a demographic survey questionnaire were used to investigate the effect of a parents' level of cultural mistrust on agreement with a diagnosis of ADHD and acceptance of services. Questions were designed to gather information regarding participants' beliefs about a diagnosis of ADHD for their child and related services that were received in the school setting. Additionally, twenty questions from the CMI, specifically the ET and IR subscales were used to determine participants' overall level of cultural mistrust. Although two different surveys were used for Caucasians and Minorities, only the wording of "Whites", from the original CMI, to "Minorities" was changed.

Duncan (2003) found that higher levels of cultural mistrust were linked with negative views towards seeking professional mental health help. Townes et al. (2009) indicated that cultural mistrust affected an individual's willingness to receive services. The results of this study do not support the findings of Duncan (2003) and Townes et al. in that higher levels of cultural mistrust had no effect on parental agreement with a diagnosis or acceptance of services in regards to ADHD. In other words, cultural mistrust did not appear to be a factor in whether or not a parent would agree with the diagnosis of ADHD given to their child or their acceptance of services that were offered in the school setting. Additionally, ethnicity did not have a significant effect on either of these perspectives. In addition, differences in levels of cultural mistrust across ethnicities were not found. The results of this study were more consistent with the findings of Weaver (2003) and Ahluwalia (1991) who found that some ethnic groups do not experience the effects of cultural mistrust to the same degree as others. When examining

the construct of ethnicity in this study, all minority groups were collapsed into one group. The combining of these groups may have resulted in the loss of differences between groups, such as groups that could be considered involuntary versus voluntary minorities.

The review of the literature suggested that SES has a limiting effect on the utilization of mental health services (Chadiha & Brown, 2002; Kohn & Hudson, 2002). Conversely, Duncan (2003) found that that SES does not have a significant influence on levels of cultural mistrust and Irving and Hudley (2008) found that individuals of all SES levels report dissatisfaction in an academic setting due to negative attitudes toward the dominant culture. The results of this study supported the findings of both Duncan (2003) and Irving and Hudley (2008) such that SES was not shown to have any impact on level of cultural mistrust, agreement with a diagnosis of ADHD, or acceptance of services.

Although no literature was found specifically linking level of education to cultural mistrust, a few studies have demonstrated that higher education levels resulted in smaller racial differences in levels of distrust of physicians in the medical setting (Armstrong et al., 2007). Rajakumar et al. (2009) found that parents of child patients with less than a high school education reported significantly higher levels of distrust in physicians when compared with parents who were college graduates. However, conflicting research has indicated that parents with lower levels of education had greater health-seeking behavior and greater level of trust (Harth & Thong, 1990). Moseley et al. (2007) posited that parents with higher education may have higher expectations and therefore may experience more dissatisfaction if those expectations are not met. The results in this study aligned with the outcomes found in the studies conducted by Armstrong et al.

(2007) and Rajakumar et al. (2009). The findings in this study indicated that as education level increased, acceptance of services in the school setting increased to a significant degree. However, there was no significant effect of education level on agreement with a diagnosis.

Limitations of the Study

There were a number of limitations to this study, which may have been amplified by several unintentional methodological weaknesses. First, the survey questions that were designed to measure parental agreement and acceptance of services may have low construct validity. The wording of the questions may have been more limiting to parents as it forced them to choose a response on a Likert scale, rather than allowing them to freely describe their feelings. A comment box was added after each question to minimize potential weaknesses of the study design, however, the responses in these boxes were not analyzed for the purpose of this study. Additionally, key questions that may have been important confounding variables such as gender of child, type of ADHD presentation, or level of child's functioning were not included in the survey. Research indicates that females are underidentified, underdiagnosed, and reported to exhibit fewer hyperactive/impulsive symptoms than males (Skogli, Teicher, Andersen, Hovik, & Øie, 2013). Therefore, the gender of the children represented in the current study may have confounded the results. Furthermore, the diagnosis of ADHD is classified into one of

three categories: Predominately inattentive presentation, Predominately hyperactive/impulsive presentation, and Combined presentation. Differences in presentation type and the severity of symptoms are likely to have an impact on not only parental agreement with a diagnosis, but the perception of the need for related services in a school setting.

Second, due to the sensitive nature of the questions regarding race, participants may have been uncomfortable answering the questions from the CMI. The questions on the CMI are strongly worded and may be perceived as racist or prejudiced towards members of racial groups that are different from the responder. Consequently, participants may have rated their responses more favorably due to social desirability. As mentioned previously, the wording of the questions may have caused some participants to feel uneasy expressing their true opinions about their level of mistrust for individuals of another race.

Third, the external validity of the study is threatened by the limited generalizability of the study results. The majority of the participants were identified as Caucasian (n = 74, 79.6%) and female (n = 77, 82%). The demographic makeup of the participants in this study was restricted to a small sample of parents that cannot be generalized to other parents across the United States. Despite efforts to ensure a sufficient sample size from a variety of respondents, the sample was limited in race and gender.

Fourth, the inclusionary criteria may have influenced the results of this study. The author made an error in the design of the study in limiting participants to parents of

children that have been formally diagnosed by a physician or mental health provider. Identifying as having a child that has been formally diagnosed with ADHD indicates that a parent, at least to some extent, has agreed that their child has this disorder. However, had the study been opened up to parents that have children experiencing difficulties with attention and/or hyperactivity but have not been formally diagnosed, then it is likely there would have been more participants that reported disagreement with a diagnosis of ADHD for their child.

Contributions of the Study

The findings of this study provide some important contributions to the existing literature on cultural mistrust. One of the biggest strengths of this study is its uniqueness. All of the studies reviewed examined cultural mistrust within minority populations, with the majority focusing solely on African Americans (Ahluwalia, 1991; Biafora et al., 1993; David, 2010; Neville & Mobley, 2001; Neville et al., 2009; Ogbu & Simmons, 1998; Terrell et al., 2009). This study has extended the literature by introducing the inclusion of Caucasians as participants in a study examining cultural mistrust.

Another contribution to the literature is the link between parental level of education and acceptance of services in the school setting. Research in the literature that focused on the effects of level of education on cultural mistrust were all conducted in the medical setting (Armstrong et al., 2007; Harth & Thong, 1990; Moseley et al., 2007; Rajakumar et al., 2009). However, there was a lack of research on parental cultural mistrust in the school setting. This study added empirical data in the school setting.

Higher levels of parental education predicted more acceptance of ADHD related services that are received at school.

Finally, this research study offers a different perspective on the effects of cultural mistrust in regards to mental health seeking behavior. Unlike previous research findings that higher levels of cultural mistrust indicated less favorable attitudes towards and less willingness to accept or seek services for mental health (Duncan, 2003; Townes et al., 2009), the results of this study do not indicate this trend. The results of the study failed to support the idea that cultural mistrust affects parental agreement with a diagnosis of ADHD or the acceptance of related services in the school setting. However, this study did indicate that parents with lower education are less willing to accept services that are provided at school. One can posit that parents with lower education levels will be less educated regarding mental health. This finding guides professionals working in schools to be cognizant that individuals with lower education levels may need increased psycho-education and in depth information regarding services that may be offered within a school setting.

Recommendations for Future Research

Future research on cultural mistrust could focus on assessing the level of cultural mistrust across age groups. This topic merits some attention as the nature of racial discrimination has changed over the years and may influence how younger individuals respond to issues of race and cultural mistrust. While more overt forms of racism and discrimination have changed drastically, covert microaggressions continue to permeate society.

A second suggestion is to develop and validate a more modern version of an inventory that assesses cultural mistrust to reflect the aforementioned societal changes in how oppression, racism and discrimination are experienced. Developing a measure that more accurately gauges the subtle nuances of racism may yield different results than the current study. It was noted that a large number of participants began the survey and stopped without completing the CMI portion of the survey. Participants may be more comfortable answering questions that are not as strongly worded as the CMI, which will likely result in a much larger sample.

A third suggestion is to increase the response rate by improving the inclusionary criteria of the study and widening the recruitment process. As mentioned previously, a suggestion to include parents of children with attention and/or hyperactivity concerns will allow researchers to tap into the perspectives of a larger representation of parents that have the potential for an increased likelihood for disagreement with a diagnosis of ADHD for their child. In addition, researchers may want to contact school districts to gain access to recruit parents directly from the school setting, such as parents who are undergoing the special education referral process or during initial Individualized Education Program (IEP) meetings, which may recruit a substantial number of participants.

A fourth suggestion for forthcoming research would be to examine geographic differences that may be found in cultural mistrust and ADHD. Research has shown that living in a suburban area can be predictive of increased likelihood for ADHD (Baumgardner, et al., 2010). In addition, McDonald and Jalbert (2013) found significant

variation in the identification and treatment practices for ADHD across the United States. Moreover, research has also indicated considerable geographic variation in levels of distrust of a physician in medical settings (Armstrong, et al., 2007). Therefore, further investigation regarding geographic differences is warranted.

A final suggestion offered is that future researchers should focus on extending the sample size in order to more closely match the populations of ethnic minorities in the United States. One of the limitations for this study was the disproportionate distribution of ethnic parent participants. The majority of the parents were Caucasian and female. A larger sample size may ensure proportional racial representations for better cross comparison. Improving the sample size would also improve the external validity of the research study, because it improves the generalizability of the results to other parents across a variety of ethnicities and genders.

Conclusion

The current study investigated what affects acceptance and utilization of services pertaining to ADHD in schools. Specifically, how cultural mistrust, ethnicity, and SES predict parental agreement with a diagnosis and acceptance of related services in the school setting. The researcher found that neither cultural mistrust nor SES predicted parental agreement or acceptance of services. However, study findings did suggest a predictive relationship between level of education and acceptance of services. Results of this study found that parents with higher levels of education were more willing to accept services offered to their child in the context of a school environment. These findings highlight the importance of identifying parents with lower education levels in effort to

increase resources and material that thoroughly explain their child's diagnosis of ADHD and how services offered within the school can improve their child's academic experience.

Continuing to research the connection between each of these variables will have significant implications for both research and practice as a school psychologist. A better understanding of the role that parental cultural mistrust plays in regards to diagnosis and the provision of mental health services in the school will allow professionals to accurately identify concerns related to cultural mistrust rather than an assumption of arbitrary resistance. Additionally, research in this area can provide further impetus for the ongoing need for more minorities in the field of school psychology. The results of this study have implications for the development of future endeavors to address the possibility of under diagnosis and underutilization of school based mental health services for ADHD.

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APPENDIX A

Cultural Mistrust Inventory-Minority Version

Demographics

Parent Information

1. Has your **child** been formally diagnosed with a disability by a professional?
    - Yes
    - No
2. Which disability does your **child** have?
    - Autism Spectrum Disorder (Autism/Asperger's)
    - Attention Deficit Hyperactive Disorder (ADHD)
3. Do you live in the United States?
    - Yes
    - No
4. What is YOUR gender?
    - Male
    - Female
    - Transgendered
5. Please specify **YOUR** ethnicity, origin, or race
    - White or Caucasian
    - Black or African American
    - Hispanic or Latino
    - Asian
    - Pacific Islander
    - Native American or American Indian
    - Middle Eastern
    - Other

6. What is **YOUR** age?
    - 18-24 years old
    - 25-34 years old

- 35-44 years old
- 45-54 years old
- 55-64 years old
- 65 years or older

7. What is the highest degree or level of school **YOU** have completed?
    - Kindergarten to 8th grade
    - Some high school, no diploma
    - High school graduate, diploma or the equivalent (for example: GED)
    - Some college credit, no degree
    - Trade/technical/vocational training
    - Associate degree
    - Bachelor's degree
    - Master's degree
    - Doctorate degree
8. What is your total household income?
    - Under $25,000
    - $25,000 - $39,999
    - $40,000 - $49,999
    - $50,000 - $74,999
    - $75,000 - $99,999
    - $100,000 - $124,999
    - $125,000 - $149,999
    - Over $150,000

Student Information

1. Age of **child**
    - 5-8 years old
    - 9-12 years old
    - 13-18 years old

- 19 years or older

2. Age of **child** at diagnosis
    - Under 3 years old
    - 3-4 years old
    - 5-8 years old
    - 9-12 years old
    - 13-18 years old
    - 19 years or older
3. Was your child diagnosed by a professional of a different race/ethnicity?
    - Yes
    - No
4. Was your child's evaluation conducted in his or her primary language?
    - Yes
    - No
5. Do you feel that your child's race and ethnicity influenced the diagnosis?
    - Yes
    - No
6. How do you feel ethnicity influenced the diagnosis?
7. Do you feel your child would have received the same diagnosis from a professional of the same race/ethnicity?
    - Yes
    - No
8. Please explain why or why not?

9. Do you agree with the diagnosis given to your child?
    - Yes
    - No

    If not, please explain why?
10. Most of the professionals at my child's school are:

- Black or African American
- White or Caucasian
- Hispanic or Latino
- Asian
- Pacific Islander
- Native American or American Indian
- Middle Eastern
- Other

11. Does your **child** receive special education or 504 services in the school for this disability?
    - Yes
    - No
12. What services does your child receive?

13. Do you feel that the services provided to your child are helpful?
    - Yes
    - No
14. Did you seek out special education services for your child's disability?
    - Yes
    - No
15. Did you willingly accept services offered to your child?
    - Very Willingly
    - Unwillingly
    - Somewhat unwillingly
    - Somewhat willingly
    - Willingly
    - Very willingly
    - No services have been offered at this time
16. Please Explain why or why not?

17. On a scale of 1-10 with 1 being least comfortable and 10 being most comfortable, how comfortable are you with asking for additional services for your child (for example Individual counseling, additional support in the classroom).

1 2 3 4 5 6 7 8 9 10

Instructions: Enclosed are statements concerning beliefs, opinions, and attitudes about various racial groups. Read each statement carefully and give your honest feelings about the beliefs and attitudes expressed, using the 6 point scale below. There are no right or wrong answers, just your own opinion, at the present time.

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

1. Whites are usually fair to all people regardless of race.
2. White teachers teach subjects so that it favors Whites.
3. White teachers deliberately ask students of other races questions which are difficult so they will fail.
4. Parents of minority children should teach their children not to trust White teachers.
5. Minorities should be suspicious of Whites.
6. Whether you should trust a person or not is based on his or her race.
7. The biggest reason Whites want to be friendly with people of other races is so that they take advantage of them.
8. A minority can usually trust his or her White peers.
9. If a White person is honest when dealing with a minority it is because of fear of being caught.
10. There are some Whites who are trustworthy enough to have as close friends.
11. Minorities should not have anything to do with Whites because they cannot be trusted.
12. It is best for minorities to be on their guard when among Whites.
13. Whites are least likely to break their promises.
14. Minorities should be cautious what they say in the presence of Whites since Whites will try to use it against them.
15. Whites can rarely be counted on to do what they say.

16. Whites are usually honest with minorities.
17. Whites are as trustworthy as members of any other ethnic group.
18. Whites will say one thing and do another.
19. Minority students can talk to a White teacher in confidence without fear that the teacher will use it against him or her later.
20. Whites will usually keep their words.

APPENDIX B

Cultural Mistrust Inventory- Caucasian Version

Demographics

Parent Information

1. Has your **child** been formally diagnosed with a disability by a professional?
    - Yes
    - No
2. Which disability does your **child** have?
    - Autism Spectrum Disorder (Autism/Asperger's)
    - Attention Deficit Hyperactive Disorder (ADHD)
3. Do you live in the United States?
    - Yes
    - No
4. What is YOUR gender?
    - Male
    - Female
    - Transgendered
5. Please specify **YOUR** ethnicity, origin, or race
    - White or Caucasian
    - Black or African American
    - Hispanic or Latino
    - Asian
    - Pacific Islander
    - Native American or American Indian
    - Middle Eastern
    - Other
6. What is **YOUR** age?
    - 18-24 years old
    - 25-34 years old
    - 35-44 years old

- 45-54 years old
- 55-64 years old
- 65 years or older

7. What is the highest degree or level of school **YOU** have completed?
    - Kindergarten to 8th grade
    - Some high school, no diploma
    - High school graduate, diploma or the equivalent (for example: GED)
    - Some college credit, no degree
    - Trade/technical/vocational training
    - Associate degree
    - Bachelor's degree
    - Master's degree
    - Doctorate degree
8. What is your total household income?
    - Under $25,000
    - $25,000 - $39,999
    - $40,000 - $49,999
    - $50,000 - $74,999
    - $75,000 - $99,999
    - $100,000 - $124,999
    - $125,000 - $149,999
    - Over $150,000

Student Information

1. Age of **child**
    - 5-8 years old
    - 9-12 years old
    - 13-18 years old
    - 19 years or older

2. Age of **child** at diagnosis
    - Under 3 years old
    - 3-4 years old
    - 5-8 years old
    - 9-12 years old
    - 13-18 years old
    - 19 years or older
3. Was your child diagnosed by a professional of a different race/ethnicity?
    - Yes
    - No
4. Was your child's evaluation conducted in his or her primary language?
    - Yes
    - No
5. Do you feel that your child's race and ethnicity influenced the diagnosis?
    - Yes
    - No
6. How do you feel ethnicity influenced the diagnosis?
7. Do you feel your child would have received the same diagnosis from a professional of the same race/ethnicity?
    - Yes
    - No
8. Please explain why or why not?

9. Do you agree with the diagnosis given to your child?
    - Yes
    - No

    If not, please explain why?
10. Most of the professionals at my child's school are:
    - Black or African American

- White or Caucasian
- Hispanic or Latino
- Asian
- Pacific Islander
- Native American or American Indian
- Middle Eastern
- Other

11. Does your **child** receive special education or 504 services in the school for this disability?
    - Yes
    - No
12. What services does your child receive?
13. Do you feel that the services provided to your child are helpful?
    - Yes
    - No
14. Did you seek out special education services for your child's disability?
    - Yes
    - No

15. Did you willingly accept services offered to your child?
    - Very Willingly
    - Unwillingly
    - Somewhat unwillingly
    - Somewhat willingly
    - Willingly
    - Very willingly
    - No services have been offered at this time
16. Please Explain why or why not?

17. On a scale of 1-10 with 1 being least comfortable and 10 being most comfortable, how comfortable are you with asking for additional services for your child (for example Individual counseling, additional support in the classroom).

1 2 3 4 5 6 7 8 9 10

Instructions: Enclosed are statements concerning beliefs, opinions, and attitudes about various racial groups. Read each statement carefully and give your honest feelings about the beliefs and attitudes expressed, using the 7 point scale below. There are no right or wrong answers, just your own opinion, at the present time.

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

1. People from minority races are usually fair to others regardless of race.
2. Minority teachers teach subjects so that it favors their own race.
3. Minority teachers deliberately ask students of other races questions which are difficult so they will fail.
4. Parents of White children should teach their children not to trust minority teachers.
5. Whites should be suspicious of minorities.
6. Whether you should trust a person or not is based on his or her race.
7. The biggest reason minorities want to be friendly with people of other races is so that they take advantage of them.
8. A White person can usually trust his or her minority peers.
9. If a minority person is honest when dealing with a White person it is because of fear of being caught.
10. There are some minorities who are trustworthy enough to have as close friends.
11. Whites should not have anything to do with minorities because they cannot be trusted.
12. It is best for Whites to be on their guard when among minorities.
13. Minorities are least likely to break their promises.
14. Whites should be cautious what they say in the presence of minorities since minorities will try to use it against them.
15. Minorities can rarely be counted on to do what they say.
16. Minorities are usually honest with Whites.
17. Minorities are as trustworthy as Whites.

18. Minorities will say one thing and do another.
19. White students can talk to a minority teacher in confidence without fear that the teacher will use it against him or her later.
20. Minorities will usually keep their words.

APPENDIX C

IRB Approval Letter

Institutional Review Board
Office of Research and Sponsored Programs
P.O. Box 425619, Denton, TX 76204-5619
940-898-3378
email: IRB@twu.edu
http://www.twu.edu/irb.html

DATE: June 20, 2014

TO: Ms. Carmen Brown
Department of Psychology & Philosophy

FROM: Institutional Review Board - Denton

Re: *Exemption for Implications of Cultural Mistrust on Diagnosis and Services for Students with ADHD (Protocol #: 17738)*

The above referenced study has been reviewed by the TWU Institutional Review Board (IRB) and was determined to be exempt from further review.

If applicable, agency approval letters must be submitted to the IRB upon receipt PRIOR to any data collection at that agency. Because a signed consent form is not required for exempt studies, the filing of signatures of participants with the TWU IRB is not necessary.

Although your protocol has been exempted from further IRB review and your protocol file has been closed, any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any adverse events or unanticipated problems. All forms are located on the IRB website. If you have any questions, please contact the TWU IRB.

cc. Dr. Dan Miller, Department of Psychology & Philosophy
Dr. Kathy DeOrnellas, Department of Psychology & Philosophy
Graduate School