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

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DEDICATION

I dedicate this dissertation to my mother, Florence Denis, whose unconditional love and support have carried me through this process. Thank you for your tireless efforts, dedication, and for all that you do. To you, I owe my life's work and eternal gratitude.

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"If I have seen further it is by standing on the shoulders of giants."-Isaac Newton.

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ABSTRACT

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The purpose of the proposed study was to examine whether the level of cultural mistrust differed between Caucasians and minorities and to explore how a number of variables including, cultural mistrust, race, income, and level of education impact parents' agreement with the diagnosis of Autism Spectrum Disorder, their willingness to accept services for their child, and their comfort level with asking for additional services for their child. One hundred thirty-seven parents were assigned to one of two surveys, depending on their race (Caucasian or Minority version). The surveys varied slightly due to alteration in the wording of questions. An ANOVA was conducted to investigate differences in levels of cultural mistrust between minority and Caucasian parents. Results indicated that minority parents' scores on the Cultural Mistrust Inventory (CMI) were statistically significantly higher than Caucasian parents' scores. Then, a factorial MANOVA was performed to examine whether the demographic variables of race, income, and level of education, along with cultural mistrust, influenced how parents reported agreeing with a diagnosis of Autism, acceptance of services offered to their child, and comfort level with asking for additional services. Subsequently, post-hoc ANOVAS were conducted on each of the dependent variables to gain insight into the

impact of the statistically significant independent variables. Results showed a main effect for race and an interaction effect for race and cultural mistrust, specifically on the third dependent variable (comfort level with asking for additional services). Minorities were not comfortable asking for additional services, regardless of their level of cultural mistrust. Conversely, cultural mistrust did impact Caucasian's comfort level with asking for services. White parents with a moderate level of cultural mistrust were less comfortable asking for additional services. These results provide information about differences in cultural mistrust between minorities and Caucasians. The current study is the first known to investigate cultural mistrust in Caucasians; thus, highlighting an area of future research. Furthermore, school psychologists can apply these results to promote positive relationships with minority parents and increase their comfort level in advocating for their children with ASD.

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CHAPTER I

INTRODUCTION

This study investigated the differences in levels of cultural mistrust amongst Caucasian and minority parents of children on the Autism spectrum. Moreover, the researcher examined whether demographic variables, including race, income, and level of education, and cultural mistrust, influence parents' acceptance of an Autism Spectrum Disorder (ASD) diagnosis for their child, willingness to accept services offered to their child, and their comfort level with asking for additional services for their child. To fully appreciate the richness of the study, it is imperative to gain a clear understanding of how the diagnosis of ASD differs across cultures and how these cross-cultural differences can impact a parent's acceptance of this diagnosis for their child. Furthermore, a review of the literature related to the aforementioned variables, specifically cultural mistrust and its historical influence and impact on individuals of color, aid in providing the foundation and rationale for the study.

Brief Overview of ASD

Individuals with ASD are characterized as having persistent deficits in social communication and social interactions across settings. They also display restricted and repetitive patterns of behaviors or interests, which limit or impair their everyday functioning (American Psychiatric Association [APA], 2013). The term ASD has been traditionally used to describe a number of developmental disorders including Asperger's Disorder, Rett Syndrome, Childhood Disintegrative Disorder, and Pervasive

Developmental Disorder-Not Otherwise Specified, with symptoms typically present across the lifespan (Dyches, Wilder, Sudweeks, Obiakor, & Algozzine, 2004). A great number of children with ASD also have intellectual disabilities, causing 75 percent of this population to have life-long challenges. Although there have been claims of uncovering the cause of ASD as well as the discovery of a cure, to date, a clear and distinct etiology of ASD remains unknown (Jones & Harwood, 2009). While the etiology of ASD has not been explained in the literature, scientific advancements have been made in investigating the molecular genetics involved in the development of ASD, as well as understanding the neurobiological underpinning of the disorder (Volkmar, Lord, Bailey, Schultz, & Klin, 2004). Most recent research has specifically focused on microdeletions in individual chromosomes as a causal explanation for the development of ASD (Mefford, Batshaw, & Hoffman, 2012).

Previously considered a low-incident disorder (Zhang, Wheeler, & Richey, 2006), ASD is currently thought of as "the fastest growing developmental disability in the United States" (Scarpa et al., 2013, p. 2270). In 2000, the estimated prevalence, according to the Centers for Disease Control (CDC), was 1 in 150; by 2006, the prevalence had increased to 1 in 110 (Rice, 2009). Recent estimates from the CDC (2013), suggest 1 in 66 children have been identified with ASD. When the data were examined according to race, 1 in 63 White children, 1 in 81 Blacks, and 1 in 92 Hispanics were diagnosed with ASD. The data for Asian Americans were very discrepant and inconsistent across regions. In New Jersey the data revealed a prevalence rate of 1 in 47, while in Arkansas it was 1 in 333; there was no national average obtained for Asian

Americans (Centers for Disease Control, 2013). While individuals across the globe experience symptoms associated with ASD, researchers have consistently reported discrepancies in the prevalence rate across gender and cultures (Centers for Disease Control, 2013; Dyches et al., 2004). ASD is much more prevalent in males with rates as high as 1 in 42, while rates for females are closer to 1 in 189 (Centers for Disease Control, 2013).

Overview of Study Variables

Cultural Mistrust

Cultural Mistrust is a construct introduced in the early 1980's by Terrell and Terrell (1981) and originally developed to describe the distrust of some African Americans towards mainstream White American culture, which includes the legal, educational, political, and health care systems (Bell & Tracey, 2006; David, 2010; Thompson, Worthington & Atkinson,1994). Thus, the vast majority of the literature regarding cultural mistrust and racism has focused on African Americans' propensity to mistrust the majority culture (Alvarez, Juang, & Liang, 2006; Phelps, Taylor & Gerard, 2001); nonetheless, the concept of cultural mistrust has been used cross-culturally (David, 2010; Soorkia, Snelgar, & Swami, 2011; Velcoff, Hernandez, & Keys, 2010). Several studies have found a strong link between cultural mistrust and racial discrimination (Combs et al., 2006; David, 2010). Terrell and Terrell (1981) found that African Americans with higher exposures to racial discrimination had high levels of cultural mistrust when compared to those with low exposure to discrimination. Perceived discrimination has also been noted to have serious negative outcomes on the

psychological well-being of African Americans (Combs et al.). Nickerson, Helms, and Terrell (1994) found that cultural mistrust significantly impacted the therapeutic relationship. Individuals with high levels of cultural mistrust are likely to hold negative attitudes toward the mental health system, which will impact their willingness to seek and receive services (David, 2010). A thorough review of the literature revealed that to date, there has not been a published study examining the relationship between the acceptance of an ASD diagnosis and cultural mistrust.

Race

There are disagreements within the social psychology literature regarding the definitions of race and ethnicity (Ponterotto & Park-Taylor, 2007). Although some efforts have been made to clearly delineate between them, the terms culture, nationality, race, and ethnicity are quite often used interchangeably (Betancourt & López, 1993), which creates difficulties for individuals who attempt to conduct research in this area (Nishina, Bellmore, Witkow, & Nylund-Gibson, 2010). Many experts debate that one's ethnicity encompasses more than their race; rather, it also includes culture, values, and beliefs (Phinney, 1996).

Cross-cultural differences in individuals with ASD. Compared to the abundance of research on ASD, there seems to be a dearth of studies specifically aimed at investigating the differences in ASD across cultures (Dyches et al., 2004). The aforementioned data clearly indicate ASD is found in many races and cultures. Epidemiological studies have yielded inconsistent results regarding the prevalence rate of ASD across races (Mandell et al., 2009). Moreover, some studies compare differences

between Whites and minorities irrespective of ethnic membership in minority groups. This does not allow for a comprehensive investigation into group-specific discrepancies (Tek & Landa, 2012).

In an extensive study including 2,568 children, researchers found that while all of the participants met criteria for ASD, only 58 percent of the children had been previously diagnosed with ASD. Children who were Hispanic, Black, or whose parents identified them as "other" were less likely than White children to have a documented diagnosis of ASD. For Black children, this disparity existed regardless of intellectual abilities. However, for Hispanic and Asian children, the disparity was higher amongst those who presented with a co-diagnosis of intellectual disability (Mandell et al., 2009). The overall consensus throughout the literature is that African American children are diagnosed with ASD later than children of other races and Hispanic children are less likely than Caucasians to display symptoms of ASD (Mandell, Ittenbach, Levy, & Pino-Martin, 2007; Mandell et al., 2009).

Whether symptoms of ASD are manifested equally across cultures is a new source of inquiry for researchers. One of the first studies to compare African Americans to Caucasians revealed African Americans children with ASD had more significant delays in language only (Cuccaro et al., 2007). In a study aimed at discovering differences in ASD amongst toddlers, the authors found that when compared to non-minority (Caucasian children) of the same SES, minority children had lower overall performance in communication and language, as well as obtained inferior gross motor scores (Tek & Landa, 2012).

Pachter and Dworkin (1997) studied the expectations of 225 mothers from various ethnic groups, including Puerto Rican, African American, Caucasian, and West Indian-Caribbean. There were no differences in maternal expectations for some developmental milestones including: crawling, rolling over, and turning heads to sounds. The researchers found that maternal expectations differed across ethnic groups, specifically on personal (putting on shoes independently or the ability to feed oneself with a spoon) and social milestones (smiling at a face and recognizing the mother). While the expectations varied across cultural groups, overall, Puerto Rican mothers expected their children to reach developmental milestones at a slower rate than the other mothers (Pachter & Dworkin 1997). Due to social demands, parenting practices, and values vary across cultures, what might be alarming in the realm of development to a parent in the dominant culture may not become an area of concern to a minority parent until later in development.

Some exploratory studies designed to investigate the psychometric properties of commonly used screening instruments for ASD found low internal consistency when used with diverse samples of individuals with low SES. This suggests that while psychometric properties may be strong with Caucasians or individuals with high SES, there may be a significant difference for diverse samples and those who are of lower SES (Scarpa et al., 2013). Asian children who are taught that making eye contact or imitating an adult is a sign of disrespect may tend to score either low, or high (depending on the scale), on many assessment tools designed to investigate symptoms of ASD (Zhang, et al., 2006). An investigation by Zhang et al. found that many of the commonly used

assessment tools utilized to help identify children with ASD, such as the Checklist for Autism in Toddlers, the Modified Checklist for Autism in Toddlers, the Vineland Adaptive Behavior Scales, and the Childhood Autism Rating Scale contained items that were not fitting for Chinese children.

It is unclear why cross-cultural disparities in ASD are present. The current literature continues to lack certainty regarding the heterogeneity of ASD symptomatology across races. Experts offer a number of hypotheses including: level of education in relation to knowledge of ASD symptoms; later age of diagnosis amongst minority, specifically African Americans; or, disparity due to inaccessibility of services and differences in diagnostic methodology (Mandell et al., 2007; Tek & Landa, 2012).

International views of ASD. The recent increase in rates of ASD has been responsible for the expansion of research in the international community. ASD has been studied in both developed and Third World countries (Scarpa et al., 2013). The prevalence rates for many South American countries, along with a number of developing countries, such as India and Kenya, were found to be lower than that of North Americans and Europeans (Dyches et al., 2004). A study specifically aimed at investigating the prevalence of ASD in Venezuela, reported a rate of 1.7 per 1,000 children (Montiel-Nava & Peña, 2008). With the exception of the United Kingdom, reported prevalence rates of ASD for children in North America, Europe, and Australia were fairly consistent across countries, with the following rates reported: North America, 4.5 per 10,000; Denmark, 4.5 per 10, 000; Australia, 4.3 per 10,000; and United Kingdom, 8.3 per 10,000 (Wong &

Hui, 2008). Studies have found a high prevalence rate of 10.3 in 10,000 and 27.2 in 10,000, for China and Japan respectively (Sun & Allison, 2010; Wong & Hui, 2008).

Socioeconomic Status

The construct of socioeconomic status (SES) has not been clearly defined in the literature. However, most researchers find income, education, and occupation to be intercorrelated (Greene & Klein Murdock, 2013) and often refer to SES in terms of household income, education, and occupational prominence (Joseph, Matthews, & Myers, 2014). For the purpose of this study, the researcher has focused on income and level of education.

The cost of receiving mental health services has been a barrier for many minority families and for those living in poverty. Experts have estimated that the cost of caring for a child with ASD is approximately $17,000 more per year than caring for a neurotypically developing child (Centers for Disease Control, 2013). Families of individuals with ASD spend 4.1 to 6.2 percent more on medical costs than those without ASD (Shimabukuro, Grosse, & Rice, 2008). Ganz (2007) suggests it costs upwards of 35 billion dollars yearly to care for individuals with ASD.

Many studies have focused on the relationship between SES and prevalence rates of ASD (Durkin et al., 2010; Fountain, King, & Bearman, 2010). Specifically, research has shown positive correlations between diagnosis of ASD and SES (Durkin et al., 2010). Thomas et al. (2012) found ASD rates to be higher amongst individuals of high SES. It is essential to remark that the literature has demonstrated minorities of higher SES (specifically Hispanics) experience ASD at the same rate as White, non-Hispanics

(Bearman & Fountain, 2011; Durkin et al., 2010), further affirming the hypothesis that SES plays an important part in the diagnostic practices of ASD.

Poverty has been associated with negative behavioral outcomes for children with ASD (Midouhas, Yogaratnam, Flouri, & Charman, 2013). Although the American Academy of Pediatrics (AAP) suggested children be screened for ASD by their second birthday (Johnson & Myers, 2007), as previously noted, individuals from low SES and ethnic minorities are often diagnosed with ASD later in life (Madell et al., 2009). Children from rural areas also tend to be diagnosed later as compared to those raised in urban areas (Mandell, Novak, & Zubristsky, 2005). Mandell et al. (2005) reported children from low SES were diagnosed 11 months later than children whose parents were 100 percent above the poverty level.

Poverty rates amongst African Americans and Hispanics are two times as high as they are for non-minority individuals (Gradin, 2008). Symptoms might be more difficult to identify in ethnic minorities because they often require more contact with a health care professional before they are identified as being on the spectrum (Scarpa et al., 2013). Early screenings lead to early identification and interventions, which has been noted in the literature to increase positive outcomes for children with ASD (Herlihy et al., 2014). Since children living in economically disadvantaged households, as well as those from diverse backgrounds, are diagnosed later in life, one can posit that they may experience more negative outcomes as a result, thus assuming they will require more extensive services, creating more financial hardships for struggling families (Madell et al., 2009).

The relationship between parents' level of education and age of diagnosis has also been investigated in the research. Fountain et al. (2010) found that children with highly educated parents tended to receive an ASD diagnosis at a younger age, much sooner than children of economically challenged parents (Kara et al., 2014; Thomas et al., 2012). This is likely due to more accessibility to specialized health care and better knowledge of the literature regarding ASD.

Willingness to Agree with Diagnosis and Services in the School

A dearth of information regarding minority parents' perception of ASD is available. While the literature offers some information regarding minorities and ASD, as well as information regarding cultural mistrust and mental health, most of the research has focused on minorities' willingness to receive services from a provider of a different race (Townes, Chavez-Korell, & Cunningham, 2009). Research specifically linking cultural mistrust with willingness to accept the diagnosis of ASD, as well as to accept psychological services, is lacking.

There is a paucity of research available with reference to general perceptions of ASD (Holt & Christensen, 2013). In a study implemented to survey the public's knowledge, perceptions, and attitudes towards ASD, 1001 individuals responded. The majority (90 percent) of participants reported being white and 7.7 percent were Hispanic or Latino. While generally respondents described accurate symptoms of ASD, such as social issues, communication problems, repetitive behaviors, and poor eye contact, many reported they felt that symptoms could be controlled by the individuals with ASD, if they chose to do so. Individuals who were Hispanic/Latino rated their knowledge of ASD

lower than Caucasian participants did (Holt & Christensen, 2013). They reported receiving most of their information regarding ASD from the media. Furthermore, compared to non-Hispanic participants, Latinos were less likely to consider education, parent training, counseling, or group therapy as treatment for ASD (Holt & Christensen, 2013).

Voelkel, LeCroy, Williams, and Holschuh (2013) investigated Latinos' understanding and knowledge of ASD, perceived barriers to obtaining adequate health care, and perceptions of people with ASD. They found significant differences between those with differing levels of acculturation. Participants with low levels of acculturations were less likely to understand the disorder, including the development of symptoms across the lifetime, as well as being less likely to access the appropriate health care (Voelkel et al., 2013). Additional barriers to obtaining adequate healthcare included three major foci: perception of the system as prejudiced; lack of confidence in service providers, specifically regarding cultural and linguistic competence; and lack of resources (Bearman & Fountain, 2011; Durkin et al., 2010).

A qualitative study with a sample of five mothers investigated the experiences of African American mothers of children with ASD and their contact with the school system (Hetherington, 2013). The mothers expressed two sets of barriers to having their children's needs met: difficulties navigating the special education system and the experiences of microagression from school personnel (Hetherington, 2013). Sansosti, Lavik, and Sansosti (2012) explored commonalities in the experiences of families with children with ASD. They found it took significantly longer for African American and bi-

racial children to receive a diagnosis. The authors also found that compared to parents of children who received an early diagnosis, parents of children who were diagnosed at an older age were less satisfied with the process of diagnosing their children (Sansosti et al., 2012). While it is difficult to generalize the results of these studies due to their small sample sizes, one can surmise that African American parents might be less willing to accept a diagnosis of ASD for their children and that experiences of microagression with school personnel and difficulty navigating the special education system, may impact their willingness to seek psychological services for their children.

A study aimed at understanding Saudi Arabian parents' understanding of the etiology of ASD and their perception of the disorder indicated that cultural differences are very influential (Alqahtani, 2012). Some parents believed the evil eye or black magic was the cause of Autism. This belief suggests that Saudi parents may not willingly endorse the use of psychological services to aid the amelioration of symptoms of Autism (Alqahtani, 2012). Jegatheesan, Miller, and Fowler (2010) found that religion is considered an important aspect of the healing process for South Asian Muslim families. These families believed it was best to integrate the children into regular education settings and to raise them similarly to their typically developing peers. Moreover, the families felt that the professionals' perception of Autism debilitated, rather than supported the children (Jegatheesanet al., 2010). Once more, this might lead to the assumption that these parents would be distrustful of the majority culture and unwilling to accept a diagnosis of Autism along with psychological services for their children.

Comfort Level with Asking for Additional Services

While a thorough review of the literature indicated that, to the knowledge of the researcher, there has been no study to date, focused on parents' level of comfort with asking for additional services for their children, some research has focused on parents' level of satisfaction with special education services; thus one can surmise that parents' satisfaction with services may increase comfort level with asking for additional services. The Texas Education Agency (TEA) found that parents with a higher level of education were more likely to be satisfied with special education services (Texas Education Agency, 2004). When parents were asked specific questions regarding special education processes, such as Admission Review and Dismissal (ARD) meetings, 75% of parents understood their roles in the ARD committee. Tweny-five percent of participants disclosed they did not understand how their children's placements were decided upon. Overall, 53% of parents reported being satisfied, and 35% were somewhat satisfied (Texas Education Agency, 2004). Authors Duhaney and Salend (2000) found that parents' beliefs regarding goals of the educational program, as well as beliefs regarding special education placement, impacted their satisfaction with programs. According to Hunt and Goetz (1997), parents felt strongly that school wide collaboration was fundamental to students' success. Parents who did not feel heard or acknowledge by school personnel and felt their child's needs were not being met, also experienced less satisfaction in their special education services (Linsday & Dockrell, 2004).

Researchers found that cultural differences also played a role in parents' level of satisfaction. Dabkowski (2004) reported that some parents may hold cultural beliefs that

lead them to agree with professionals' decisions out of respect for authority, rather than actual consent. The language used during ARD/IEP meetings may make it difficult for parents to understand decisions made regarding their child (Miles-Bonart, 2002). If parents do not understand the decisions being made, it is unlikely that they will feel comfortable requesting additional services. Economic factors may also influence parents' satisfaction with the overall process of special education. Often parents are unable to attend meetings due to a variety of reasons (e.g., lack of transportation, inability to miss work) when significant decisions are made regarding their child's educational programming (Gordon & Miller, 2003). It has been reported in the literature that higher income parents are more likely to participate in their child's education than low-income parents (Lareau, 1989). The literature also indicates that some teachers presume that low-income parents cannot partake in educational activity, and thus contact them less often than their more wealthy counterparts (Garcia & Ortiz, 2006). While the aforementioned research does not directly speak to parents' comfort level with asking for additional services, it does point to parents' satisfaction with the special education system; this suggests that higher satisfaction with the system would more than likely lead to a higher level of comfort with asking for additional services.

Purpose of the Study

The study attempted to examine the difference in levels of cultural mistrust between Caucasian and minority parents of children with Autism. Additionally, the study strove to ascertain the effects of cultural mistrust, income, level of education, and race on parents' agreement of an Autism diagnosis, acceptance of services offered to their

children in the school, and their comfort level with asking for additional services. The majority of research on the special education population has focused on Caucasians (Zhang et al., 2006). Although there has been research on minorities' cultural mistrust and their attitudes toward the mental health system, the literature has not focused on mistrust for school mental health clinicians or services. An investigation focusing on how cultural mistrust has affected parents' agreement with a diagnosis has not been launched.

The current literature provides a clear link between cultural mistrust and mental health seeking attitudes and behaviors (David, 2010; Townes et al., 2009). While research has concluded that cultural mistrust affects mental health seeking behaviors, a comprehensive study that examines parental agreement with an Autism diagnosis and their willingness to accept special education services for their child seems warranted. This information could add to the paucity of research regarding the perception of Autism from the view of minority parents, as well as lead to better understanding of the effect of cultural mistrust on parents' willingness to trust and work with school personnel and mental health professionals. Moreover, the results of this study will also help professionals realize the existence of cultural mistrust as a barrier to providing mental health services to minority students.

Research Questions

The research questions guiding the proposed study are: (1) Is there a difference in cultural mistrust between Caucasian and minority parents of children diagnosed with autism? (2) Does cultural mistrust affect parents' agreement with an Autism diagnosis

for their child? (3) Does cultural mistrust also affect parents' willingness to accept psychological services for their child in the school setting? (4) Does cultural mistrust affect parents' level of comfort with asking for additional services for their child, and finally, (5) Do race, income, and level of education of parents moderate the effects of cultural mistrust on parents' agreement with an Autism diagnosis, willingness to accept psychological services, and comfort level with asking for additional services?

Definition of Terms

The following terms are defined for the purposes of this dissertation.

Accommodations: This term refers to "alternative ways to learn, practice, and show mastery of content. For example, students who require more time to process information may have accommodations of extended time on English quizzes, or a student who has difficulty focusing may sit in a carrel to write an essay or complete math problems"(King-Sears & Bowman-Kruhm, 2011, p. 173).

Acculturation: This term refers to "the intragenerational process of cultural change that occurs as a person encounters a different culture" (Nieri, 2012, p. 460).

Americans with Disability Act (ADA): ADA refers to civil rights legislation signed in 1990 that prohibits discrimination against individuals with disabilities.

Asian: This term is used to refer to people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (U.S. Census Bureau, 2010).

Autism Spectrum Disorder (ASD): ASD refers to individuals with Autism who are characterized as having persistent deficits in social communication and social

interactions across settings. They also display restricted and repetitive patterns of behaviors or interests, which limit or impair their everyday functioning (American Psychiatric Association, 2013).

Black or African American: These terms refer to a person having origins in any of the Black racial groups of Africa (U.S. Census Bureau, 2010).

Comorbidity: This term refers to "combinations of any types of psychiatric disorders that co-occur in the same individual" (Bennett & Gjonbalaj-Morovic, 2007, p. 34).

Cultural mistrust: This phrase refers to a construct used to describe the distrust of African Americans toward mainstream White American culture; which includes the legal, educational, political and health care systems (Bell & Tracey, 2006; David, 2010; Thompson et al., 1994).

Hispanic or Latino: These terms are used to refer to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race (U.S. Census Bureau, 2010).

Individuals with Disabilities Education Improvement Act (IDEIA): IDEIA is federal legislation passed in 2004 that guarantees a free and appropriate primary and secondary school education with children with disabilities ages 3-21 (Individuals with Disabilities Education Improvement Act; 2004).

Level of education: This term refers to the number of years of formal education received by an individual.

Microaggression: This term refers to “brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group” (Sue et al., 2007, p. 273).

Middle Eastern/Arab: This term is used to refer to “most people with ancestries originating from Arabic-speaking countries or areas of the world are categorized as Arab. For example, a person is included in the Arab ancestry category if he or she reported being Arab, Egyptian, Iraqi, Jordanian, Lebanese, Middle Eastern, Moroccan, North African, Palestinian, Syrian,Tunisian abd Yemeni to be of Arab ancestry” (U.S. Census Bureau, 2013).

Modifications: This term refers to “minor to major revisions of the criteria and learning outcomes than those typical students are mastering” (King-Sears & Bowman-Kruhm, 2011, p.173).

Native American, American Indian, or Alaska Native: These terms are used to refer to people having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment” (U.S. Census Bureau, 2010).

Section 504: This phrase refers to section 504 of the Rehabilitation Act of 1973, a federal legislation that requires postsecondary institutions to provide services and accommodation to students with a documented disability.

Socioeconomic status (SES): SES refers to “rank order or prestige in one’s society, for example, by occupational prestige or educational status, and access to

resources, for example, by household income or housing quality" (Joseph et al., 2014, p. 139). As previously stated, for the purpose of this study, the researcher focused on income and level of education.

White or Caucasian: **"**These terms are used to refer to a person having origins in any of the original peoples of Europe, the Middle East, or North Africa" (U.S. Census Bureau, 2010).

CHAPTER II

LITERATURE REVIEW

There is a plethora of research focused on investigating cultural mistrust; however, there is a dearth of information regarding how cultural mistrust affects parents' willingness to accept psychological services in the schools. This review of the literature will focus on a number of variables postulated to influence parents' willingness to accept a diagnosis of Autism Spectrum Disorder (ASD) and psychological services within the educational setting. The literature relevant to this dissertation includes: understanding cultural mistrust, including the historical foundations and early thoughts on racial inferiority; examining the phenomenon of cultural mistrust across races; understanding how cultural mistrust is manifested across settings; and how socioeconomic status affects cultural mistrust.

Historical Foundations of Cultural Mistrust

While history may not give a definite explanation for how cultural mistrust develops, it aids in understanding how a high level of mistrust can become prevalent across a group of people. A history of enslavement, abuse, prejudice, and segregation will undoubtedly lead to mistrust of the oppressor. Cultural mistrust cannot be understood outside of the historical context upon which these beliefs were founded. While the specific term of cultural mistrust emerged in 1981 (Terrell & Terrell), the phenomenon began receiving attention many decades prior. Moreover, the historical foundations of cultural mistrust date to the inception of American society. Throughout American history

minorities have experienced numerous traumatic events that have led to, for many, an overall mistrust of the majority culture (Benjamin, 2009; Guthrie, 2004). The mistrust of African Americans for the majority culture comes from a long history of racism and maltreatment. From our founding fathers to prominent psychologists, early literature related to minorities is plagued with attempts to prove their subserviency (Benjamin, 2009; Feinstein, 1971; Guthrie, 2004).

Early Thoughts on the Inferiority of Minorities

Dr. Benjamin Rush, signatory of the Declaration of Independence, hypothesized that African Americans suffered from negritude, which he believed to be a form of leprosy (Feinstein, 1971). Although Dr. Rush did not support slavery, he considered Blacks to be an aberration from nature, for which he attempted to find a cure. Dr. Rush went as far as comparing African Americans to the mentally ill as he referred to both as children of darkness. 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 Black inferiority (Feinstein, 1971).

In the 1860's, mental health experts viewed freedom as a source of pathology for African Americans and physical bondage was perceived to be the cure (Hughes, 1992). A popular view was that African Americans could not adjust from their savage ways to the demands of Western culture and became insane as a result (Summers, 2010). In 1869, Francis Galton, father of eugenics, published his book *Hereditary Genius,* in which he highlights the many different ways that he found Africans to be considerably inferior to the White race (Benjamin, 2009; Galton & Galton, 1998). Galton noted both

intellectual and behavioral differences between the races (Benjamin, 2009). He defined eugenics as a science of improving the superior race by actively mating members of this race; therefore, preserving the superior characteristics of the chosen race (Galton & Galton, 1998). These sentiments were widely shared by the intellectual community who believed that all minorities were inferior to the White race (Benjamin, 2009; Guthrie, 2004).

While most individuals held firmly to their beliefs, scientific data was needed to fully confirm these theories. One of the first studies of this sort was conducted by Lightner Witmer. He tested the reaction time of Caucasians and minorities to prove the intellectual superiority of Caucasians (Benjamin, 2009). When the data revealed that Native Americans had the fastest reaction time, followed by Blacks, many were shocked, because these results did not support the theory of White superiority; however, the findings were interpreted much differently. It was proposed that the slower reaction time of Whites was indeed a demonstration of their superiority, for it showed contemplation rather than an automatic and reflexive response (Benjamin, 2009).

According to Guthrie (2004), in 1904, at the St. Louis World Fair, a group of researchers gathered to perform psychological tests, "including motor control, reaction time, and tests of intelligence" (p. 48), on Filipino, Malaysian, African, American Indian, and Pygmy individuals. The atmosphere was reported to be like a circus. One of the participants, Ota Benga, a pygmy from the Congo, was placed in a monkey cage at the zoo in New York after the fair. Benga committed suicide a short while later (Guthrie, 2004). This persistent negative view of minorities as subordinate individuals has

dominated perceptions of both Whites and minorities for decades. Psychologists have theorized that the long history of enslavement, prejudice, and institutionalized racism has left a significant and long-lasting negative effect on many African Americans' consciousness (Scott, 1997) thus affecting how they view themselves in reference to other minorities and specifically to the broader majority culture.

Lasting Effects of the Black Inferiority Theory

For many years, African Americans were not welcomed in academia. This was no different for the field of psychology (Black, Spence, & Omari, 2004). Between 1876 and 1920, 11 African Americans were awarded doctorates while 10,000 Caucasians received advanced degrees (Black et al., 2004). In 1920, Cecil Sumner received his doctorate in psychology. Sumner attended Clark University and was the first African American to receive this degree. During his graduate work, Sumner was very outspoken against the government's treatment of African Americans (Black et al., 2004). He compared the treatment of Blacks to that of the Jewish people in Germany. Both the local community and Clark University had strong reactions to this and petitioned for Sumner's dismissal from the program.

Soon after completing his doctoral studies, Sumner disconnected himself from the African American community when he wrote two articles on the intellectual inferiority of African Americans. It has been posited that Sumner felt that supporting the view of the majority culture was necessary at the time to advance African Americans in the field (Black et al., 2004). Although Sumner cast a negative light on African Americans, he paved the way for Blacks to enter the field of psychology. However, even when African

Americans were finally permitted to enter the field, they felt obligated to maintain the disparaging views of the dominant culture (Black et al., 2004).

Sumner may have been struggling with the phenomenon described by W. E. B. DuBois as double consciousness (Black et al., 2004). Double consciousness is described as identifying with the perspectives of the dominant culture, while also identifying with the perspectives of the African American culture (Black et al., 2004). In many cases, one view may become more intrinsic than the other. African Americans who see themselves from the dominant culture's perspective tend to experience a low self-concept (Allen & Bagozzi, 2001).

While the overall attitude toward racial minorities was changing within the field, much of the irremediable damages caused by such attitudes had caused permanent afflictions in the lives of many. In the 1940's Kenneth Clark and his wife Mamie conducted their famous doll studies. They gave young African American children multiracial dolls and asked them to pick which doll was nice and was a nice color, which one looked "bad", and which doll they would like to play with (Black et al., 2004; Hraba & Grant, 1970). Reportedly, Black children preferred the White dolls in most cases (Black et al., 2004; Hraba & Grant, 1970). One child replied by saying that the Black doll was "ugly and dirty" (Benjamin, 2009, p. 355). In cases where African American children chose the Black doll, they responded using pejorative language to describe both themselves and the doll (Benjamin, 2009, p. 355).

In Clark's study, Black children found representations of themselves to be either ugly, or referred to themselves in a derogatory manner, which to them seemed natural

(Hine-St. Hilaire, 2006). This internalized racism can lead to self-hatred in childhood (Hine-St. Hilaire, 2006). As evidenced by Clark's research, messages of inferiority are often internalized at a very young age. In adulthood, individuals begin to mistrust the system that has marginalized and oppressed them. When a member of a minority group becomes an adult and begins perceiving themselves as equally intelligent and competent as members of the majority group, a sense of betrayal and mistrust may develop toward the majority group (Phelps et al., 2001).

Residual Effects of Slavery

In recent years, the fields of psychology and social work have examined the residual effects of slavery on modern African American culture (Price, Darity, & Headen, 2008; Wilkins, Whiting, Watson, Russon, & Moncrief, 2013). Following the emancipation proclamation slaves were free, but yet not afforded the same rights as White individuals. Specifically in the South, Jim Crow laws continued to instill inferior treatment of African Americans (Substance Abuse and Mental Health Services Administration, 2001). The added trauma that came from segregation laws has been referred to in the literature as Post-Traumatic Slave Syndrome (PTSS). PTSS has been defined in the literature as a phenomenon that occurs as the result of multigenerational trauma coupled with continuous enduring of oppression, coercion, and abuse (Leary, 2005). Key symptoms associated with PTSS are anger, feeling of inferiority, and racist socialization that has been passed down from generation to generation by African Americans. PTSS has been tied to the development of cultural mistrust in the African American culture (Wilkins et al., 2013).

This transgenerational trauma has left visible wounds on the African American experience. A recent study was conducted to compare the lingering impact of trauma on different cultural groups (Carson, 2013). African Americans were compared to descendants of Holocaust survivors as well as to descendants of Japanese internment survivors. The distinct difference between these three groups is that the trauma of African Americans has been ongoing and transgenerational whereas Holocaust survivors and Japanese internment survivors' trauma was described as a discontinuous or discrete trauma. Significant differences were found in socialization practices between the groups (Carson, 2013).

Racial and Ethnic Identity Development

In order to gain a thorough understanding of how cultural mistrust impacts individuals, it is important to investigate one's development of their cultural and racial identity. This review of the literature will demonstrate that a person's environment and culture are major contributors to the development of their sense of "self." Furthermore, it will elucidate how the establishment of beliefs and attitudes, such as mistrust, are greatly impacted by one's understanding of themselves and their culture in relation to the world. Focus will be placed on theories of racial and ethnic identity development. Special attention will be given to how negative experiences encountered during one's identity development can lead to cultural mistrust of the majority culture.

Understanding within Group Differences

While it may be impossible to include every ethnic group in a research project, when attempting to study a construct across ethnocultural groups, it is imperative to

outline that within group differences undoubtedly exist. Currently, approximately 30 percent of the United States population belongs to a racial or ethnic minority group (Center for Disease Control, 2011). This growing minority population continues to shape the composition of this country and it is becoming increasingly important for psychologists to understand how racial and ethnic differences influence various aspects of people's lives.

The Hispanic population encompasses a number of subgroups, including Mexicans, Cubans, Puerto Ricans, and South Americans (to name a few). While they share similar attributes, such as language and culture, there are vast within-group differences that can be observed in this diverse population (Ferdman & Gallego, 2001). Latinos often trace their roots to Africa, Europe, Asia, and to the indigenous population of the Americas (Ferdman & Gallego, 2001). Many Latinos' heritage is a mixture of some, if not all, of these racial groups. Their experiences vary upon immigration status, assimilation, and country of origin (Alba, Jimenez & Marrow, 2014). Similar to Latinos, while African Americans, Africans, and Afro-Caribbean's may all share similar physical features; their worldview based on individual histories is vastly different (Hunter, 2008). A study by Hunter (2008) revealed that being raised within a different historical context and having had different experiences of oppression and discrimination impacted one's world-view significantly. There is a paucity of research dedicated specifically to investigating a minority's perceptions and experiences; thus, it is of upmost importance to conduct research targeted at these specific groups. However, results of studies aimed

at understanding the experience of different racial and ethnic groups, cannot be generalized to encapsulate the lived experience of every member of that ethnic group.

Ethnic Identity Development

Several theories have shaped the current understanding of racial and ethnic identity development. It has been posited that individuals with positive racial identities will tend to develop better self-concept and more positive self esteem. Pope (2000) found that African Americans who had a strong and positive racial identity also had higher overall self-esteem. A number of racial identity theories have turned into models of ethnic and racial identity development. 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). Unlike many models of racial identity development, Phinney's model does not focus particularly on the African American experience and can be applied to any minority group (Negy, Shreve, Jensen, & Uddin, 2003).

Phinney (1996) proposed that ethnic identity development begins in childhood. During this stage ethnicity is unexamined; however, the individual is not really aware of what it means to develop an ethnic identity. Typically, during this stage, morals and values of parents and other adults are accepted and practiced. During the second stage, individuals begin to explore their ethnicity and want to know more about their ethnic group. There is a need to understand their traditions, culture, and history. In the final stage, individuals develop a secure understanding of their group as well as a strong

understanding of their own ethnic identity (Negy et al., 2003). While models of racial and ethnic identity vary across minority groups, they all hold the premise that racial identity develops subsequent to an experience with prejudice and racism in late adolescence or early adulthood. The process includes advancing through stages from internalizing negative stigma regarding one's own race, to renouncing those stigmas, and finally defining one's identity (Twenge & Crocker, 2002).

African American identity development. The most significant and widely cited model of racial identity development is William Cross' (1971) model of Black Identity Development (Ponterotto & Park-Taylor, 2007; Negy et al., 2003). According to Cross (1971), African Americans advance from a stage in which being Black is degrading and negative, to one where their "blackness" and racial identity is embraced. Individuals do this through four distinct stages: pre-encounter, encounter, immersion-emersion, and internalization (Cross, 1971; Negy et al., 2003). In the pre-encounter stage, the person sees their environment as being non-Black or anti-Black (Cross, 1971, 1991). During this stage, an individual attempts to degrade their blackness because they want to embrace what is opposite of Black. They often have a distorted understanding of Black history, and view Black forms of cultural expression negatively. In the encounter stage, the individual begins to show an interest in being Black that is triggered by some specific encounter or experience, and then begins to reinterpret the world and their environment as a result of the experience (Cross, 1971, 1991).

Stage three is characterized by immersion-emersion when the person immerses completely into the Black world. They value everything that is related to blackness and it

is their entire focus (Cross, 1971, 1991). During this stage the person will often want to express themselves in the form of songs and poetry, allowing their Black pride to exude from every aspect of their life. There is a rejection of everything that represents the majority group. During the internalization stage some individuals experience disappointment and rejection and revert to a view of Black people as being inferior. Others continue to be fixated on the previous stage and experience additional aversion towards the majority culture. As they progress, a person becomes more peaceful with him- or herself and the world. They shift from hostility towards individuals of the majority culture to anger toward oppression and racism (Cross, 1971, 1991). They develop self-love and a sense of community that was absent in the previous stages. Individuals at this stage become committed to a plan of action and become a force in their community, advocating for change (Cross, 1971, 1991).

In the aforementioned model of Black identity development, the minority individual reaches a pivotal point when they experience a negative interaction with majority group members. This leads them to realize that they have suffered from racism and discrimination (Bell & Tracey, 2006). Such experiences can often lead to cultural mistrust. Research has found that an individual's level of racial identity development may be directly related to their level of mistrust (Nickerson et al., 1994). Parham and Helms (1981) found that individuals in the pre-encounter stage of Cross's model rejected the idea of having a Black counselor and were likely to prefer a White counselor. On the other hand, individuals in either the encounter or the immersion-emersion phase varied in their preference of Black counselors and their non-acceptance of White counselors.

Individuals in the internalization phase, however, did not express a strong preference for either race. As stated previously, cultural mistrust can serve as a barrier to help-seeking attitudes and practices in African Americans (Alston & Bell, 1996; Nickerson et al., 1994). Understanding African American's identity development can help psychologists understand parents who may be reluctant to seek or accept psychological services for their children.

Caucasian American identity development. Helms (1984) developed a model that specifically focuses on how White individuals develop their racial identity and consists of five stages: contact, disintegration, reintegration, pseudo-independence, and autonomy. During the contact stage, individuals know very little about other races and are unaware of racial differences. During the disintegration stage, Whites begin to recognize instances of racism and may feel some guilt regarding the maltreatment of minorities. They may also experience fear of being excluded by members of the majority culture when they attempt to interact or form relationships with minorities. The third stage is marked by animosity and resentment towards the Black culture, while forming strong allegiance to their own race. The pseudo-independence stage is characterized by a true interest in relationships with members of the minority group while maintaining a positive view of their own culture. During the final stage, Whites gain a more positive regards for diversity and seek to interact with individuals of differing cultures (Helms, 1984). From Helms' work, rating scales, including the White Racial Identity Attitude Scale and The White Racial Consciousness Development Scale, have been developed and

used to investigate White racial identity and comfort with African Americans (Choney & Rowe, 1994).

Latino American identity development. The Latino population is the fastest growing minority group in the United States (Ferdman & Gallego, 2001). While Latinos remain underrepresented in research, in recent years more studies aimed at investigating issues related to Latinos have emerged (Ferdman & Gallego, 2001). Understanding how Latinos develop their ethnic identity can help elucidate how cultural mistrust might develop in this population. The term Latino encompasses a very heterogeneous group of individuals from different races and a wide range of nationalities. Unlike many other minority groups, while race might be important to Latinos, it is seen as secondary to culture; therefore, their identity development is most likely to focus on culture rather than race. Similar to the identity development of Blacks and Whites, Latinos first understanding of culture takes place during childhood. During this time, they are exposed mostly to their group's culture; the majority of their interactions are with other Latinos (Ferdman & Gallego, 2001).

Early interactions with other ethnic groups can have a significant effect on one's identity development. Upon entering the educational system, many Latinos begin receiving contrasting messages regarding their culture (Ferdman & Gallego, 2001). Depending on their environment, some of the messages can be positive, while others can be disparaging. Some Latino children are discouraged from speaking Spanish once they enter the public school system. While some may view this as encouragement towards being better prepared academically, others view it as coercion to assimilate to the

majority culture. The level of exposure to other ethnic groups will not only impact how the Latino individual sees him or herself in relation to those groups, but also whether members of other groups are viewed as potential companions or as adversaries (Ferdman & Gallego, 2001). Individuals raised in predominately Latino communities can face difficulties as adults. Late exposure to other cultural groups that lead to negative experiences that can significantly alter their view of themselves on an individual level, as well as their perceptions of other cultures, which in turn can lead to cultural mistrust. Restricted interactions with individuals of differing ethnic groups can hinder Latinos' ability to communicate and collaborate with those populations. On the other hand, if messages received in childhood concerning other ethnic groups were positive, it will likely be difficult to manage experiences of prejudice and racism. The way in which each individual perceives their experiences with others, whether positive or negative, frames the way they view themselves in relation to other Latinos and to members of other culture groups (Ferdman & Gallego, 2001).

Unlike Helms (1984) who developed a linear model of racial identity development based on various stages, Ferdman and Gallego (2001) proposed an "orientations toward Latino identity" (Ferdman & Gallego, 2001, p. 50). Individuals in the Latino-integrated group comprehend and are comfortable with their Latino identities. They embrace both negative and positive attributes of their cultural group. Those who are Latino-identified oriented have a more accepting view of other groups while maintaining a strong sense of pride in their culture, language, and ethnic heritage. Latino-identified individuals view Latino as a separate race that encompasses all Latino

subgroups. The third orientation discussed by Ferdman and Gallego (2001) is the subgroup identified. This group identifies themselves only within the context of their subgroup. They do not resonate with being White, but also do not identity with other Latinos or people of color. Those with the orientation Latino as "other" do not have a strong sense of their ethnic origin, culture, and history. They most likely see themselves as people of color, without a strong sense of Latino pride. While they do not endorse Latino cultural norms, nor do they conform to White cultural values. Those with an undifferentiated orientation do not have a strong connection with their Latino roots. They prefer to see themselves as just people rather than identifying with a particular cultural group. Latinos with a white-identified orientation view themselves a white and in general view themselves as more distinguished than individuals of color. These individuals tend to quickly assimilate to the White culture and distance themselves from the Latino culture (Ferdman & Gallego, 2001).

Middle Eastern American identity development. While there have been some studies in the area of identity development in Middle Eastern individuals, similar to the Latino model, a specific model of cultural identity development has not been suggested. The literature in this area hones in on a number of aspects that must be taken into consideration when discussing the identity development of these individuals. Similar to the Latino population, individuals from the Middle East share a complex culture and history, while having distinct differences between subgroups. People from the Middle East are often identified in terms of their identities as Muslims (Abu-Lughod, 2004). This is a very deceptive way of describing this cultural group, since the Middle East is

comprised of individuals from a wide range of religions, including Muslim, Christianity, and Judaism.

Individuals from the Middle East often find their identity across a number of factors including: religion, nationality, and ethnicity (Abu-Lughod, 2004). Thus, similarly to Latinos, it can be difficult to derive one homogeneous model to encompass this very diverse group of people. Like other minority ethnic groups in the United States, people of Middle Eastern background have experienced a considerable amount of prejudice and discrimination. Incidents of bigotry and intolerance significantly increased following the terrorist attacks in New York on September 11, 2001 (Marvasti, 2005). These experiences have shaped and changed the identity development of Middle Eastern Americans and possibly led to mistrust of other cultures by many.

During the late 1940's and 1950's the term Middle Eastern was coined to describe people from that geographic region of the world. Prior to this, individuals from the Middle East were considered White (Tehranian, 2008). In the early 1900s, the federal courts rendered decisions considering certain ethnic groups such as Syrians, Armenians, Lebanese, and Turkish and classified them as White (Tehranian, 2008). Prior generations of Middle Easterners were predominately Christians and generally adhered to the values and social norms of Whites in America. They were not viewed as a threat to American society and were often seen as friendly and easily assimilating to the White culture. However, the growing number of Middle Easterners began to pose a perceived economic and political threat, and individuals of that region slowly became marginalized by the majority culture. Tehranian (2008) explains "Race comes into existence only when a

group grows sufficiently large, in terms of both numbers and power, to become a threat" (p. 12). As a result of this shift of power, Middle Eastern Americans are often viewed as Muslim terrorists with anti-American attitudes and propensity for violence (Tehranian, 2008).

This overall change in perception has resulted in markedly different opinions regarding individuals of Middle Eastern origin (Tehranian, 2008). Negative perceptions of Middle Easterners are deeply rooted. When individuals of Middle Eastern lineage are regarded as positive members of society, they are often viewed as White, rather than Middle Eastern (Tehranian, 2008). Conversely, when they misbehave and engage in unethical behavior they are racialized as Middle Eastern.

Due to the less than favorable perceptions of Middle Easterners in the U.S. many have attempted to assimilate to the American culture in order to escape racism and prejudice. Yoshima (2002) explains the construct of covering as an individual's attempt to curtail unfavorable facets of their identity in order to assimilate. Many Middle Eastern Americans have engaged in covering as a result of the intolerance and prejudice they have faced.

Asian American identity development. Most investigations aimed at understanding identity theory in Asian Americans distinctively separate racial from identity development. Researchers assert that for Asian American individuals, racial and ethnic identities are two separate processes that develop independently from one another (Kim, 2012). For a number of Asian Americans ethnic identity is connected to their country of origin. Current theories on Asian American identity development place a

focus on ethnic identity development, rather than race (Kim, 2012). Chang and Kwan (2009) assert that ethnic identity may develop prior to racial identity for many Asian Americans. The need for acculturation and assimilation takes precedence over the exploration of one's ethnic identity. Moreover, it has been hypothesized that many Asian Americans experience less direct forms of discrimination compared to other minority groups. Asians have been considered to be the "model minority group (Gary, 2005; Kohatsu et al., 2000) and therefore may face the racism and discrimination often encountered by other minority individuals to a different degree. Yip (2005) theorized that whether race or ethnic identity is more salient to Asian Americans depends on the social situation an individual encounters. If they feel undervalued within their racial group, they may choose to develop a stronger ethnic identity.

Many individuals of Asian origin share an inclination for group orientation (Kim, 2012). Asian Americans tend to have a collectivistic perspective; thus, their racial identity development is heavily contingent upon interactions with their social environment. As Asian Americans become more exposed to White American culture, they can develop feelings of inferiority. Kim (1981) posits at some juncture in their lives, Asian Americans have a desire to be White, which causes them to reject their Asian identity. Some Asian women have gone as far as creating double-folded eye lids in order to appear more White (Kim 2012). This leads to low self-esteem for many Asian Americans.

Kim (2012) presents a five stage model of Asian American Racial Identity Development (AARID). The first stage is ethnic awareness and, like previously

discussed models of identity development, takes places in childhood prior to beginning formal education. Their understanding of ethnicity comes primarily from people of their own ethnic background. Children who are raised surrounded primarily by other Asians tend to gain a better sense of pride and have a more positive ethnic awareness. Those raised in predominantly White environments do not develop a strong sense of their Asian culture. Broader experience with the Asian community at this stage leads to a more positive self-concept. The second stage of White identification is marked by a realization of being different from one's White peers. During this stage they are likely to encounter taunting and bullying, which is likely to cause shame. The disgrace and embarrassment can lead the individual to assimilate to the White culture at all cost in order to avoid further degradation (Kim, 2012).

The third stage, Active White Identification or Passive White Identification, depends on the degree to which the Asian individual identifies with being White (Kim, 2012). Asian individuals who are typically surrounded by White individuals will likely repress adverse incidents associated with being Asian and experience Active White Identification. They do not recognize the dissimilarities between themselves and their White peers. Those who experience Passive White Identification are more likely to have a positive self-concept and are more likely to be surrounded by the Asian community. They do not view themselves as White, nor do they separate themselves from others in their ethnic group. In the fourth stage: Redirection to an Asian American Consciousness, the Asian individual begins to expose themselves more to the Asian culture. Learning about their history brings feelings of anger and outrage towards the White culture for

deplorable acts of bigotry committed against their people. The individual eventually moves away from this stage into the final stage: Incorporation, when they are able to accept their identity as Asian Americans. They are able to balance all aspects of their identity (Kim, 2012).

Native American identity development. The terms American Indians and Native American are often used interchangeably. Individuals who were born prior to 1950 often self-identify as American Indians, while later generations find more comfort in the term Native American (Horse, 2005). For the purposes of this dissertation, the term Native American will be used to encompass both American Indians and Native Americans. Models of identity development burgeoned in the 1980s and 90s (Horse, 2005); however, there is a paucity of research dedicated to the ethnic identity development of Native Americans (Johnson, Robinson, Dixon, Arredondo, & Tovar-Gamero, 2005). Weaver and Brave Heart (1999) noted Native Americans had the most stable cultural identification compared to Asians, Mexicans, Whites, and African Americans. Native Americans' collectivistic culture places significant emphasis on being a member of a larger group such as a tribe or clan (Johnson et al., 2005).

Native America identity development is quite complex due to the fact that Native Americans belong to specific tribes or clans that each have their own history and culture. The tribal government of each tribe decides whether or not an individual can be considered a citizen of their tribal nation (Horse, 2005). Thus they are both citizens of their tribal nations and also citizens of the United States. For the majority of Native Americans, their racial identity is subsidiary to their identity with a specific tribe;

however, their racial identity takes precedent over their identification with overall American society. Many individuals strongly identify with their tribal name, tribal language, and norms and traditions of the tribe (Horse, 2005).

Horse (2001) defined five factors that influence Native American consciousness and identity. First, is the magnitude to which the Native American person is immersed in the culture and language, followed by the validity of their Native American lineage. Furthermore, the degree to which the individual ascribes to Native American world view, and finally one's self concept as a Native American in addition to one's membership in a clan or tribe.

Development of Cultural Mistrust

After Terrell and Terrell created the term cultural mistrust, along with a way to measure it in African Americans, the construct of cultural mistrust seized the attention of researchers interested in investigating how this phenomenon transpired with other races and ethnic groups. Although the term cultural mistrust was coined in 1981 (Terrell & Terrell), the construct of African Americans' mistrusting the majority culture has been researched since the late 1960's. Grier and Cobbs (1968) first introduced the term healthy cultural paranoia, which they deemed essential for the survival of African Americans in a White dominated world. In order to avoid confusion with clinical paranoia, it was described as African Americans' sustainment of a high level of distrust towards the motives of White individuals while not permitting their mistrust to debilitate their view of reality. In essence, it is a term used to describe an African American who is apprehensive of Whites but continues to remain mentally healthy (Ridley, 1986). In

response to this term, some authors, such as Ashby (1986), argued against the use of the term, since the term paranoia is not grounded in reality and is a form of emotional instability, whereas this phenomenon experienced by African Americans was based on reality and is a healthy way to protect oneself from a system of oppression.

Close to a decade after Grier and Cobbs' work, the term ecosystem distrust was introduced (Triandis, Feldman, Weldon, & Harvey, 1975). "Ecosystem distrust refers to distrust of people, things, and institutions in one's environment" (Trandis et al., 1975, p. 44). The perception of one's environment as harmful leads to lack of trust, skepticism towards the intentions of others, a sense of lack of control over one's environment, and a feeling of wariness that difficulties are eminent. Adding to the body of research, Terrell and Terrell (1981) coined the term cultural mistrust, which is mistrust that develops as a result of experiencing prejudice and bigotry. Cultural mistrust is displayed across a number of areas, including work and business, the legal system, educational settings, and social interactions. Thompson, Neville, Weathers, and Poston (1990) used the term racism reaction to describe the protective response of an African American to perceived racism. According to the authors, it is simply a healthy adjustment to a potentially dangerous situation.

While the construct of mistrust towards an oppressing culture has evolved over decades and has been described through a number of terms, the premise remains the same. It is a negative reaction that takes place subsequent to an adverse interaction in which an individual experiences prejudice or discrimination by a person of a different

race. As a result, the individual develops a lack of trust towards members of that particular race or ethnicity.

Learning to Mistrust Other Cultures

Researchers agree that social learning influences cultural mistrust (Barrett, 1984). Negative experiences with members of a particular racial group will influence the level of trust toward members of the group. Perceptions of prejudice, inequality, and discrimination are all contributing factors to cultural mistrust (Barrett, 1984). One can infer from the literature that children learn mistrustful behavior through observational learning. Bandura posits that learning occurs in the environment through observation, imitation, and modeling (Bandura, 2002; Grusec, 1992).

Children who see their parents seeking help are possibly more likely to seek services themselves. Children whose parents refuse to seek services have not had the behavior model and are therefore unlikely to engage in help-seeking behaviors (Crain, 2005). On the other hand, children could also be exposed to negative behaviors that parents exhibit after receiving psychological services. If they observe parents' anger towards the system or are exposed to negative attitudes about the system directly after the parents have received services, the child is likely to associate help seeking behavior with negativity, and subsequently it will be avoided (Crain, 2005).

Cultural mistrust amongst African Americans. Minority status has been categorized into two classifications: voluntary and involuntary status (Ogbu, 1988). African Americans and Native Americans are considered involuntary minorities, while Asians and Latinos are regarded as voluntary minorities. Involuntary minorities tend to

have a higher level of cultural mistrust due to a history of negative interaction with the White majority culture.

The majority of studies on cultural mistrust have examined the propensity for African Americans to mistrust White counselors (Whaley, 2001). African American's cultural mistrust is said to be rooted in the oppression and injustice many African Americans have faced over the last two centuries. "Historical and contemporary negative treatment have led to mistrust of authorities, many of whom are not seen as having the best interests of African Americans in mind" (Substance Abuse and Mental Health Services Administration, 2001, np). Cultural mistrust on the part of African Americans often leads to negative attitudes towards White mental health workers and a preference for same-race, African American clinicians (Nickerson et al., 1994; Townes et al., 2009; Thomson et al., 1994), and early termination of the therapeutic relationship (Terrell & Terrell, 1984). In other words, research affirms that cultural mistrust in African Americans leads to a higher level of negative help-seeking behaviors in regards to mental health services (David, 2010). Ahluwalia (1990) researched parents' attitudes towards mental health services for their children and found that African American parents with high levels of cultural mistrust were less likely to seek mental health services. Thompson, Bazile, and Akabar (2004) found that African Americans felt psychologists were not sensitive to their cultural experience, and that lack of trust was a significant barrier to their use of psychological services.

According to the American Psychological Association, only 1.9 percent of psychologists are identified as Black or African American (Townes et al., 2009). The

disparity among health care professionals across ethnic groups is quite significant (Gary, 2005). This gap between the number of patients and available same-race professionals makes it difficult for African American clients to seek therapeutic services from same-race counselors. The lack of available same-race professionals diminishes the help-seeking behavior of African American clients and perpetuates the lack of trust in the mental health system. Cultural mistrust significantly impacts the therapeutic relationship (Nickerson et al., 1994). African American clients who find it difficult to trust their White counselors are more likely to end the therapeutic relationship. The level of trust that a client has in his or her counselor affects their expectations of the counseling relationship as well as their perception of the counselor as a competent professional. The literature affirms that mistrust is an essential factor in issues between Black clients and White therapists (Nickerson et al., 1994); therefore, one might conclude that high levels of cultural mistrust would lessen the chances of seeking therapeutic services.

Experience of mistrust across sub-cultures. It is often easy to categorize individuals based on common factors. Often those factors tend to be what is most visible such as skin color and outward physical appearance. As discussed in previous sections, one vital key to understanding the African American experience is to understand the history from which that experience emerged. It is very important to account for group heterogeneity among individuals of African descent when speaking of cultural mistrust.

Results from a study by Hunter (2008), indicated that when compared with Caribbean Americans, African Americans had different perceptions of racial discrimination. African Americans were more likely to perceive racial discrimination

than their Caribbean born counterparts. While both ethnic groups carried the emotional scars of slavery, some Caribbean Blacks were not subject to the same atrocities that African Americans experienced in the United States. While Afro-Caribbeans were experiencing racial majority and self-governing privileges, African-Americans were fighting for the right to vote. African Americans were faced with legalized segregation and a lack of civil liberties, which many Afro-Caribbeans did not have to endure. This created a very different relationship between African Americans and Caucasian Americans than the one experienced between Afro-Caribbeans and Caucasians. Afro-Caribbean's "do not perceive themselves as having or coming from a racial minority experience" (Hunter, 2008, p. 322).

Several studies have found a strong link between cultural mistrust and racial discrimination. Terrell and Terrell (1981) found that African Americans with higher exposure to racial discrimination had high levels of cultural mistrust when compared to those with low exposure to discrimination. Perceived discrimination has been noted to have serious negative outcomes on the psychological well-being of African Americans (Combs et al., 2006). Low self-esteem, low levels of life satisfaction, and overall psychological distress have all been associated with perceived discrimination (Hunter, 2008). Combs et al. (2006) also found that perceived racism was a predictor of cultural mistrust.

Phelps et al. (2001) found that African American students' ratings for cultural mistrust varied significantly from that of African and Afro-Caribbean students. African Americans' scores on the Cultural Mistrust Scale were much higher than scores of the

other Black students. Individuals from Caribbean countries who may not have experienced such an aversive history between themselves and Caucasians were less likely to develop high levels of cultural mistrust.

Cultural mistrust amongst Asian Americans. The majority of race related research has focused on African-Americans and Caucasians and the racial attitudes of other minority groups have been greatly under investigated by researchers (Kohatsu et al., 2000). Asian Americans make up approximately 5.6 percent of the US population (U.S. Bureau of the Census, 2010); however, they seek mental health services at one-third of the rate predicted given the size of their population in the United States (David, 2010). A study by Zhang, Snowden, and Sue (1998) suggested that stigma played a strong role in mental health-seeking behaviors. When surveyed only four percent of Asians would seek help from a mental health specialist, and only twelve percent would share psychological problems with friends or family members (Zhang et al., 1998).

Similarly to all minorities, Asian Americans did not escape the racism and persecution so common in the history of the United States. The Chinese Exclusion Act of 1882 prohibited individuals of Chinese descent from becoming U.S. citizens until 1952 (U.S. Department of Health and Human Services, 2001). They were segregation laws kept them out of certain schools and housing (Kim, 2012). During World War II over 100,000 Japanese were incarcerated based on suspicions and sent to concentration camps. Many found that in order to survive, they needed to downplay their minority status (Kim, 2012). Having to conceal or deny their culture may have created a feeling of resentment, which has led to cultural mistrust for many older Japanese Americans. Researchers

postulate that similarly to other cultures, cultural mistrust by Asian Americans sprouted from intolerance and bigotry. In the early 1900s many laws existed that precluded Asians from land ownership. Discriminatory practices were accepted at a national level for they were thought to prevent the American public from diseases carried by a number of minority races (as cited in Gee, Ro, Shariff-Marco, & Chae, 2009). In 2005, Parrillo and Donoghue replicated a famous study originally conducted by Bogardus, to measure the degree of tolerance the American public had towards minorities of various races. When the original study was conducted in 1926, 1,700 Caucasian students were interviewed. They were asked to rank 30 different racial groups. Chinese were ranked 28th, while Koreans, and Asian Indians were ranked 29th, and 30th. In 2005, Chinese ranked 17th, Koreans 24th, and Asian Indians ranked 26th (Parrillo & Donoghue, 2005). This data clearly shows that to date, Asian Americans must continue to struggle with sentiments of intolerance.

The literature regarding the psychological well-being of Asian Americans refers to the "model minority" myth, in which Asian Americans are seen as a well-adjusted minority group resulting in a scarcity of research regarding their experience with prejudice and mistrust (Gary, 2005; Kohatsu et al., 2000). This myth brings individuals to the faulty conclusion that Asian Americans do not experience intolerance and bigotry (Ong, Burrow, Fuller-Rowell, Ja, & Sue, 2013). Moreover, this myth negates the psychological impact of acculturating to a White dominated society (Kim, 2012).

The model minority cliché is supported by the fact that, while Asian Americans make up only about 3 percent of the US population, in 1999 Asian American students

comprised 40 percent of the freshman class at UC Berkeley. Institutions such as MIT and Harvard also saw a large percentage of Asian students (Yin, 2000). However, there is a polarity within Asian Americans' experience in America. While 57 percent of Indian Americans have a college degree, compared to 19 percent of the general population, Vietnamese, Cambodians, and Laotians ranked well below the national average.

Disparities in education, immigration status, and socioeconomic status make it difficult to study the Asian American experience homogeneously (Gee et al., 2009). A review of the literature indicates that the lack of mental health seeking amongst Asian Americans is partly due to a lack of perceived needs and partly created by the "model minority myth." This misconception leads many to think that Asians are not in need of mental health services and can add an extra layer of shame when an individual does find themselves in need of psychological help.

Research concludes Asian Americans experience psychopathology at a rate similar to other racial groups (David, 2010). Racism and discrimination experienced by Asian Americans have affected the psychological well-being of Asian Americans (Kim, 2012). Phinney (1989) found that compared to adolescents of other minority groups, Asians American youth felt less pride in their ethnic heritage and were more likely to state a willingness to change their race to White if they could. Furthermore, a study conducted in the late 1990's showed that Filipina American adolescents had the highest rate of suicidal ideations when compared to all other racial groups (Wolf, 1997). In 2006, Alvarez and colleagues found that 98 percent of the Asian American students who participated in their study reported encounters with racial microagression (Alvarez,

Juang, & Liang, 2006). Many Asian Americans students reported feeling socially isolated and experiencing racial segregation on campus (Suyemoto, Kim, Tanabe, Tawa, & Day, 2009). A study by Noh and colleagues found that perceived discrimination was correlated with symptoms of depression is Southeast Asian immigrants (Noh, Beiser, Kaspar, Hou, & Rummens, 1999). The literature affirms that socioeconomic status (American Psychological Association Task Force, 2007), assimilation to the American culture, comfort level with the English language, cultural values, and avoidance of shame are strong factors associated with a decreased likelihood to seek mental health services with individuals of Asian descents (Shea & Yeh, 2008).

Chinese Americans and Filipinos make up the largest group of Asian Americans in the United States and the preponderance of research focuses on these groups (David, 2010). Similar to African Americans, individuals of Asian descent report experiencing racism on a regular basis (Alvarez et al., 2006). In a study focused on the experience of racial microagression among Asian Americans, 78 percent of participants reported experiencing racial microagression within a two-week period. Higher levels of racial microagression were also associated with poor psychological outcomes (Ong et al., 2013). Similar to results with African American subjects, discrimination was associated with mental health problems for a number of Asian Americans (Gee et al., 2009).

The literature suggests that Filipino's cultural mistrust sprouted from the American occupancy of the Philippines, during which they focused on educating and Christianizing the Filipino people (David, 2010). The mistrust of Filipinos for the White American culture continued when Filipinos migrated to the U.S. in search of

employment. During this time they faced harsh discrimination policies and exploitation. David (2010) believes all these historical events have led to a mistrust of the White American culture.

Cultural mistrust amongst Hispanics/Latinos Americans. Recent legislation (such as Arizona's SB 1070) focused on the enforcement of stringent immigration laws have been debated to have had a profound effect on Latinos (Gallego & Ferdman, 2012). Ethnic and racial profiling by law enforcement has more than likely created some level of mistrust in Hispanic individuals. These laws aimed at controlling undocumented workers, have significantly impacted American citizens of Hispanic origins (Gallego & Ferdman, 2012) and lead to the mistrust of the majority culture, by whom they feel persecuted.

There are several factors that have impacted the level of cultural mistrust, specifically mistrust of the mental health system, for Hispanics in the United States (Ruiz, 2002). Studies have also pointed to several factors that served as barriers to receiving mental health for this population (Koss, 1987; Marcos, 1979; Ruiz, 2002). Marcos (1979) noted that when assessed by an English-speaking therapist, Hispanic patients were much more likely to receive a diagnosis of severe mental illness than when interviewed by a Spanish-speaking professional. In addition to the language barrier, lack of cultural knowledge can also affect how a therapist perceives psychological symptoms. Hispanics often present with supernatural explanations for mental illness (Koss, 1987). Furthermore, Hispanic patients tend to somaticize much more than Caucasians (Canino, Rubio-Stipec, & Canino, 1992). These misinterpretations on behalf of the therapist are

likely to lead to an inappropriate diagnosis and inadequate psychological services for Hispanic individuals (Ruiz, 2002).

Cultural mistrust amongst Caucasian Americans. Whites are considered to be the culturally dominant group in the United States (Twenge & Crocker, 2002); therefore, limited information can be found regarding Caucasians and cultural mistrust. Research has shown that attitudes of Whites towards minority groups differ significantly. Whites have a more negative attitude towards Blacks and Hispanics than towards Asians (Stangor, Sullivan, & Ford, 1991; Wilson, 1996)**.** The movements towards cultural sensitivity and cultural acceptance have nearly eradicated cases of explicit racism. Caucasians are now less likely to make pejorative statements regarding individuals of color (Hardiman & Keehn, 2012).

Due to the notable advancements towards racial equality, and the significant decrease in cases of implicit racism, many White individuals are inclined to believe that racism is no longer an issue of concern in American society. Doane and Bonilla-Silva, (2003), found that racism is now expressed in more explicit ways and occur in a term he describes as "color-blind racism" (p. 272). Racist thoughts are now expressed in more indirect and underhanded ways. Whites avoid talking about racism, at the fear of being labeled as racist. Furthermore, Doane and Bonilla-Silva, (2003) asserts that model minorities are now often integrated into institutions and used to foster the claim that biased practices and procedures no longer exist. Some Caucasians disclosed they have been victims of reverse racism. While this phenomenon warrants attention, the empirical literature does not seem to address these experiences; nonetheless, the same manner in

which minorities develop cultural mistrust, one can assert that Caucasians likely develop mistrust following an interaction where they experienced prejudice from a minority.

Cultural mistrust amongst Native Americans. Colonialism of Native Americans has played a significant role in their history, significantly impacting their language, culture, and religion, as well as their identity development as a people (Horse, 2005). Their level of mistrust towards the White majority culture has also been significantly influence by their history. By 1903 Native Americans were confined to reservations and were not considered to be citizens of the United States until the Indian Citizenship Act of 1924 (Horse, 2005). The use of native languages and religions were declared illegal (Pacheco, 2013). Native American children were forcibly removed from their homes and sent to residential schools purposely designed to assimilate them into the majority culture (Churchill, 2004). The assimilation of Native Americans into the White majority culture has created feelings of anxiety in many older Native Americans for it brings forth a fear that assimilation will lead to loss of ethnic identity for younger generations (Horse, 2005). Native Americans, also considered an involuntary minority, have expressed, through research, that cultural mistrust impedes their willingness to seek and receive psychological services (Ahluwalia, 1990).

Cultural mistrust amongst Middle Eastern Americans. Information regarding the rate of mental health services utilized by Middle Eastern Americans is insufficient. Like many minorities, individuals of Middle Eastern origin are under-represented in research. Aloud and Rathur (2009) assert that individuals from the Middle East hold negative attitude towards psychological services. Since September 11, 2001, Middle

Easterners have experienced significant mental health distress including post-traumatic stress disorder and depression (Abu-Ras, 2003; Farrag & Hammad, 2005). The Federal Bureau of Investigation reported aggression towards individuals of Middle Eastern descent increased by over 1000 percent in 2002 (Lynn, 2002).

The literature reveals a number of factors that hinder Middle Easterners from seeking mental health services. The first is their adverse views of mental health. Fischer and Farina (1995), found that those who view mental health services positively are more likely to seek those services when necessary. The language barriers, as well as lack of understanding regarding culture and religion from the therapist, add to negative attitudes towards mental health seeking behaviors (Aloud & Rathur, 2009). Similarly to Latinos, individuals from the Middle East often attribute psychological distress to a supernatural phenomenon (Al-Issa, 2000). It has also been reported that some Muslim Middle Eastern believe that mental illness is a punishment or test from Allah and will stop the same way it began (Aloud & Rathur, 2009). Perceived social stigma is also a significant barrier to seeking mental health services for Middle Easterners. It is common for them to view the use of psychotropic medications as shameful and for it to be inappropriate to discuss private matters with outsiders (Abu-Ras, 2003). Therefore, mental health problems are often kept secret. Limited research has investigated the construct of cultural mistrust with individuals from the Middle East. It appears that for Middle Easterners, cultural and religious beliefs, rather than overwhelming mistrust of the majority culture significantly affect their mental health seeking attitudes; although, prejudice and bigotry surrounding the terrorist attacks of 911 may increase overall mistrust of the American culture.

Cultural Mistrust within the Field of Psychology

The field of psychology has left an impact on the African American experience. Many African Americans have negative views of the mental health system, as well as a deep level of mistrust towards most medical and mental health professionals (Thompson et al., 2004). The history of minorities and the mental health system dates back to the early years of psychology. In order to fully understand why mistrust continues to be a barrier to receiving mental health services in today's society, a brief historical investigation into the topic is warranted.

The idea of White superiority permeated and was perpetuated in the field of psychology for quite some time. Numerous distinguished psychologists, including Robert Woodworth and G. Stanley Hall, the first president of the American Psychological Association , publically affirmed their perspective on the matter (Benjamin, 2009). Hall reported that the cognitive development of an African American adult was equivalent to that of a Caucasian adolescent and the intelligence of a Native American adult was equivalent to that of a White child. Lewis Terman, another important figure in the field, spoke of the mental inferiority of Blacks. Terman thought that both Black and Latin races were cognitively inferior to Whites, and he reported that he had found supporting evidence for this in his research (Vialle & Wollonggong, 1994).

The Eastern Asylum for the Colored Insane, the first mental hospital for Blacks, was built in North Carolina in 1880 (Jackson, 2002). Soon thereafter a number of asylums reserved for individuals of color opened across the nation. In 1925, a 17-year-old deaf-mute Black man who was accused of rape, was castrated and sent to a mental

hospital, where he remained incarcerated for 72 years (6 of which he spent in the criminal ward), until he was found not-guilty and not insane (Burch & Joyner, 2007). The Alabama mental hospital housed 100 African Americans whose sole treatment provided to them was hard physical labor. In states like Maryland where there were no facilities for African American patients, many Black individuals who were deemed insane were sent to prison or were made to live in tents on the grounds of the state mental hospital for months a time.

Cultural Mistrust and Psychology: African Americans' Attitudes towards Mental Illness

Beliefs and attitudes toward mental health vary across races and ethnic groups. A study by Anglin, Alberti, Link, & Phelan (2008) found that, when compared to Caucasians, African Americans were more likely to think that psychiatric illness could improve without the intervention of a professional. Research has also shown that compared to Whites, Blacks have a more negative attitude towards mental illness (Nickerson et al., 1994). Hines-Martin, Malone, Kim, & Brown-Piper (2003) found that lack of knowledge about the mental health field resulted in negative attitudes toward the field. For example, many African American clients verbalized that mental health treatment was for "crazy" individuals. Many of the study's participants minimized the severity of their symptoms and felt that they could manage their problems without the interference of mental health professionals (Hines-Martin et al., 2003). Many African American clients seek mental health services as a last resort (Townes et al., 2009). Hines-Martin et al. (2003) found that African Americans were more likely to seek

pastoral counseling than mental health services when faced with psychological problems. Research also suggests that African Americans are less likely than Whites to find psychotherapy efficacious (Nickerson et al., 1994).

All of these negative attitudes towards the mental health system have been attributed to cultural mistrust (Bell & Tracey, 2006). Individuals with high levels of cultural mistrust will most likely also hold negative attitudes toward the mental health system, which will impact their willingness to seek and receive services (David, 2010).

Cultural Mistrust within the Medical Field

Most of the well documented cases of abuse within the field of medical research occurred with involuntary minorities. One of the most well-known cases of unethical treatment is the Tuskegee syphilis experiment. The American Social Hygiene Association (ASHA) created the Negro Project which was aimed at reducing the incidence of venereal diseases among African Americans; reportedly, at the time, the prevalence of syphilis in African Americans was six times that of Whites (Sharma, 2010). The Tuskegee syphilis experiment, which was originally titled "The Effects of Untreated Syphilis in Negro Males", was conducted in Alabama and lasted from 1932 to 1972. 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 40-year longitudinal study was aimed at examining the effects of the untreated disease (Sharma, 2010). The rationale of the study was that syphilis was untreatable in Black men; therefore, not offering treatment was not viewed as unethical. Many of the participants were told that they were being treated for bad blood. Participants were not explained the risks associated with

participation in the study (Sharma, 2010). This case is of paramount significance today and has led to the establishment of ethical standards.

When Armstrong, Crum, Rieger, Bennett, and Edwards (1999) investigated attitudes of Black patients regarding their lack of participation in research, they found that many African Americans reference the Tuskegee study as their reason for not willingly participating in medical research. "For many blacks, the Tuskegee study became a symbol of their mistreatment by the medical establishment, a metaphor for deceit, conspiracy, malpractice, and neglect, if not outright racial genocide" (Armstrong et al., 1999, p. 255). Study participants reported high levels of mistrust towards medical doctors, scientists, and the government. The authors concluded by noting "African-American participants in this study described distrust of the medical community as a prominent barrier to participation in clinical research" (Armstrong et al., 1999, p. 570).

In addition to the maltreatment of African Americans, Native American women underwent significant medical neglect at the hands of government doctors during the 1960's and 70's (Lawrence, 2000). Allegedly, between 1970 and 1976, the Indian Health Service (IHS), a government agency created to tend to the health care needs of Native Americans, sterilized between 25 and 50 percent of Native American women between the ages of 14 and 44 (Dillingham, 1977). The IHS failed to fully explain the process of sterilization to women and some victims were told the process was reversible. Some young women were sterilized during an unrelated procedure without their knowledge. Consent was either obtained with an incorrect consent form or through coercion. Native American women were targeted by the United States government for family planning

services due to their high birth rate. An examination of the records reveals that the IHS sterilized 3,406 women between 1973 and 1976 alone. Women reported being harassed by government social workers who came to their homes on multiple occasions to convince them to agree to the procedure (Lawrence, 2000).

Involuntary minorities have suffered greatly at the hand of their own government. These two cases of medical neglect and unethical practices have left a permanent scar in the memories of both African Americans and Native Americans. Such practices undoubtedly plague minorities with a sense of doubt and mistrust of not only the medical field, but of the majority culture in general. In a study aimed at investigating level of physician distrust across ethnic groups, the researchers found that minorities have a higher level of distrust towards their physicians when compared to Caucasians (Armstrong, Ravenell, McMurphy, & Putt, 2007).

Cultural Mistrust within the Educational System

There has been a long-standing controversy in the fields of psychology and education regarding the use of intelligence tests to evaluate African American children. Countless studies have reported that, when compared to Caucasian children, African Americans scored significantly lower than their White counterparts (Review of the Literature, 1963). This pattern emerged from the early testing of African American adults and children. The tests used at the time were the Stanford-Binet and the Army Alpha and Beta tests (Review of the Literature, 1963). These results led many educators and psychologists to postulate that Blacks were inferior to Whites in their cognitive abilities.

These views have been sustained throughout the years and have made their way into modern psychological literature. *The Bell Curve*, written by a Harvard psychologist, Herrnstein and Murray (1994), supported the theory of biological and genetic differences across racial groups when it comes to intelligence rather than taking into account environmental differences between the races (Hernstein & Murray, 1994). The authors of *The Bell Curve* posited the overrepresentation of African Americans and Mexican Americans in economically disadvantaged groups was a clear indication of their intellectual shortcomings (Blanton, 2000). This theory was prevalent well into the 1990s. Both African Americans' IQs and those of individuals of Mexican descent were investigated by researchers in Texas. Although the research was flawed and had many errors in methodology, the outcome of the studies revealed Caucasians were intellectually superior followed by those of Mexicans decent with African Americans as the intellectually inferior race (Balton, 2000). With such views permeating our education system today, it is difficult for many minority groups to fully trust the educational system. Most psychologists today are trained to consider the cultural bias inherent in many IQ tests. Tests standardized on White middle class children can yield varying results for children of color (Braden, 1995; Munford, Meyerowitz, & Munford, 1980).

Over the last few decades the state of Texas has adopted a number of standardized tests to measure students' academic achievement (Lubbock Avalanche-Journal, 1999). While these tests are supposed to be a representation of what is taught in the classroom, African American and Hispanic children continue to perform at rates much lower than their White counterparts. On the Texas Assessment of Academic Skills (TAAS), African

American and Hispanic children had a passing rate that was 10 to 30 percent lower than that of Caucasian children. As a result of this disparity, African American and Mexican American civil rights leaders filed a law suit against the State of Texas to ban the TAAS test from being administered as a requirement for graduation (Lubbock Avalanche-Journal, 1999).

Tatum (1999) has brought to light some valuable theories regarding African Americans and cultural mistrust in the educational setting. The author posits that African American youth may start to experience oppositional social identity as they begin to learn about the maltreatments of African Americans in the past. Oppositional social identity is akin to the term healthy cultural paranoia, discussed in previous sections. African American youth begin to reject anything related to the majority culture and embrace what they perceive to be associated with the Black culture, including speech and dress. Their attempt to adhere to perceptions of Black culture, may lead to less than desirable academic achievement. Some African American youths affiliate academic success with whiteness, and therefore to avoid rejection from their peer group, do not always perform to their academic potential (Tatum, 1999).

Studies have also examined the correlation between cultural mistrust, intelligence, and educational achievement (Whaley, 2001). African American students with high levels of cultural mistrust were found to have a better performance on IQ tests when measures were administered by a Black examiner. While cultural mistrust can serve as a protective factor for minorities, it can also have deleterious outcomes. Biafora et al. (1993) found that students with high cultural mistrust scores were also more likely to

engage in antisocial behaviors. When working in the educational setting with minority students, it is imperative that teachers, counselors, school psychologists, and administrators understand the concept of cultural mistrust and how it may not only impact their relationships with these students, but how it influences the identity development and self-concept of minority students.

Socioeconomic Status Impact on Psychological Services

Socioeconomic status (SES) often has a vast influence on many aspects of one's life. Individuals of lower SES are more likely to suffer from diseases, physical ailments, and mental health issues (Gary, 2005). The American Psychological Association Task Force on Socioeconomic Status conducted in 2007, encourages researchers who strive to investigate the fields of mental health and education to include SES as part of their studies. The majority of researchers have used level of education, household income, and occupation as indicators of SES (American Psychological Association Task Force on Socioeconomic Status, 2007; Gary 2005). Level of education is a strong predictor of SES. While both level of education and household income are strong predictors of overall SES, the American Psychological Association Task Force on Socioeconomic Status (2007) found that, "It is generally more informative to assess the different dimensions of SES and understand how each contributes to an outcome under study rather than merge the measures" (pg. 11).

Higher level of education is often correlated with better economic stability as well as increases in one's overall access to resources. Higher SES is strongly correlated with better access to mental health services (David, 2010). Those who are unemployed are at

greater risk for mental illness, or perhaps, are unemployed due to a mental illness. Sociologists and social psychologists have extensively studied the role of race in SES. There is a disproportionate percentage of ethnic minorities in individuals with low SES (American Psychological Association Task Force on Socioeconomic Status, 2007). In a 2003 study, O'Hare and Mather found that 27 percent of African American youth lived in "severely distressed" areas, as compared to 13 percent of Latinos and 1 percent of Whites. SES can also be difficult to investigate in immigrant populations. Some who immigrate to the US are forced to take much lower paying job than would be expected for their education level. The field of health psychology has discovered that low SES increases exposure to extreme stress and increases the likelihood of exposure to chronic stress, which is well known to affect overall mental health. Developmental psychologists have produced a plethora of research linking the effect of parent's education and income on their children's mental health (American Psychological Association Task Force on Socioeconomic Status, 2007).

In 2012 the poverty rate for Whites was 9.7 percent, lower than any other racial group. The rate of poverty for Blacks was 27.2 percent, 26.6 percent for Hispanics, and 11.7 percent for Asians (DeNavas-Walt, Proctor, & Smith, 2012). The literature has well documented that African American children are at higher risk for poverty than their Caucasian counterparts (Aber, Bennett, Conley, & Li, 1997; Moore, Redd, Burkhauser, Mbwana, & Collins, 2009). Low SES has been associated with a plethora of deleterious outcomes for children. Children who grow up in economically deprived environments

are at risk for poor health outcomes, academic problems, social problems, and lower cognitive functioning (El-Sheikh et al., 2001).

Children who live in poverty are also at higher risk of experiencing social and emotional problems during their development (Eamon, 2001). These problems include depression, problematic peer relations, and behavioral issues in the classroom. Children surrounded by poverty likely grow up in a stressful environment due to the parents' inability to meet their basic needs (Eamon, 2001). Studies show that individuals living in poverty are two to three times more likely to experience mental health problem (Muntaner, Eaton, Diala, Kessler, & Sorlie, 1998; Substance Abuse and Mental Health Services Administration, 2001). Other factors associated with low SES and poverty, such as malnutrition, negatively affect children's cognitive development (Eamon, 2001). SES is also correlated with children's physical development; when it comes to issues of weight, height, and overall physical development, children of low SES fare much worse (El-Sheikh, Harger, & Whitson, 2001).

School readiness is an important factor for academic success and children of low SES tend to experience some problems in this area (Engle & Black, 2008). Research has documented that when students are behind their peers academically, a gap starts to form between themselves and the other students. It becomes nearly impossible to bridge that gap. Early academic failure leads to drop-out, which perpetuates the cycle of poverty (Engle & Black, 2008). Children who grow up in poverty have increased risk factors and decreased protective factors when it comes to their overall development (Engle & Black, 2008).

Socioeconomic Status as a Barrier to Mental Health

There are numerous barriers that inhibit minorities' access to mental health services (Snowden, Masland, & Guerrero, 2007). Economic status has been identified in the literature as a significant barrier to mental health access for minorities (Gary, 2005). Studies have found that the lower levels of education and lower annual incomes minorities attain limit their access to mental health services (Chadiha & Brown, 2002; Kohn & Hudson, 2002). In a study designed to investigate cultural mistrust and help-seeking attitudes of Filipinos, David (2010) found that higher income was negatively correlated with cultural mistrust. The higher their income, the lower their cultural mistrust, and the higher their likelihood to seek mental health services (David, 2010). Black, Spence, and Omari (2004 found that that the high cost of psychological services was strongly correlated with lack of mental health seeking behaviors.

Being of low socioeconomic status is often associated with lack of or inadequate insurance coverage (Hines-Martin et al., 2003). This puts minorities, including African Americans, at a greater risk of not receiving appropriate mental health care (Gary, 2005). While some researchers argue that low SES alone can account for health seeking behaviors across races and show that, when SES is controlled for, disparities in health care seeking behavior of minorities becomes virtually non-existence (Krieger, 2000), the majority of research finds that the differences amongst races remain even after adjusting for SES (Smedley & Smedley, 2005).

Purpose of the Study

The purpose of this study was to investigate whether Caucasian parents differed in their level of cultural mistrust from Minority parents. Furthermore, the study was conducted to examine whether cultural mistrust, race, level of education, and income influence how parents of children with ASD report agreeing with the diagnosis, accepting the services offered to their children, and their comfort level with asking for additional services. Most research addressing the needs of the special education population has focused on Caucasians (Zhang et al., 2006). Although there has been research on minorities' cultural mistrust and their attitudes toward the mental health system, the literature has not directly focused on mistrust for school mental health clinicians or services. Until this study, an investigation into how cultural mistrust has affected parents' agreement with a diagnosis of ASD, as well as their willingness to accept special education services in the schools, has not been launched.

The hope was that the results of this study will add to the dearth of research regarding the perception of Autism from the view of minority parents, as well as lead to better understanding of the effect of cultural mistrust on parents' willingness to trust and work with school personnel and mental health professionals. Furthermore, the outcome of this study will inform professionals how cultural mistrust can be a barrier to parents' willingness to ask for additional services.

Research Questions and Hypotheses

The research questions guiding the proposed study are: (1) Is there a difference in the level of cultural mistrust between Caucasian and minority parents of children

diagnosed with ASD? (2) Does cultural mistrust affect parents' agreement with a diagnosis of Autism diagnosis for their child? (3) Does cultural mistrust also affect parents' willingness to accept services for their child in the school setting? (4) Does cultural mistrust affect parents' level of comfort with asking for additional services for their child, and finally, (5) Do race, income, and level of education of parents moderate the effects of cultural mistrust on their agreement with a diagnosis of an Autism diagnosis, willingness to accept special education services, and comfort level with asking for additional services for their child?

The hypotheses stemming from these research questions are: (1) minority parents will have a higher level of cultural mistrust than Caucasian parents. (2) Parents with a higher level of cultural mistrust will be less likely to agree with a diagnosis of Autism for their child (3) Parents with a higher level of cultural mistrust will be less willing to accept psychological services for their child in the school setting (4) Parents with a higher level of cultural mistrust will be least comfortable with asking for additional services for their child, and finally, (5) Race, income and level of education of parents will moderate the effects of cultural mistrust on their agreement with an Autism diagnosis, willingness to accept psychological services, and comfort level with asking for additional services.

CHAPTER III

METHOD

This section will describe the methodology for the study. Participant selection, survey design, and study procedure of the original study from which the present study gathered archival data, will be discussed. Additionally, the statistical analyses for this study will be examined.

Participants

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 during the Spring of 2014. The participants were recruited through various online media including, but not limited to, Autism blogs and journals, national and local organizations supporting families with children with Autism, support groups, and practitioner networks. Each of these organizations notified their members of the survey using email mailing lists, newsletters, message board postings, social networking sites, including Facebook and Twitter. In addition, flyers were distributed at Autism clinics in the Dallas/Fort Worth area. Research team members also sent notices to families they knew that have a child with Autism 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 met the criteria for participation.

Characteristics

One hundred and thirty seven parents completed the study and 100% of participants reported having a child with Autism who had been formally diagnosed by a professional (medical, mental health, or school personnel). Participants ranged in age from 18 to 65, with the majority being females (89.4%) between the ages of 25 and 54. For the purpose of this study, cultural mistrust, race, level of education, and household income were collapsed into the following categories: low, moderate, and high mistrust; Caucasian and Minorities; Bachelor's degree and no Bachelor's degree; income less than $49,999, $50,000-99,999, and above $100,000.

The majority of participants identified as Caucasian (75.2%) while 24.8% identified as Minorities (including Black or African American, Hispanic or Latino, Asian, Pacific Islander, Native American or American Indian, Middle Eastern, and other). With regard to education level, 58.4% reported having a Bachelor's degree, while 40.9% reported not having a degree. A great percentage of the respondents had an annual household income of over $100,000 (40.1%), while 31.4% reported an income between $50,000 and $99,999, and 28.5% made less than $49,000 a year. In regards to their children, participants reported 34.3% were diagnosed by a professional of a different race and 65.7% of children were diagnosed by a professional of their race. A small majority of children (29.2%), were diagnosed between the ages of 3 and 4, 24.8% of children were diagnosed under the age 3, 15.3% between the ages of 5-8 and 6.6% between the ages of 9 and 12, and only 1.5% of children were diagnosed as adolescents, between the ages of

13 and 18. Parents reported that 83.2% of children receive special education or 504 services. See Table 1 for descriptive statistics of these demographic variables.

Table 1

Descriptive Statistics for Sample Demographics: Categorical Variables

Variable	Frequency	Percentage
Race		
Minorities	34	24.8
Caucasian	103	75.2
Gender		
Male	14	10.6
Female	122	89.4
Transgendered	0	0.0%
Level of Education		
No Bachelor's Degree	56	40.9
Bachelor's Degree	80	58.4
Income		
Less than 49,999	39	28.5
50,000-99,999	43	31.4
Above 100,000	55	40.1
Respondent's Age		
18-24 Years	6	4.4
25-34 Years	25	18.2
35-44 Years	64	46.7
45-54 Years	39	28.5
55-64 Years	2	1.5
65 Years or Older	1	.7
Age of Respondent's Child at Diagnosis		
Under 3 Years	34	24.8
3-4 Years	40	29.2
5-8 Years	21	15.3
9-12 Years	9	6.6
13-18 Years	2	1.5
Diagnosed by Professional of Different Race		
Yes	47	34.3
No	90	65.7
Child Receiving Special Education or 504 Services		
Yes	114	83.2
No	22	16.1

n=137

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 consisted of 41 questions, 32 of which will be the focus of the current study.

For the two versions of the survey, the order of the Likert scale answer choices, as well as the choices themselves, were the same and in the same order. There were 6 points on the Likert scale, ranging from strongly agree to strongly disagree. The Likert scale is one of the most widely used instruments for measuring preference, attitude, and opinion (Leung, 2011). The items on this survey were based on a 6 point Likert scale because it has been found that more choices increase sensitivity (Leung, 2011). The first set of questions answered by respondents involved demographic information and included country location of participant, gender, race, age, level of education, income, child's age, age of child at diagnosis, and race of professional that diagnosed child. Subsequently, respondents answered five questions about their beliefs regarding the diagnosis given to their child and how much they agree with this diagnosis. Participants then answered seven 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 B and the Caucasian survey can be found in Appendix C.

Cultural Mistrust Inventory

Included in each survey was a modified version of 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 that 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 comparing the CMI and the Racial Discrimination Index. 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, education/training, business/work, and interpersonal relations. Inter-correlations of the four subscales ranged from .11 to .23, which suggests independence of each scale. Moreover, Ponterotto and Casas (1991) reported that, because there is weak correlation between the subscales, it is appropriate to use the subscales independently. For the purpose of the current study, only the twenty items included in the education/training and interpersonal relations subscales were used. The instrument and scale were selected for the study because of its 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 or 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). The CMI can be found in the complete survey from question 27 to 47 in Appendices B and C.

Procedure

The Institutional Review Board (IRB) at TWU approved the original study, from which the archival data for the current study was obtained. As previously noted, participants were recruited through various online media. Flyers were distributed to Autism clinics in the Dallas/Fort Worth area. 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. The principal investigator's contact information was also provided. At the end of the consent form, participants were asked to indicate whether they wanted to proceed with the survey (indicating informed consent) by selecting an agree button. Those participants who elected to proceed were directed to the survey.

Participants were first asked to confirm they were parents of a child formally diagnosed with an Autism Spectrum Disorder, by a medical professional, mental health professional, or school personnel. If parents replied no to this question, they were routed to the end of the survey. Upon answering the question regarding their own race, respondents were directed to complete either the minority or the Caucasian survey. After being assigned to either the Caucasian or Minority survey, participants answered

demographic questions, followed by a series of items, including whether or not they agreed with their child's diagnosis, their willingness to accept services offered to their child, and their comfort level with asking for additional services. Lastly, study participants were directed to the modified version of the Cultural Mistrust Inventory. While the consent form outlined 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. A subsequent IRB application was approved in order for the data from the original study to be analyzed.

Statistical Analyses

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. The scores can range from 1 to 6. The sample was divided into three groups: Low, Moderate and High. The groups were 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, Biafora, & Warheit, 1994; Terrell & Terrell, 1984; Whaley & Smyer, 1998). The following ranges were used to determine placement of participants into groups based on levels of cultural mistrust: Low = 1.00-2.50; Moderate = 2.51-4.00; and High = 4.01-6.00. Upon review of the data, it was observed that none of the participants reported high levels of cultural mistrust, thus the two categories used for the analyses were low and moderate.

Preliminary Analyses

Preliminary data analysis, including defining types of missing data, and examining general statistics should be conducted prior to completing primary data analyses (Tabachnick & Fidell, 2001). After participants completed the survey, data was downloaded to a SPSS file. Following the suggestions of Tabachnick & Fidell (2001), data were screened for type of missing data, since type of missing data in the data set can change the interpretation of data analysis. For this study, three inclusionary criteria were established: first, participants must have reported being the parent of a child or children with Autism. Second, the child must have been diagnosed by a professional (medical professional, mental health professional, or school personnel). Third, participants must have completed the Cultural Mistrust Inventory (CMI). The last criterion was included because of the level of interest in this variable. In this study, missing data were a problem, since 25% of participants who started the survey did not complete the CMI.

Analysis of missing data. Three major categories of missing data have been identified in the literature: *data missing completely at random* (MCAR), *data missing at random* (MAR), and *data not missing at random* (NMAR) (Allison, 2001; Howell, 2007). MCAR refers to data that are missing randomly, in other words, data that are missing independently from other data, and not dependent on other variables. For example, in a data set that includes measures of hours playing video games and race, there is no relation between the time spent on video games and race. Thus MCAR data are just as likely to be missing as any other piece of datum (Allison, 2001; Howell, 2007).

In a survey it is difficult to know whether data truly are MCAR, a more likely occurrence is data MAR. According to Allison (2001) and Howell (2007), data MAR is related to a particular variable (e.g., the cultural mistrust variable), but it is not related to the value of the variable missing the data (the level of cultural mistrust). NMAR refers to data that are not missing either at random (MAR) nor completely at random (MCAR). This generally means that the missing data are missing because they are related to another variable under study (Allison, 2001; Howell, 2007). As an example of NMAR data, consider the possible association between race and levels of cultural mistrust. Parents who have a high level of cultural mistrust may be less willing to complete the survey. Therefore, based on the pattern of the data, one can conclude that parents with high levels of cultural mistrust may not complete the CMI.

Missing data can be deleted in several different ways. According Howell (2007), MCAR data can be list-wise deleted from a data set. List-wise deletion occurs when a participant is dropped completely from all analyses, regardless of the number of missing data point. When using list-wise deletion, the loss of data can affect the power of the analysis, however, the deleted data will not bias the overall results.

List-wise deletion is an option for data missing at random (MAR), Tabanchnik and Fidell (2001) suggest that if five percent of data points are (MAR) from a large data set, then the cases with missing variables can either be dropped by list-wise deletion, or by case-wise deletion (dropped only in certain analyses). NMAR can be handled in the following ways: list-wise deletion, imputation, and the analysis of missing data as data. When NMAR is list-wise deleted the researcher increases the likelihood of interpreting

biased results (Howell, 2007). However Howell (2007) suggested that this is the best way to handle NMAR data. The second option is imputation, which occurs when estimated values for missing data are substituted (Allison, 2001). Imputation for data NMAR are possible, but depending on what data are missing (e.g., dependent versus independent variables) and the proposed analyses, imputation of missing data is not always recommended (Allison, 2001; Tabanchnik & Fidell, 2001). The third option is to treat missing data as data. It should be used, whenever possible, to aid in the interpretation of the data (Allison, 2001; Howell, 2007; Tabanchnik & Fidell, 2001).

Given the aforementioned considerations for missing data, all survey measures, specifically the CMI were screened for missing data. As suggested by Cohen and Cohen (1983), in order to determine if the missing CMI were MAR or NMAR, a dichotomous dummy variable was created representing the parents who completed the CMI and those who did not (those who completed the CMI were coded as 1 and those who did not were coded as 0). Two types of analyses (4 chi-squares and an ANOVA) were conducted to detect patterns in the missing data and to determine whether the CM data were MAR or NMAR (Allison, 2001; Cohen & Cohen, 1983).

Three chi-squares were conducted for the first set of preliminary analyses. As described by Gravetter and Wallnau (2009), a chi-square is a nonparametric test used to examine population distributions. A chi-square is designed to analyze categorical data and provide information regarding how independent the different variables are from one another. The researcher was interested in knowing whether or not parents in the two groups (completed CMI and non-completed CMI) differed from one another based on the

independent variables (race, household income, and level of education). A chi-square was conducted with each of the independent variables to determine whether completion of the CMI was due to chance, or better attributed to race, household income, or level of education.

Second, the researcher ran three Analysis of Variance (ANOVA) on the dependent variables (parents' agreement with the diagnosis, parents' willingness to accept services, and parents' comfort level with asking for additional services), to determine if there was a mean difference for each of the DVs across those who did and did not complete the CMI. An ANOVA is a parametric test designed to compare mean differences across groups (Gravetter & Wallnau 2009) as it accounts for variation between and within each group (Mertler & Vannatta, 2010). Therefore, an ANOVA was the most appropriate analysis to investigate whether there were significant differences in attitude between those who answered the questions and those who did not. This test was chosen over a *t* test, because ANOVAs can be used to compare mean difference across two or more groups while reducing the chance of Type I errors (Mertler & Vannatta, 2010).

Following the analyses for missing data, the researcher did a list-wise deletion of all participants who did not complete the CMI. Prior to running the major statistical analyses, descriptive statistics were gathered for the demographic variables. Measures of central tendency including means and standard deviations, as well as frequencies and percentages were calculated to describe the variables.

Primary Analyses

A one-way ANOVA and a factorial multivariate analysis of variance (factorial MANOVA), followed by post hoc analysis were conducted. The ANOVA was deemed most appropriate to answer the first research question, as the researcher simply sought to investigate mean group differences on level of cultural mistrust in the Caucasian and Minority groups. As previously noted, the race variable was collapsed from eight choices down to two, due to limited minority participants. The original research question was then modified from: Which ethnocultural group will have the highest level of cultural mistrust? To: Is there a difference in level of cultural mistrust between Caucasian and minority parents of children diagnosed with Autism? For this analysis, the independent variable was race (Caucasian or minority), and the dependent variable was cultural mistrust.

Then, a 2 (race: White and minorities) x 2 (level of education: BA or no BA) x 3 (income: low, medium, high) x 2 (cm- low, moderate) factorial MANOVA with planned interaction on the dependent variables (agreement with the diagnosis, willingness to accept services, and comfort level with asking for additional services) was conducted to address the remaining research questions. Specifically, do the demographic variables (race, income, and level of education), along with cultural mistrust, affect parrents' agreement with the diagnosis of Autism, acceptance of services offered to their child, and comfort level with asking for additional services.

A factorial MANOVA is optimal when researching "scenarios with two or more IVs that are categorical and two or more quantitative DVs" (Mertler & Vannatta, 2010, p.

16). There are several reasons why the researchers chose to run a factorial MANOVA, as opposed to a series of ANOVAs for each of the research questions, followed by additional ANOVAs with race, income, and level of education as moderators. First, based on the number of variables, a factorial MANOVA was considered most appropriate to address the aforementioned questions. MANOVAs can uncover differences not delineated in separate ANOVAs, additionally, the use of multiple ANOVAs reduces the likelihood of Type I error rate (Mertler & Vannatta, 2010). Finally, the researcher was not only interested in group differences based on the 4 independent variables (cultural mistrust, race, income, and level of education), but also in the interaction between the levels of independent variables. "A factorial MANOVA allows the researcher to test multiple hypotheses simultaneously in one analysis" (Mertler & Vannatta, 2010, p. 119). An ANOVA was conducted as a post hoc analysis to gain a clearer understanding of the results.

CHAPTER IV

RESULTS

The purpose of this chapter is to describe the results of this study as they relate to each of the proposed research questions. Preliminary analysis to address missing data, as well as descriptive statistics are discussed, followed by the introduction of primary analyses with subsequent post-hoc analyses to address research questions.

Preliminary Analyses

Chi-Square for Missing Data

A Chi-square analysis test was conducted to determine whether there was a significant difference between race of the parents who did and did not complete the Cultural Mistrust Inventory. In other words, are the differences between the two groups (completed survey and non-completed survey) due to race? Chi-square results $\chi^2 = 0.015$, $p = .902$, suggested that there were no differences in race for individuals who did or did not complete the cultural mistrust survey. Because of sample size considerations, for this analysis, all non-Caucasians (Black or African American; Hispanic or Latino; Asian; Pacific Islander; Native American or American Indian; Middle Eastern; Other) were grouped into a minority category. See Table 2 for expected and observed frequencies and standardized residuals.

Table 2

Missing Data Chi-square 2(Cultural Mistrust Inventory) X 2(Race) Test of Independence

	CM Inventory Completed	CM Inventory Not Completed
Minority	34(33.7)	11(11.3)
Standardized Residual (Minority)	0.1	-0.1
Caucasian	103(103.3)	35(34.7)
Standardized Residual (Caucasian)	-0.1	0.1

Note. (Expected) percent within CM Inventory.

A Chi-square analysis for income (Less than $49,999; $50,000-99,999; Above $100,000), $\chi^2 = 1.286$, $p = .526$, suggested that there were no differences in income for individuals who did or did not complete the cultural mistrust survey. Because of sample size considerations, for this analysis, income levels (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) were grouped into three categories (Less than $49,999; $50,000-99,999; Above $100,000). See Table 3 for expected and observed frequencies and standardized residuals.

Table 3

Missing Data Chi-square 2(Cultural Mistrust Inventory) X 3(Income) Test of Independence

	CM Inventory Completed	CM Inventory Not Completed
Less than $49,999	39(41.5)	14(11.5)
Standardized Residual (Less than $49,999)	-1.0	1.0
	43(40.7)	9(11.3)
$50,000-99,999	0.9	-0.9
Standardized Residual ($50,000-99,999)		
	55(54.8)	15(15.2)
Above $100,000	0.1	-0.1
Standardized Residual (Above $100,000)		

Note. (Expected) percent within CM Inventory.

A Chi-square analysis for level of education (bachelor's degree and no bachelor's degree), $\chi^2 = 1.584$, $p = .208$, suggested that there were no differences in level of education for individuals who did or did not complete the cultural mistrust survey. Because of sample size considerations, for this analysis, levels of education (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; Doctoral degree) were grouped into two categories (bachelor's degree and no bachelor's degree). See Table 4 for expected and observed frequencies and standardized residuals.

Table 4

Missing Data Chi-square 2(Cultural Mistrust Inventory) X 2(Education) Test of Independence

	CM Inventory Completed	CM Inventory Not Completed
With Bachelor's Degree	80(76.6)	18(21.4)
Standardized Residual (With Bachelor's Degree)	1.3	-1.3
Without Bachelor's Degree	56(59.4)	20(16.6)
Standardized Residual (Without Bachelor's Degree)	-1.3	1.3

Note. (Expected) percent within CM Inventory.

In conclusion, the three chi-square analyses revealed that minorities were no more likely than Caucasians to complete the cultural mistrust survey, and individuals who had household incomes of Less than $49,999; $50,000-99,999; and Above $100,000 did not vary significantly in their likelihood to complete the CMI. Furthermore, results also indicated that race, nor education impacted the likelihood of survey completion. In other words, differences in the two groups (completed survey and non-completed survey) were due to chance and not attributable to the demographic variables.

ANOVA for Missing Data

A one-way univariate analysis of variance (ANOVA) for completion of the Cultural Mistrust Inventory (CMI) was conducted to determine if mean differences were present for each of the DVs (parents' acceptance of the diagnosis, parents' agreement with the diagnosis, and parents' comfort level with asking for additional services) across those who did and did not complete the CMI. For all dependent variables, there were no statistically significant differences between parents who did complete the survey and

those who did not (parents' agreement with the diagnosis, $F(1, 166) = 0.273$, $p = .602$; parents' willingness to accept services, $F(1, 152) = 2.038$, $p = .155$; and parents' comfort level with asking for additional services, $F(1, 152) = 0.280$, $p = .597$). For means and standard deviation for the two groups, see Table 5.

Table 5

Missing Data ANOVA for the Dependent Variables

Dependent Variables	Completed CMI			Not Completed CMI		
	M	*(SD)*	95% Confidence Interval	M	*(SD)*	95% Confidence Interval
Parents' Agreement with the Diagnosis	4.85	*(1.67)*	4.57—5.14	4.68	*(1.82)*	4.01—5.34
Parents' Willingness to Accept Services	5.23	*(1.50)*	4.97—5.48	5.76	*(1.20)*	5.15—6.38
Parents' Comfort Level with Asking for Additional Services	7.57	*(3.18)*	7.03—8.11	8.00	*(3.00)*	6.46—9.54

Descriptive Statistics

Means, deviations, and ranges were calculated for all of variables (except race) measured in this study. See Table 6 for the descriptive data for dependent variables and Table 7 for the descriptive data for the non-demographic independent variable (cultural mistrust). Scores on the dependent variable 1 (agreement with the diagnosis given to child) and 2 (accept services offered) show negative to positive perspectives, with high scores (six being the highest) indicating more positive responses from the participants. Scores on dependent variable 3 (comfort level with asking for additional services) shows

a positive to negative perspective, with high scores (10 being the highest) indicating more negative responses from participants. The scores on the CMI reflect individuals' level of mistrust, with higher scores being indicative of higher level of cultural mistrust. Overall, participants reported a mean of 1.16, which indicates a low level of cultural mistrust across participants. For means and standard deviation for the two groups, see Tables 6 and 7.

Table 6

Descriptive Data for Dependent Variables

Variable	M	Range	*SD*
Agreement with diagnosis given to child	4.85	1.00 – 6.00	4.85
Willingness to accept services offered to child	5.23	1.00 – 7.00	1.5
Comfort level with asking for additional services	7.57	1.00 – 10.0	3.18

Table 7

Descriptive Data for Non-Demographic Independent Variable

Variable	M	Range	*SD*
Cultural Mistrust	1.16	1.00 – 2.00	.368

Primary Analysis: Question One

A one-way ANOVA was conducted to determine whether minority participants differed from Caucasian participants on their cultural mistrust scores. Specifically, is there a statistical difference between cultural mistrust for Caucasian and minority parents of children diagnosed with Autism? The hypothesis that there would be statistically significant difference between cultural mistrust for Caucasian and minority parents was

supported, $F(1, 135) = 6.718$, $p = 0.011$, $\eta^2 = 0.047$. For means and standard deviation for the two groups, see Table 9. Because there were only two levels to the ANOVA, no post hoc analysis was necessary to further investigate the nature of the significance. It is evident that the difference is between the two groups (Caucasians and minorities). For means and standard deviation for the two groups, see Table 8.

Table 8

Means and Standard Deviations for Cultural Mistrust by Race

Race	M	*(SD)*	95% Confidence Interval
Minority	2.20	*(0.71)*	1.95—2.45
Caucasian	1.93	*(0.46)*	1.84—2.02

Primary Analysis: Questions Two through Five

Preliminary Analysis

A 2 (race: white and minorities) x 2 (level of education: BA or no BA) x 3 (income: low, medium, high) x 2 (cm: low, moderate) factorial MANOVA with planned interaction on DV1 (agree with diagnosis given to child), DV2 (accept services offered), DV3 (comfort level with asking for additional services) identified only one multivariate main effect for race, Wilks'Λ = .773, $F(3,124) = 12.14$, $p = <.001$, multivariate $\eta^2 = 0.047$ (see table 9). There was one, two-way interaction effect for cultural mistrust × race, Wilks'Λ = .930, $F(3, 124) = 3.09$, $p = .029$, multivariate $\eta^2 = 0.014$ (see table 13). There were no significant main effects for level of cultural mistrust, Wilks'Λ = .972, $F(3, 124) = 1.21$, $p = .310$, multivariate $\eta^2 = 0.014$ (see table 10), or household income, Wilks'Λ = .934, F(6,

248*)* = 1.43, p = .205, multivariate η^2 = 0.028 (see table 11), or level of education, Wilks'Λ = .986, F(3, 124) = 0.594, p = 0.620, multivariate η^2 = 0.033 (see table 12). There were also no significant two way interaction effects for cultural mistrust × income Wilks'Λ = .943, F(6, 248) = 1.23, p = 0.289, η^2 = 0.070 (see table 14), or cultural mistrust × level of education Wilks'Λ = .993, F(3, 124) = 0.294, p = 0.830, multivariate η^2 = 0.029 (see table 15). Means and standard deviations for these effects may be found in Tables 9-15.

Table 9

Means and Standard Deviations for Dependent Variables by Race

	Minority		Caucasian			
Dependent Variables	M	*(SD)*	M	*(SD)*	*F*	*P*
Parents' Agreement with the Diagnosis	4.78	*(0.35)*	4.86	*(0.26)*	0.034	0.855
Parents' Willingness to Accept Services	4.71	*(0.31)*	5.28	*(0.23)*	2.154	0.145
Parents' Comfort Level with Asking for Additional Services	4.91	*(0.49)*	8.45	*(0.37)*	32.890***	≤ .001

Note. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Table 10

Means and Standard Deviations for Dependent Variables by Level of Cultural Mistrust

	CM Low		CM Moderate			
Dependent Variables	M	*(SD)*	M	*(SD)*	*F*	*P*
Parents' Agreement with the Diagnosis	4.79	*(0.19)*	4.84	*(0.39)*	0.014	0.905
Parents' Willingness to Accept Services	5.13	*(0.17)*	4.86	*(0.34)*	0.512	0.475
Parents' Comfort Level with Asking for Additional Services	6.13	*(0.27)*	7.23	*(0.54)*	3.267	0.073

Note. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Table 11

Means and Standard Deviations for Dependent Variables by Income

	Less than 49,999		50,000-99,999		Above 100,000			
Dependent Variables	M	*(SD)*	M	*(SD)*	M	*(SD)*	*F*	*P*
Parents' Agreement with the Diagnosis	5.21	*(0.40)*	4.82	*(0.38)*	4.41	*(0.36)*	0.985	0.376
Parents' Willingness to Accept Services	5.04	*(0.36)*	4.73	*(0.34)*	5.22	*(0.32)*	0.558	0.574
Parents' Comfort Level with Asking for Additional Services	7.21	*(0.57)*	7.20	*(0.53)*	5.63	*(0.51)*	2.708	0.071

Note. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Table 12

Means and Standard Deviations for Dependent Variables by Education Level

	Without BA		With BA			
Dependent Variables	M	*(SD)*	M	*(SD)*	*F*	*P*
Parents' Agreement with the Diagnosis	4.62	*(0.30)*	5.01	*(0.34)*	0.690	0.408
Parents' Willingness to Accept Services	4.80	*(0.27)*	5.19	*(0.30)*	0.855	0.357
Parents' Comfort Level with Asking for Additional Services	6.49	*(0.42)*	6.87	*(0.47)*	0.342	0.560

Note. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Table 13

Means and Standard Deviations for Dependent Variables by Race

	Minority				Caucasian					
	CM Low		CM Moderate		CM Low		CM Moderate			
Dependent Variables	M	*(SD)*	M	*(SD)*	M	*(SD)*	M	*(SD)*	*F*	*P*
Parents' Agreement with the Diagnosis	4.76	*(0.34)*	4.79	*(0.60)*	4.82	*(0.18)*	4.90	*(0.50)*	0.002	0.969
Parents' Willingness to Accept Services	4.96	*(0.30)*	4.47	*(0.53)*	5.31	*(0.16)*	5.25	*(0.44)*	0.312	0.577
Parents' Comfort Level with Asking for Additional Services	3.42	*(0.48)*	6.40	*(0.85)*	8.85	*(0.26)*	8.06	*(0.70)*	9.322**	$\leq .01$

Note. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Table 14

Means and Standard Deviations for Dependent Variables by Income and Cultural Mistrust

	Less than 49,999				50,000-99,999				Above 100,000					
	CM Low		CM Moderate		CM Low		CM Moderate		CM Low		CM Moderate			
Dependent Variables	M	*(SD)*	M	*(SD)*	M	*(SD)*	M	*(SD)*	M	*(SD)*	M	*(SD)*	*F*	*P*
Parents' Agreement with the Diagnosis	5.26	*(0.32)*	5.16	*(0.75)*	4.49	*(0.29)*	5.16	*(0.70)*	4.62	*(0.31)*	4.20	*(0.65)*	0.590	0.556
Parents' Willingness to Accept Services	5.47	*(0.28)*	4.61	*(0.66)*	4.74	*(0.26)*	4.72	*(0.62)*	5.19	*(0.28)*	5.24	*(0.57)*	0.532	0.589
Parents' Comfort Level with Asking for Additional Services	6.52	*(0.44)*	7.89	*(1.05)*	5.88	*(0.41)*	8.53	*(0.99)*	6.00	*(0.44)*	5.27	*(0.91)*	2.561	0.081

Note. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Table 15

Means and Standard Deviations for Dependent Variables by Education Level and Cultural Mistrust

	Without BA				With BA					
	CM Low		CM Moderate		CM Low		CM Moderate			
Dependent Variables	M	*(SD)*	M	*(SD)*	M	*(SD)*	M	*(SD)*	*F*	*P*
Parents' Agreement with the Diagnosis	4.39	*(0.28)*	4.85	*(0.53)*	5.19	*(0.24)*	4.83	*(0.63)*	0.690	0.408
Parents' Willingness to Accept Services	4.91	*(0.25)*	4.69	*(0.47)*	5.35	*(0.21)*	5.03	*(0.56)*	0.855	0.357
Parents' Comfort Level with Asking for Additional Services	5.83	*(0.40)*	7.15	*(0.75)*	6.43	*(0.33)*	7.31	*(0.89)*	0.342	0.560

Note. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Post Hoc Analysis

Analysis of variance (ANOVA) was conducted on each dependent variable as a follow up test to the MANOVA. Univariate follow-up analyses for the racial group indicated significant effects for parents' comfort level with asking for additional services. Caucasians $F(1, 101) = 5.71$, $p = 0.019$, were more comfortable asking for services than minorities $F(1, 32) = 3.537$, $p = 0.069$. More specifically, for Caucasian parents, those with low levels of cultural mistrust reported being more comfortable asking for additional services than parents with moderate level of mistrust. Furthermore, there were no

differences for minority parents who had low or moderate levels of cultural mistrust.

Means and standard deviations for these effects may be found in Tables 16 and 17.

Table 16

Means and Standard Deviations for Cultural Mistrust by Parents' Comfort Level with Asking for Additional Services (Caucasians)

Variables	Low Level Of CM			Moderate Level of CM		
	M	*(SD)*	95% Confidence Interval	M	*(SD)*	95% Confidence Interval
Parents' Comfort Level with Asking for Additional Services	8.88	*(1.841)*	8.49—9.26	7.46	*(2.90)*	5.71—9.22

Table 17

Means and Standard Deviations for Cultural Mistrust by Parents' Comfort Level with Asking for Additional Services (Minorities)

Variables	Low Level Of CM			Moderate Level of CM		
	M	*(SD)*	95% Confidence Interval	M	*(SD)*	95% Confidence Interval
Parents' Comfort Level with Asking for Additional Services	3.48	*(3.343)*	2.14—4.82	6.00	*(4.00)*	2.93—9.07

CHAPTER V

DISCUSSION

Throughout previous chapters the researcher examined the current literature pertaining to individuals with ASD, as well as the literature on cultural mistrust, as it relates to the variables of interest. A number of research questions were investigated for the purpose of this study and results were reported. This final chapter is divided into sections. First, the findings will be integrated with relevant literature. Next, implications of these findings for research and the practice of school psychology are noted. Furthermore, the strengths and limitations of the study will be discussed. Lastly, the researcher will explore recommendations for future research and provide conclusions at the end of the chapter.

Summary of Findings

Preliminary Analyses

Preliminary analyses were run to investigate whether there were statistically significant differences between parents who completed the Cultural Mistrust Inventory (CMI) and those who did not. Three separate analyses suggested demographic variables did not impact willingness to complete the CMI. Minorities were no more likely than Caucasians to complete the cultural mistrust survey. When compared to individuals with higher income, those with lower income did not differ in their likelihood to complete the cultural mistrust survey. Moreover, level of education also did not influence likelihood of survey completion. An additional preliminary analysis was conducted to examine

mean differences for each of the dependent variables (agreement with the diagnosis; willingness to accept services; and comfort level with asking for additional services) across those who did and did not complete the CMI. The analysis revealed there were no statistically significant differences between parents who did complete the survey and those who did not across all three of the dependent variables.

These analyses suggest that the survey data were missing at random (MAR). As Tabachnik and Fidell (2001) suggested, the survey data was not missing systematically; consequently, it is considered missing at random (MAR), as there were no statistically significant differences between those who completed the cultural mistrust survey and those who did not, based on race, level of education, and household income. Moreover, there were no statistically significant differences in parents who did complete the CM survey from those who did not complete it on three dependent variables (i.e., parents' willingness to agree with the diagnosis, parents' willingness to accept services, and parents' comfort level with asking for additional services). The List-wise deletion option (Tabanchnik & Fidell, 2001) was selected and all individuals who did not complete the CMI were deleted from the data set. Originally, 184 parents started the survey; 137 completed the CMI and were included as participants in the study.

Examination of Research Question One

As noted in previous chapters, cultural mistrust in African Americans has been well documented in the literature (Nickerson et al., 1994; Thompson et al., 2004; Townes et al., 2009), while the racial attitudes of other minority groups have been virtually ignored by researchers (Kohatsu et al., 2000). The construct of cultural mistrust has

never been explored with Caucasians. In order to investigate cultural mistrust in Caucasians and minorities, the first research question examined by this study was to explore whether race influences cultural mistrust. Specifically, do Caucasians and minorities differ on cultural mistrust scores? The hypothesis that there would be a statistically significant difference between cultural mistrust scores of Caucasian and minority parents of children diagnosed with Autism was supported. Furthermore, the difference indicated that minority parents had a higher level of cultural mistrust.

While these results may add to the literature on cultural mistrust, due to the very small sample of minorities represented in this study (n = 34), results must be interpreted with extreme caution and cannot be generalized to minorities as a whole. Additional data is required to increase generalizability and more specifically, to decipher which ethnocultural group has the highest level of cultural mistrust.

Examination of Research Questions Two through Five

One statistical analysis was conducted to address questions two through five. The researcher attempted to determine if demographic variables and cultural mistrust influence how parents of children with Autism report agreeing with the diagnosis, acceptability of services, and comfort level with asking for additional services for their children.

Of the three dependent variables, comfort level with asking for additional services was significant. There was one main effect for race, with Caucasians reporting they are more comfortable asking for additional services than minorities. There were no main effect for level of education, cultural mistrust, or income level. There was also one

interaction effect for cultural mistrust and race. The interaction indicates that it is not only race, but also cultural mistrust (low or moderate) that influences the level of reported comfort for seeking additional services within a race. Level of cultural mistrust did not influence minorities' comfort level with asking for additional services; overall, they are not comfortable asking for services. However, for Caucasians, level of cultural mistrust does play a role in their comfort level with asking for additional services. Caucasians with lower levels of cultural mistrust reported being more comfortable asking for additional services, whereas those with moderate levels of cultural mistrust had lower levels of comfort. These results are likely due to the fact that those with a higher level of mistrust are doubtful of the system to begin with, and therefore will be less likely to ask for services from a system they do not trust. The interaction between race and cultural mistrust is also significant, because Caucasian parents who moderately trusted the system, felt less comfortable asking for services for their children.

The study yielded some interesting and unexpected results. While cultural mistrust was posited to influence the effect of race in parents' comfort level with asking for additional services, results show that regardless of their level of cultural mistrust, minorities are not comfortable asking for additional services for their children. To the researcher's knowledge, there are no studies specifically aimed at acceptance of services in the school setting, or willingness to ask for additional services, including counseling. However, in reviewing the research regarding counseling, the literature suggests that many African American clients seek mental health services as a last resort (Townes et al., 2009). Additionally, research has also shown that compared to Caucasians, African

Americans have a more negative attitude towards mental illness (Nickerson et al., 1994). Moreover, studies aimed at exploring minorities' mental health seeking attitudes, find that minorities are more likely than whites to delay or fail to seek mental health treatment and are more likely to terminate treatment prematurely (Dobalian & Rivers, 2008; McGuire & Miranda, 2008). Studies also show minorities are more likely to seek help if they believe the treatment is efficacious and if they find it to be necessary (Anglin et al., 2008). From this information, one might infer that while minority parents may be willing to accept services provided to their child as part of their Individual Educational Plan, they are not comfortable asking for more services due to the fact that they may not find that treatment is efficacious or necessary.

Strengths of the Study

The greatest strength of this study is that the researcher began to bridge a significant gap in the literature. This is the first known study to explore cultural mistrust in Caucasians and to examine the difference in level of cultural mistrust between Caucasians and minorities. The findings suggest that further inquiry into Caucasian's cultural mistrust is warranted. Additionally, the researcher was unaware of any studies aimed at investigating cultural mistrust in the schools as it relates to special education services for students with Autism.

The survey was distributed online across the United States, thus there was a nationally representative sample. The sample obtained for the current study was representative of the US population, in that 30% of Americans belong to a minority group

(Center for Disease Control, 2011), while 25% of study participants identified as minorities. Recruiting participants online helped to broaden the diversity of the overall sample. The researcher was not limited to individuals in one geographic area. Also, there was a wide range of ages represented; most participants reported being between the ages of 18 and 54.

Limitations of the Study

As with all research, there were several limitations to this study. The researcher attempted to bring to light various limitations related to sample size, methodology, and instrumentation.

Limitations Due to Sample

The sample size of this study presented some limitations. While the sample size of this study was adequate to conduct all of the analyses presented in this dissertation, a larger sample size would allow for more generalizability. Due to the sample size, demographic independent variables (level of education, household income, and race) have been collapsed to create new variables (level of education changed from twelve choices down to bachelor's degree or no bachelor's degree; household income from eight choices down to Less than 49,999; 50,000-99,999; Above 100,000, and race changed from 8 choices down to Caucasian or minority). These changes are viewed as problematic across all variables, particularly for race.

The majority of the literature regarding cultural mistrust has focused on African Americans' propensity to mistrust Caucasians (Alvarez et al., 2006; Phelps et al., 2001). The researcher was curious as to whether the same level of mistrust was found across

other ethnocultural groups. While the results indicated statistically significant differences in cultural mistrust between Caucasian and minority participants, the small sample size of minority participants made it difficult to decipher level of cultural mistrust between minority groups.

A larger sample size would also allow for a wider range in response pattern. For example, responses to the Cultural Mistrust Inventory (CMI) were calculated and placed into three categories, low, moderate, and high levels. However, none of the participants reported having a high level of cultural mistrust, thus low and moderate were the only levels included across all analyses. A larger sample size would have more than likely increased the range of responses and therefore created greater variety in response patterns.

In addition to size, a few other issues related to the sample should be noted. As previously discussed the majority of respondents self-identified as White or Caucasian (75.2%) and 89.4% of participants were female; thus the findings better relate to mothers of children with Autism rather than to parents in general. Interestingly, 40% of the sample reported a household income of over $100,000, which is significantly above the national average. According to the American Community Survey (ACS), in 2012, the median household income was $51,371 (U.S. Census Bureau, 2012). While income was not a statistically significant variable, it nonetheless affects the study's generalizability.

Limitations Due to Methodology

The study also presented some limitations in terms of methodology. Using the internet to collect data is convenient, in that it allows for easy access and can help

maintain participants' anonymity. However, internet research also poses its limitations. Participation is limited only to those with internet access; thus perhaps excluding low income participants. To access a large number of parents of children with Autism, emails requesting participation were sent to hundreds of Autism centers, support groups for Autism, and organizations focused on working with and supporting individuals with Autism. While this helped gain access to the targeted population it is likely that parents who seek these support groups agree with their child's diagnosis. Thus, the answers to the question regarding agreement with diagnosis did not have a wide range of responses, 80% responded to agree or strongly agree.

The CMI is strongly worded and may have affected the response pattern of some participants. In order not to appear biased or even racist, participants may have responded in a socially desirable way. Phillips and Clancy (1972) described social desirability as the propensity to answer questions in a way that is deemed socially appropriate. Social desirability can pose a significant limitation in collecting valid data regarding the construct of cultural mistrust. It is possible that participants may have endorsed even higher levels of cultural mistrust if the inventory was worded in a different manner. In order to avoid socially desirable responses, the researcher chose to conduct the study online in the hopes that increased anonymity would encourage participants to answer honestly. A study by Kiesler and Sproull (1986) concluded that when participants completed an electronic survey, they were less likely to answer in a socially desirable manner than when completing paper versions of the survey. Thus, using a computer

based electronic survey as a means of data collection, may be both a strength and limitation to the study.

The survey questions generated by the researcher to gather demographic information, as well as, parents' perceptions towards Autism and services may lack reliability and construct validity. Furthermore, several variables, which may have confounded the results of the study, were omitted from survey questions. Research has shown that males have a much higher rate of Autism than females (Centers for Disease Control, 2013). Symptom presentation has also been found to differ across gender (Fombonne, 2003; Sipes, Matson, Worley, & Kozlowski, 2011). The survey also failed to inquire into the level of functioning of the children represented in this study. Given that ASD is a spectrum disorder, individuals exhibit a wide range of symptoms. Additionally, as previously highlighted in the review of the literature, many children with ASD also present with intellectual disabilities (Jones & Harwood, 2009), thus impacting their overall level of functioning. The severity of Autism symptoms is likely to influence parents' perception of the accuracy of diagnosis and need for services in the school setting.

Implications for Research

While the previous sections outlined a number of limitations related to this study, the uniqueness of the research, along with some of the findings, can inspire future research. The insignificant findings may also be further investigated with a larger and more diverse sample. As previously mentioned, this study attempted to focus on a number of gaps in the literature regarding cultural mistrust, ethnicity, and psychological

services in the school. While the study provides a small glimpse into the influence of cultural mistrust, and race on parents' acceptance of services and comfort level with asking for additional special education services, there are a plethora of questions that remain to be answered. This study should first be replicated with a larger sample size. It is the opinion of the researcher that a larger percentage of minorities may yield significantly different results.

Most studies regarding cultural mistrust have focused specifically on African Americans. While this study expanded beyond African Americans, future research should focus on differences within minorities and attempt to decipher which ethnocultural group has the highest level of cultural mistrust. Second, future research should attempt to uncover why minorities did not feel comfortable asking for additional services for their children. A qualitative study, including focus groups with a number of minority parents can be conducted to thoroughly understand this phenomenon. The results of the current study did not indicate a main effect for level of education and household income, when combined with the other variables. However, it cannot be determined that income and education had no impact on individuals' comfort level with asking for additional services regardless of the other variables. Past research has suggested that parents with higher income are more likely to participate in their child's education (Gordon & Miller, 2003). Therefore, future research may want to analyze these variables in isolation. Additionally, a future study could focus on Caucasians and what contributes to their level of mistrust. While the results of this study indicated that minorities had a higher level of cultural mistrust, the researcher also found that

Caucasians with a moderate level of cultural mistrust were less comfortable asking for additional services than those with a low level of mistrust. Since cultural mistrust has not been studied in the Caucasian population, this would be an interesting area of research.

The current study did not inquire about the geographical location of participants. Previous research has supported regional differences in rates of Autism (Mandell & Palmer, 2005; Rosenberg, Daniels, Law, Law, & Kaufmann, 2009). In addition, racial and ethnic differences in physician distrust were found to vary based on geographical location (Armstrong, Ravenell, Mc Murphy, & Putt, 2007). A study focused on geographic differences in cultural mistrust of parents of children with ASD may yield valuable results.

Furthermore, future research could investigate the variability amongst parents of children with different diagnoses on agreeability with diagnosis, acceptability of services, and level of comfort with asking for additional services. Lastly, research indicates minority children are diagnosed with ASD at a later age than Caucasian children, and that Hispanic children are less likely than Caucasians to display symptoms of ASD (Mandell et al., 2007; Mandell et al., 2009). Subsequent research could be dedicated to investigating the variety of data collected, but not included in this dissertation (i.e., age of parent and age of child at diagnosis).

Implications for School Psychology

The knowledge that minority parents of children with Autism have a higher level of cultural mistrust than Caucasian parents, presents significant implications for the field and practitioners in the schools. For this study, 73% of parents reported that most of the

professionals at their child's school are White. According to the American Psychological Association, only 1.9 percent of psychologists are identified as Black or African American (Townes et al., 2009). Moreover, in 2010, the National Association of School Psychologists (NASP) reported 90.7% of school psychologists self-identified as Whites, while 3% identified as African Americans, 3.4% as Hispanic, and 1.3% as Asian (Castillio, Curtis, Chappel, & Cunningham, 2011).

These data indicate that more than likely, the minority parents with moderate levels of cultural mistrust are being served by Caucasian professionals in the schools. The counseling literature suggests cultural mistrust on the part of African Americans often leads to negative attitudes towards White mental health workers and a preference for same-race, African American clinicians (Nickerson et al., 1994; Townes et al., 2009; Thomson et al., 1994). Cultural mistrust also leads to early termination of the therapeutic relationship (Terrell & Terrell, 1984). Moreover, Ahluwalia (1990) researched parents' attitudes towards mental health services for their children and found that African American parents with high levels of cultural mistrust were less likely to seek mental health services. In other words, research affirms that cultural mistrust in African Americans leads to a higher level of negative help-seeking behaviors in regards to mental health services (David, 2010). Even though the small minority sample in this study did not allow the researcher to analyze levels of cultural mistrust across ethnic groups, this information is, nonetheless, important.

When seeking counseling services, parents are often free to choose their providers. In a school setting, children receive services from whomever the school

district has chosen to hire. If parents' levels of cultural mistrust interfere with their satisfaction with the school psychologist and services being provided through special education, they have no choice but to continue working with that individual. Practitioners who expect to be successful in working with children and parents of different ethnic groups must be aware of the construct of cultural mistrust, its deleterious effects, and its likelihood to impede progress. Furthermore, results of this study indicate that minority parents are not comfortable asking for additional services and that Caucasian parents with moderate levels of mistrust are less likely to seek extra services. With this knowledge, school psychologists can advocate for parents.

Conclusion

The current study explored the construct of cultural mistrust across racial groups and whether cultural mistrust affected a number of variables related to special education services. Particularly, the researcher sought to investigate if Caucasians and minorities differentiated in their levels of cultural mistrust, and if demographic variables (race, level of education, household income) and cultural mistrust influence how parents report agreeability with the diagnosis of ASD, acceptability of services offered, and comfort level with asking for additional services in the school setting. The researcher found that minority parents of children with ASD had a statistically significantly higher level of cultural mistrust than Caucasian parents. Although minorities had higher levels of cultural mistrust, due to sample size, it was not possible to deduce which specific ethnocultural minority group had the highest level of cultural mistrust. Thus, these

results must be interpreted with caution and generalization to any specific minority group avoided until additional data can support the findings.

Current findings also suggest that while minority parents may willingly accept services for their child, regardless of cultural mistrust, they may not be comfortable with asking for additional services. Lastly, results of the study suggest that cultural mistrust affects Caucasian parents' comfort level with asking for more services. White parents with moderate levels of cultural mistrust are less comfortable with asking for additional services for their child, when compared to those with low levels of mistrust.

Continuing to research cultural mistrust across ethnocultural groups is essential to the field of school psychology. Unlike selecting a provider in the private sector, parents are unable to choose who provides services in the school; therefore, it is imperative that school psychologists understand the construct of cultural mistrust. This information can assist school psychologists to become aware of how cultural mistrust can create a barrier to providing adequate services for children. Often parents must advocate for their child's needs. However, if they are not comfortable doing so due to lack of trust in the school service providers, the burden may be upon the school psychologist to advocate for their student, rather than empowering the parent. The role of school psychologists should be to serve as a liaison between the school and home, ensuring that services are provided in the best interest of the student. Thus, the knowledge gained from this study can help school psychologists embolden parents to fully invest in the educational programing of their child.

This study also explored the construct of cultural mistrust with Caucasians. Results indicate that for White parents of children with autism, their level of cultural mistrust influences their comfort level with asking for additional services in the schools. Since no research has previously been conducted on cultural mistrust and Caucasians, further investigation is needed to better understand the implications of these results, more specifically, well as how cultural mistrust is manifested in the Caucasian population. The findings of this research project have implications for both research and the practice of school psychology.

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APPENDIX A

Consent to Participate in Research

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title: Cultural Mistrust

Investigator: Kathy DeOrnellas, PhD..... KDeOrnellas@twu.edu
940/898-2315

Explanation and Purpose of the Research

You are being asked to participate in a faculty research study conducted by Kathy DeOrnellas, PhD at Texas Woman's University. The purpose of this study is to look at differing levels of parental mistrust of people from different cultural backgrounds and the possible implications this mistrust may have on diagnoses and related services for mental health. You have been asked to participate in this study because you are the parent of a child with autism and/or attention deficit/hyperactivity disorder (ADHD).

Description of Procedures

As a participant in this study you will be asked to spend approximately 25 minutes of your time completing an online survey. The survey asks questions about your family, your child, and your views on various cultural/racial issues. In order to be a participant in this study, you must be at least 18 years of age or older and be the parent of at least one child that has been diagnosed with either autism or ADHD.

Potential Risks

The survey will ask you questions about your family and your thoughts on sensitive cultural and/or racial topics. A possible risk in this study is that you may feel uncomfortable answering some of these questions. If you become tired or upset you may take breaks as needed. You may also stop answering questions at any time and end the survey. If you feel you need to talk to a professional about your discomfort, the researcher has provided you with a referral source.

Another possible risk in this study is loss of confidentiality. Confidentiality will be protected to the extent that is allowed by law. You may take the survey at a private location on a computer of your choice. You will not be asked to give your or your child's name. Your responses to the survey will be collected on a secure server and the principal investigator will not know who completed the survey. All of the responses to the survey will be deleted from the server within three months of the end of the survey. The results of the study will be reported in journal articles or in a book but your names or any other identifying information will not be included.

The researcher will try to prevent any problem that could happen because of this research. You should let the researcher know at once if there is a problem and she will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Participation and Benefits

Your involvement in this study is completely voluntary and you may withdraw from the study at any time. There are no financial benefits for participating in this study.

Questions Regarding the Study

If you have any questions about the research study you should ask the researcher; her phone number is at the top of this form. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Texas Woman's University Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu.

APPENDIX B

Minority Survey

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 C

Caucasian Survey

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title: Cultural Mistrust

Investigator: Kathy DeOrnellas, PhD..... KDeOrnellas@twu.edu
940/898-2315

Explanation and Purpose of the Research

You are being asked to participate in a faculty research study conducted by Kathy DeOrnellas, PhD at Texas Woman's University. The purpose of this study is to look at differing levels of parental mistrust of people from different cultural backgrounds and the possible implications this mistrust may have on diagnoses and related services for mental health. You have been asked to participate in this study because you are the parent of a child with autism and/or attention deficit/hyperactivity disorder (ADHD).

Description of Procedures

As a participant in this study you will be asked to spend approximately 25 minutes of your time completing an online survey. The survey asks questions about your family, your child, and your views on various cultural/racial issues. In order to be a participant in this study, you must be at least 18 years of age or older and be the parent of at least one child that has been diagnosed with either autism or ADHD.

Potential Risks

The survey will ask you questions about your family and your thoughts on sensitive cultural and/or racial topics. A possible risk in this study is that you may feel uncomfortable answering some of these questions. If you become tired or upset you may take breaks as needed. You may also stop answering questions at any time and end the survey. If you feel you need to talk to a professional about your discomfort, the researcher has provided you with a referral source.

Another possible risk in this study is loss of confidentiality. Confidentiality will be protected to the extent that is allowed by law. You may take the survey at a private location on a computer of your choice. You will not be asked to give your or your child's name. Your responses to the survey will be collected on a secure server and the principal investigator will not know who completed the survey. All of the responses to the survey will be deleted from the server within three months of the end of the survey. The results of the study will be reported in journal articles or in a book but your names or any other identifying information will not be included.

The researcher will try to prevent any problem that could happen because of this research. You should let the researcher know at once if there is a problem and she will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Participation and Benefits

Your involvement in this study is completely voluntary and you may withdraw from the study at any time. There are no financial benefits for participating in this study.

Questions Regarding the Study

If you have any questions about the research study you should ask the researcher; her phone number is at the top of this form. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Texas Woman's University Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu.

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
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Student Information

1. Age of **child**
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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
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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.

ADDPENDIX D

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. Meroudjie Denis
Department of Psychology & Philosophy

FROM: Institutional Review Board - Denton

Re: *Exemption for Implications of Cultural Mistrust on Diagnosis and Services for Students with Autism (Protocol #: 17737)*

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