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“Is therapy for me?” Perceptions of Therapy Inclusivity and Willingness to Seek Help among
Black Emerging Adults

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of
Philosophy at Virginia Commonwealth University

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Abstract

“Is therapy for me?” Perceptions of Therapy Inclusivity and Willingness to Seek Help among Black Emerging Adults

By: Randl B. Dent, M.S.

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University

Virginia Commonwealth University, 2020

Director: Nao Hagiwara, Ph.D.
Associate Professor of Psychology
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Mental health issues are prevalent among Black emerging adults; however, they tend to underutilize mental healthcare services. The goals of the current study were to examine whether: (1) perceived therapy inclusivity would predict willingness to utilize mental healthcare services and (2) the relationship between perceived therapy inclusivity and willingness would be moderated by two indices of racial identity (i.e., centrality and private regard). Results provide evidence that greater perceptions of therapy inclusivity are associated with greater willingness to seek mental health services even after controlling for factors, such as gender, self-stigma, and previous mental healthcare utilization. Additionally, there was no evidence to suggest that racial identity moderates the relationship between perceived therapy inclusivity and willingness to use mental health services. These findings suggest that Black emerging adults may be more willing to utilize mental health services and engage with the mental healthcare system if they perceive that mental health services are for them. Findings from this dissertation project have implications for clinical practices to increase Black adults’ perceptions of therapy inclusivity. Recommendations include developing trainings about Black people’s experiences in the mental health system, building relationships with Black communities, and providing culturally

responsive treatments. The findings also have policy implications. Specifically, structural changes (e.g., increasing Black adults' representation in clinical staff and leadership) must be made to the mental healthcare system to increase Black adults' perceptions of therapy inclusivity and willingness to seek care. Such intentional measures will help to create a better, more inclusive system for all Black adults.

“Is therapy even for me?” Perceptions of Therapy Inclusivity and Willingness to Seek Help among Black Emerging Adults

Introduction

From its inception, the mental healthcare system in America has been characterized by exclusion, mistreatment and misdiagnosis for Black Americans (Davis, 2018; Jackson, 2001; Logan, Denby, & Gibson, 2007). Currently, the system is plagued by a lack of Black mental health professionals and culturally-responsive treatments for Black Americans (American Psychological Association, 2018; Leong & Kalibatseva, 2011; Murray & Hairston, 2017). Consequently, mental healthcare utilization rates are substantially lower for Black Americans than they are for White Americans (Alegria et al., 2002; De Luca, Blosnich, Hentschel, King, & Amen, 2016; McGuire & Miranda, 2008), even though incident rates for any mental illness only slightly differ or are similar between the populations (Breslau et al., 2006; Substance Abuse and Mental Health Services Administration [SAMHSA], 2015).

This trend of underutilization of mental healthcare services among Black Americans is consistent even in a pivotal developmental stage, such as emerging adulthood (Broman, 2012; Ketchen Lipson, Kern, Eisenberg, & Breland-Noble, 2018). Black American¹ emerging adults underutilize mental healthcare services, even though prevalence rates are similar to that of other racial groups (Broman, 2012). This has important implications because untreated mental illnesses can perpetuate social and economic inequities (Burns, 2009). Given the history of mistreatment and underutilization of mental health services by Black adults, it is reasonable to

¹ For this paper, the term Black American is inclusive of both U.S.-born and non-U.S.-born Black individuals. African American refers to U.S.-born Black people. Caribbean Black refers to Black adults of Caribbean Descent (Williams et al., 2007). In the majority of the research on people of African descent in the U.S., non-U.S. born Black individuals and African Americans are collapsed into one category: Black/African American.

consider Black Americans as an underserved population in the mental healthcare system (Briggs, Briggs, Miller, & Paulson, 2011).

There has been some research investigating factors influencing mental and physical healthcare utilization in the emerging adult population (Bonnie, Stroud, & Breiner, 2014). However, the racial disparities reported in the mental healthcare utilization literature suggest that there may be unidentified barriers that contribute to the underutilization of mental healthcare services among Black emerging adults. One potentially important barrier might be Black emerging adults' perceptions of therapy inclusivity (i.e., the extent to which Black people perceive that therapy is meant for them or people who look like them). Drawing on two lines of research, critical race theory (Ford & Airhihenbuwa, 2010; Graham, Brown-Jeffy, Aronson, & Stephens, 2011) and identity-based motivation theory (Oyserman, Fryberg, & Yoder, 2007; Oyserman, Smith, & Elmore, 2014), the present study examines the role of perceptions of therapy inclusivity in the underutilization of mental healthcare services among Black emerging adults.

Mental Health and Mental Health Service Use of Black American Populations

Some research has indicated that non-Hispanic Black Americans have lower lifetime risk of a psychiatric disorder than their non-Hispanic White counterparts (Breslau et al., 2006; Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005). However, according to the Office of Minority Health, non-Hispanic Black Americans are 10% more likely than non-Hispanic White Americans to report having serious psychological distress (U.S. Department of Health and Human Services Office of Minority Mental Health, 2017). The National Center for Health Statistics (National Center for Health Statistics [NCHS], 2015) also reported that non-Hispanic Black Americans reported experiencing symptoms of serious psychological distress 3.4 days out

of the last 30 days, while non-Hispanic White Americans reported 3.2 days (NCHS, 2015). In this report, serious psychological distress was measured by a six-item scale that asked survey respondents how often they experienced six symptoms of psychological distress in the past 30 days.

The prevalence of generalized anxiety disorder, panic disorder and social anxiety has been found to be lower among Caribbean Black and African American adults compared to White Americans (Himle, Baser, Taylor, Campbell, & Jackson, 2009). However, in the same study conducted by Himle and colleagues (2009), they also found that Caribbean Black and African American respondents were more likely to meet the criteria for posttraumatic stress disorder. Additionally, when Caribbean Black and African American survey respondents did meet the criteria for one of the anxiety disorders listed above, they were more likely to experience greater severity in symptomology and functional impairment from their disorder, compared to White Americans (Himle et al., 2009).

Additional studies have found a similar trend for depression disorders (Breslau et al., 2006; Williams et al., 2007). For example, Williams and colleagues (2007) found that lifetime prevalence of major depressive disorder (MDD) was higher for White Americans (17.9%), compared to Caribbean Black (12.9%) and African Americans adults (10.4%). However, similar to the experience of anxiety disorders, the severity and disabling nature of MDD was worse for Caribbean Black (56.0%) and African American adults (56.5%), compared to White adults (38.6%). Importantly, most Caribbean Black and African American adults with MDD did not receive treatment for their depression disorder. Only 24.3% of Caribbean Black adults and 45% of African American adults received therapy treatment for their MDD. No data were collected on

treatment from White Americans in the National Survey of American Life (Williams et al., 2007).

Furthermore, research consistently demonstrates that Black Americans are more likely than White Americans to delay or fail to seek mental healthcare services (Alegría et al., 2002; Sussman, Robins, & Earls, 1987; Wang et al., 2005). Alegría and colleagues (2002) examined the use of special mental health services (i.e., “treatment by a psychiatrist, psychologist, psychotherapist, or treatment by any professional in a specialty mental health setting”, pg. 1548) among African Americans, Hispanic Americans and non-Hispanic White Americans. They found that non-Hispanic White adults reported the highest proportion of specialty mental healthcare utilization (11.8%), followed by African Americans (7.2%) and then Hispanic adults (5.9%). Additionally, Alegría and colleagues (2002) provided evidence that African American and Hispanic adults had lower odds of utilizing mental healthcare services, compared to non-Hispanic White adults, even after accounting for income, geographic location, and zone of residence. For African Americans, this trend continued even after accounting for psychiatric illness and disability. This suggests that compared to White adults, both Black and Hispanic adults are less likely to utilize mental health services, even after accounting for various sociodemographic factors.

Moreover, the Substance Abuse and Mental Health Services Administration (SAMHSA)’s most recent report on racial/ethnic differences in mental health service use indicated that only 8.6% of Black adults reported utilizing mental health services in the past year, compared to 16.6% of White adults (SAMHSA, 2015). However, Black adults (1.4%) were twice as likely to have used an inpatient mental health service, compared to White adults (0.7%). One probable reason may be because Black adults are more likely to delay utilizing mental

health services until symptoms are so severe that inpatient services are the appropriate course of care (SAMHSA, 2015). Taken together, these findings provide evidence that Black Americans may be less likely to utilize mental health services than their White counterparts and this trend may also be seen in the Black emerging adult population.

Emerging Adulthood as an Important Developmental Period

Description of Emerging Adulthood. Emerging adulthood, a term coined by Jeffrey Arnett in 1999, encompasses adults aged 18 to 29, with a specific focus on those aged 18 to 25 (Arnett, 2006). The current study uses this definition of emerging adulthood and focuses on emerging adults aged 18 to 29. At this stage, generally individuals are beginning their post-secondary education or entry into the workforce, initiating serious intimate relationships, forming families, and solidifying career paths (Arnett, 2006; Newman & Newman, 2011).

By and large, emerging adults are negotiating a greater number of responsibilities than was necessary in adolescence. Emerging adults may be entering into the workforce and experimenting with potential job options while others are enrolling in college. Some may live on their own and others may still live with their parents (Arnett, 2006). Because of the important life changes occurring during emerging adulthood, utilization of mental healthcare services is particularly important. In fact, it is during this developmental period when most serious psychological disorders are usually diagnosed (de Girolamo, Dagani, Purcell, Cocchi, & McGorry, 2011; Kessler et al., 2005). These changes may partially explain their increased risk for the onset of serious psychological disorders during this time (Arnett, 2000).

Healthcare Utilization among Emerging Adults. Compared to all other groups, emerging adults have the lowest rates of healthcare utilization, regardless of race (Bonnie et al., 2014). Within the emerging adult population, older emerging adults are more likely to be

uninsured than younger emerging adults (Cohen, Martinez, & Zammitti, 2018); this may be particularly true after the passing of the Affordable Care Act, which allowed adults aged 18 to 26 to stay on their parents' insurance (Keith, 2018). For example, in 2017 and 2018, adults in the 18-24 age group were more likely to be insured compared to adults in the 25-34 age group. Adults aged 25 to 34 are more likely to be uninsured than any other age group among non-elderly adults (Berchick, Hood, & Barnett, 2018; Cohen et al., 2018; Keith, 2018). Older emerging adults fall into this latter age category (Arnett, Žukauskiene, & Sugimura, 2014).

One study found that for those with mental health conditions, the psychiatric service utilization falls from 20% of adolescents to about 10% of emerging adults, suggesting an increase in untreated cases of mental health disorders during the transition from adolescence to adulthood (Copeland et al., 2015). Additionally, behavioral healthcare utilization is lower among younger adults compared to children and older adults (Pottick, Warner, Stoep, & Knight, 2014). Additionally, emerging adults, compared to mature adults, are more likely to terminate outpatient therapy earlier than recommended (Bonnie et al., 2014; Edlund et al., 2002). Taken together, emerging adults face expected stressors based on developmentally appropriate life changes; however, they generally underutilize mental healthcare services during this time and may have variable health insurance statuses.

One important subset of the emerging adulthood population are those who are currently enrolled in college. Current college students may experience stressors that are specific to being on a college campus (Greer & Brown, 2011; Mushonga, 2019). Importantly, research indicates that many college students have access to free or low cost mental health services on campus (Gallagher, 2014). However, despite the availability and apparent access to services, college students still underutilize mental healthcare on campus and this is particularly true for

Black college students (Eisenberg, Hunt, Speer, & Zivin, 2011). This suggests that access to mental healthcare does not always lead to utilization in this population, and that there may be other important factors preventing Black college students from seeking professional mental health services. Importantly, students who have utilized mental health services on college campuses have reported that counseling services helped them improve their academic performance and stay in school (LeViness, Bershad, Gorman, Braun, & Murray, 2019). These findings emphasize the necessity of students having access to, and utilizing, equitable mental health services, not only for their mental health and well-being but also for their retention on college campuses.

Black emerging adults comprise another important subset of this developmental population. In addition to normal stressors, Black emerging adults may also face stressors specific to their experience of being Black in America that may affect their mental health. While facing these challenges, Black emerging adults are also at risk for underutilizing mental health services and being uninsured.

Mental Health Challenges for Black Emerging Adults in the Age of “Black Lives Matter.” Though emerging adulthood can be stressful regardless of an individual’s race or ethnicity, it may be particularly so for Black emerging adults who are coming of age in this sociohistorical moment as they may face additional stressors on top of the usual developmentally appropriate challenges. In the U.S., Black emerging adults are forming their identities, building careers, and starting families all while being Black in America. They are seeing Black Americans attacked and killed by police on nationally televised networks, social media platforms, and news sites (Bailey, 2017). They are seeing or experiencing the fact that Black maternal and child mortality rates are more than three times that of White women (Villarosa, 2018). They may face

racism in their everyday interactions (at school, work, and in healthcare settings) with others and within our societal systems (Green, 2016; Mays, Jones, Delany-Brumsey, Coles, & Cochran, 2017). The cumulative effect of witnessing or experiencing these events may result in race-related stress—stress associated with the experience of racism and discrimination that Black individuals in America face (Utsey, Payne, Jackson, & Jones, 2002).

Discrimination has been found to be associated with higher stress and poorer mental health among racial/ethnic groups (Williams, Lawrence, & Davis, 2019; Williams & Mohammed, 2013; Williams & Williams-Morris, 2000). Race-related stress, specifically, has been associated with depression, anxiety and feelings of hopelessness (Jones, Cross, & DeFour, 2007; Odafe, Salami, & Walker, 2017). For example, Black Americans witnessing or experiencing chronic police brutality are more likely to experience high levels of stress and have an increased likelihood of depression, anxiety, and PTSD, as well as other stress-related illnesses (Bryant-Davis, Adams, Alejandre, & Gray, 2017; Ford, Chapman, Connor, & Cruise, 2012). In response to these experiences of structural and interpersonal discrimination, many Black adults aged 18 to 29 are engaging in more activism against systems of oppression as they enter emerging adulthood (Hope, Gugwori, Riddick, & Pender, 2019).

Although there is some evidence that such activities are associated with well-being (Klar & Kasser, 2009), continued or prolonged activism still can have negative consequences, such as increased stress and anxiety, for Black emerging adults (Eligon, 2018; Hope, Velez, Offidani-Bertrand, Keels, & Durkee, 2018). Given these pervasive stressors, Black emerging adults may be at particular risk for experiencing mental health problems. Thus, it is especially imperative that researchers, policymakers, communities and health systems explore the factors that

influence the mental health and use of mental health services in the Black emerging adult population.

Mental Health and Use of Mental Health Services among Black Emerging Adults

Compared to research on the general adult population, there is limited research around the prevalence rates of mental health disorders among emerging adults (Eisenberg, Hunt, & Speer, 2013; Hunt & Eisenberg, 2010; Jackson et al., 2004). One study with a nationally representative sample of college students found that Black students had a higher prevalence rate of depression, but a lower rate of non-suicidal self-injury, compared to White students (Eisenberg et al., 2013). For anxiety disorders the rates between Black and White students were similar in prevalence, and there was no significant difference between Black and White students in functional impairments caused by mental health symptoms (Eisenberg et al., 2013). These findings are inconsistent with previous studies among the general Black population indicating that Black Americans experienced greater severity and functional impairment from a mental health disorder (Williams et al., 2007). Jackson and colleagues (2004) found that Black emerging adults actually had higher 12-month rates of major depression than White emerging adults. This suggests that there is a specific need to examine mental health and utilization in Black emerging adults, because it may be different from the trends seen in the general Black population.

Underutilization of mental health services may be particularly prevalent in the Black emerging adult population (Broman, 2012; Eisenberg et al., 2011). For example, Eisenberg and colleagues (2011) found that in the overall student population, Black college students were significantly less likely than White college students to utilize medication or therapy for mental health in the past year and currently. Specifically, 15.5% of Black students reported use of medication or therapy in the past year, compared to 24.2% of White students. In regard to current

use, 7.4% of Black students reported use of medication or therapy, compared to 14.2% of White students. This trend, seen in the overall student population, was also seen among college students with a mental health problem (Eisenberg et al., 2011). Among students with a mental health problem, 25.9% of Black students, compared to 39.9% of White students, reported use of medication or therapy in the past year and 11.5 % of Black students, compared with 25% of White students, reported current use of medication or therapy. Ketchen Lipson and colleagues (2018) conducted a nationally representative survey and found that among college students with a mental health problem, compared to White college students, Black college students had 73% lower odds of being diagnosed. Importantly, the mental health of and use of mental health services by Black emerging adults in the present day is influenced by the history of Black Americans' experiences in the mental healthcare system.

History of the Black American Experience within the Mental Health System

To understand the factors that may contribute to the underutilization of mental healthcare services among Black emerging adults, it is important to, first, understand the historical context. There is a long history of mistreatment of Black Americans in medical and mental health settings that has contributed to the attitudes toward mental health and mental health help-seeking among Black Americans in the present day. From 1700 to 1840, enslaved people of African descent were thought to be immune to mental illness (Davis, 2018). Dr. John Galt, a medical director at an asylum in Virginia, theorized that their immunity to mental illness was due to them not being “exposed to the stresses of profit making,” such as owning property, engaging in the workforce, and participation in voting or holding offices, which were rights only for full citizens. Thus, using this “immunity hypothesis” the people most at risk for “lunacy” or mental illness were

wealthy white men. This same sentiment is seen in the present attitudes of Black Americans, with many stating that Black people don't get depression or anxiety (Alang, 2016).

After the 1840 census, White American views of mental health issues among enslaved Africans shifted. Specifically, enslaved Africans were allowed to be admitted to the Eastern Lunatic Asylum in Virginia (though this was not commonplace in other states), indicating a recognition that people of African descent could experience mental illnesses. However, admission was granted only under the following conditions: (1) their owner (or a person “who held jurisdiction over them”) gave permission for the admission ; (2) their owner agreed to pay for their course of care while at the asylum; and (3) the admission to enslaved Africans could not deny or compromise treatment for White admitted patients (Davis, 2018). In the north, data from the 1840 census was used to claim that free Black people in the north were experiencing significantly higher rates of mental illness than enslaved Africans in the southern states. However, this theory neglected to recognize that the vast majority of asylums were not allowed to grant admission to enslaved Africans by law (Davis, 2018). Taken together, both northern cities and southern rural states created a narrative that free people of African descent were unable to manage their freedom (Jackson, 2001).

This narrative likely encouraged some physicians to argue that people of African descent had mental health issues that differed from White Americans. For example, Dr. Samuel Cartwright outlined two specific disorders: drapetomania (i.e., the disease causing enslaved Africans to run away) and dysaesthesia aethiopica (i.e., a disease affecting both the mind and body and causing lethargy and lesions; (Jackson, 2001; Logan et al., 2007). These physicians used medicine and diagnoses to “pathologize a human instinct for freedom and dignity” (Jackson, 2001, pg. 8) in order to continue to uphold slavery as necessary and even beneficial to

the mental and physical health of enslaved Africans in America (Jackson, 2001). In this way, mental illness, diagnoses and treatments were used as a tool to uphold white supremacy. This constituted the shift from the “immunity hypothesis” to the “exaggerated risk hypothesis.” The exaggerated risk hypothesis stated that if enslaved Africans were freed that they would suffer significantly from mental illness and become dependent upon the government and extremely dangerous (Davis, 2018).

Additionally, treatment of Black Americans in the mental healthcare system was horrific in many cases. For example, in 1868, the Freedmen’s Bureau negotiated with Virginia policymakers to have the first mental institution for Black people in America, the Central Lunatic Asylum for the Colored Insane (renamed Central State Hospital in 1895). The quality of care provided to residents of the asylum was poor from its establishment, as the state was not willing to allocate funding given that the Black asylum residents there were not a priority (Jackson, 2001). There were reports of cruel treatment of patients; admitted patients at Central State Hospital were the “bedrock of the institution’s labor force” (Jackson, 2001, pg. 13). They were used to grow and cook food, do laundry, and were sometimes even sent to do work at the homes of some of the hospital staff and community residents. In this way, it was a continuation of slavery. The hospital was segregated until 1968 and was the only hospital that granted admission to African Americans in Virginia.

During the twentieth century, Black adults continued to receive inferior treatment and severe mental health diagnoses (Logan et al., 2007). Some early twentieth century research showed that Black individuals had “higher rates of insanity” than White Americans (Logan et al., 2007). This is in contrast to present-day studies, indicating that Black and White adults have similar prevalence of mental health disorders and sometimes Black adults have a lower lifetime

risk for most mental health disorders (Breslau et al., 2006). Despite this, many African Americans are more likely to be and have been diagnosed with schizophrenia rather than depression (Baker & Bell, 1999; Gara, Minsky, Silverstein, Miskimen, & Strakowski, 2019; Schwartz & Blankenship, 2014), indicating a trend of misdiagnosis that has continued into the present. This historical account provides evidence that the U.S. mental healthcare system was explicitly built to cater to wealthy White men, while excluding people of African descent until they were deemed too dangerous as freed persons. These actions justified the creation of an under-resourced and inferior mental healthcare system for Black Americans (Briggs et al., 2011). The legacy of these two hypotheses (i.e., “immunity hypothesis” and “exaggerated risk hypothesis”) has continued to impact the experiences of Black Americans to the present day.

Another important historical factor relevant to the current (under)utilization of mental healthcare services among Black Americans is medical mistrust (i.e., a lack of trust in medical providers and the medical system). The U.S. healthcare system has a long and storied history of mistreating and exploiting Black people (Feagin & Bennefield, 2014; Gamble, 1993; Skloot, 2010). An example of this is the Tuskegee Syphilis Study, one of the most well-known instances of government experimentation on Black citizens. The Tuskegee Syphilis Study was a government-run experiment during which nearly 400 Black men from Alabama were intentionally denied effective treatment for syphilis in order to understand what the full progression of the disease looked like (Gamble, 1997). Similarly, Henrietta Lacks was exploited by the American healthcare and research system. Ms. Lacks was diagnosed with cervical cancer and underwent a biopsy procedure to collect cancer cell samples during the course of her treatment. Her cancer cells, also known as HeLa cells, were used by researchers without her consent. Dr. Gey, a prominent pathologist, even told other researchers in his lab that the cells

were taken from a woman named “Helen Lane,” attempting to erase the great contribution Ms. Lacks had made to the field of medicine (Hassan, 2018). HeLa cells have been used to develop an effective vaccine for polio and many other diseases and are still used in present-day cancer research (Skloot, 2010). Researchers made and continue to make large sums of money based on the discovery of her cells (Feagin & Bennefield, 2014; Skloot, 2010). This experimentation on Black citizens “set a white model for later discriminatory experimentation and treatment” (Feagin & Bennefield, 2014, pg. 9) and such mistreatment and experimentation has led to a culture of medical mistrust in Black communities (Sabin, Nosek, Greenwald, & Rivara, 2009).

This long history of medical mistreatment of Black Americans and warranted mistrust in medicine has been passed down from generation to generation within Black communities (Harrell, 2000), which has contributed to the development of mistrust in the medical system in general among Black Americans in our present-day society. This historical context is necessary for understanding Black Americans’ attitudes toward utilizing mental healthcare and their perceptions of the inclusiveness of therapy services and the mental healthcare system.

Implications of Historical Perceptions of Black Mental Illnesses and Medical Mistrust

The consequences of inaccurate perceptions of Black mental illness underlie the current-day attitudes of Black Americans toward use of mental health services, such as the belief that Black people do not get mental illness and professional help-seeking is for mainstream society (Alang, 2016; Campbell & Long, 2014; Mishra, Lucksted, Gioia, Barnet, & Baquet, 2009) . There are cascading effects of the mistreatment that Black Americans have experienced in the medical and mental healthcare systems. Historical medical mistrust may have contributed to both a preference for seeking informal care (Williams & Cabrera-Nguyen, 2016) as well as a present-day lack of trust in the healthcare system (Lee, Ayers, & Jacobs Kronenfeld, 2009; Mishra et al.,

2009). Because of this warranted mistrust of healthcare systems, there is a current lack of diversity in clinical trials and lack of culturally sensitive treatment (Ayonrinde, 2003; Davey & Watson, 2008; Mak, Law, Alvidrez, & Pérez-Stable, 2007).

Lack of culturally sensitive treatment is highlighted in the experiences of current Black mental health professionals, who have said that “mental health models are not adapted to families of color and their structure and their needs” (Hackett, 2014, pg. 21). Additionally, they noted concerns about proper diagnoses for Black Americans, as the Diagnostic and Statistical Manual of Mental Disorders (DSM) was created by and for the dominant racial group (i.e., White Americans). When individuals do not meet the norms as described by the DSM, they are considered to be abnormal, even when that may be normal or protective for their racial and cultural background (Whaley, 2001). For example, because Black Americans have been discriminated against and oppressed in U.S. society, some have developed a cultural mistrust (e.g., distrust of White Americans because of direct or indirect exposure to racism or discrimination; Trinh et al., 2019). Sometimes this cultural mistrust which has been protective to Black Americans can be misdiagnosed as clinical paranoia (Mosley, Owen, Rostosky, & Reese, 2017; Trinh et al., 2019; Whaley, 2001). These narrow perspectives may allow for important cultural factors to go unseen and unknown by mental healthcare providers who are responsible for assigning appropriate diagnoses (Briggs et al., 2011). Another respondent also stated that DSM is specifically based on White men and thus “we are basing everyone else off of White men” (Hackett, 2014, pg. 26).

Current evidence-based treatments have not been developed for and tested with Black Americans and other racial and ethnic populations (Briggs et al., 2011). The DSM and mental health treatments, like the mental healthcare system, was built and based on the experiences and

needs of the majority (i.e. the White American population). In the U.S., Black people devised their own guidelines for interacting with mainstream society in order to cope with discrimination, prejudice, and lack of cultural sensitivity in their daily lives (Cooper-Patrick et al., 1999; Davey & Watson, 2008). The historical mistreatment and misdiagnosis of Black Americans by the mental healthcare system are connected to the factors that presently contribute to mental healthcare utilization in the Black emerging adult population (e.g., lack of trust in providers and preference for seeing informal care).

Factors Contributing to Mental Healthcare Utilization among Black Emerging Adults

“Jovita said she would never have gone to therapy had she not met Shirley, her African-American therapist. She didn’t believe therapy was for people like her. It was only for rich White people. She was surprised that an African-American woman was even in the profession. She didn’t believe that a White therapist could possibly understand some the issues she faced” (Kaiser, 2008, p. 54).

The lack of culturally sensitive treatment due to the unique historical context of African Americans likely contributes to two attitudes related to mental illness and seeking care for mental distress seen in Black populations: (1) they do not suffer from mental illness and (2) even if they did, they would not seek mental healthcare services because that is something that White people do. These two types of fundamental attitudes may further manifest in a number of potential barriers to utilization of mental healthcare among Black adults. Below, I provide brief reviews of those potential barriers.

“We don’t suffer from mental illness”. For some Black Americans, there is a belief that Black people do not have mental illness and those that do lack “inner strength” or have made themselves “mentally ill by choosing to give into problems” (Alang, 2016; Campbell & Long,

2014; Mishra et al., 2009). For example, interviewees from a mid-Western U.S. city revealed that they believed depression was a sign of weakness and that it was not a legitimate sickness, like heart failure (Alang, 2016). In addition to providing evidence that Black Americans believe depression is weakness, it also shows a stark disparity between how physical and mental health are prioritized. This view of depression as weakness made some Black adults feel like they had to get better without help and if they could not that there was something wrong with them (Campbell & Long, 2014). This belief is consistent with some culturally-specific expectations within Black American communities.

For Black women, many ascribe to the Strong Black Woman/Superwoman (SBW) schema (Watson & Hunter, 2016; Woods-Giscombé, 2010). The SBW schema is thought to stipulate a set of both cognitive and behavioral expectations for Black women, which include “standing up for oneself, exhibiting self-reliance and taking care of others” (Watson & Hunter, 2016). John Henryism, a similar coping mechanism seen among both Black women and men, is a high-effort coping response to serious psychosocial stressors; it includes individuals actively working to eliminate the stressors (James, 1994). Both the SBW schema and John Henryism support a need for Black men and women to show strength in the face of adversity and complete whatever tasks necessary to eliminate the stressor. Though this belief of always exhibiting strength and actively working to eliminate stressors was once protective, there is evidence that these high-effort coping responses may be detrimental to the mental health of Black men and women (Abrams, Hill, & Maxwell, 2019; Hudson, Neighbors, Geronimus, & Jackson, 2015; Watson & Hunter, 2015). These conceptions of strength may lead Black adults to believe that they do not experience mental health issues because they are strong and mental illness is a sign of weakness.

“Therapy is for White people”. Even if Black adults believe they are able to experience mental illness, they may not think they have the luxury to be vulnerable or they may think that they need to be strong in all circumstances as indicated by the SBW schema and John Henryism (Watson & Hunter, 2016; Williams, 2017). Noting the history and roots of mental health and therapy services, many Black Americans may believe that “therapy is a white middle class apparition” that was generally for affluent White Americans (Hackett, 2014, p. 21) and that it is not an option for people like them (Campbell & Long, 2014; Kaiser, 2008). Such beliefs can discourage Black adults from seeking mental health services, even if they recognize the need to do so.

Need for Mental Health Services. As noted in the previous section, Black adults may think they are not able to experience mental illness and if they do, that professional help and mental healthcare services are not necessary to get better. The literature demonstrates that there are two types of need when examining healthcare utilization: (1) perceived need (i.e., individuals’ perceptions of their need for mental healthcare services) and (2) evaluated need (i.e., professionals’ perceptions of an individual’s need for mental healthcare services; Andersen, Davidson, & Baumeister, 2014). Both types of need are predictive of help-seeking (Ketchen Lipson et al., 2018; Williams, 2014). Perceptions of need are also tied into the severity of stress. Some Black adults noted that they were not “crazy” and thus did not need mental health treatment (Hines-Martin, Malone, Kim, & Brown-Piper, 2003). Among a sample of Black adults aged 18-59, with the mean age approximately 34, Hines-Martin and colleagues (2003) found that one barrier to mental healthcare was a lack of knowledge on whether participants were experiencing mental health symptoms. Because of the aforementioned conceptions of strength, Black adults may be less likely to feel that the stress they are experiencing is severe enough to

warrant use of mental healthcare services. This suggests that only people with severe mental illness utilize mental health treatment, which is not the case.

Evaluated need is also an important predictor of utilization of mental healthcare services. Williams (2014) examined facilitators to mental healthcare use among Black emerging adults, aged 18-29, using the National Survey of American Life. She found that those with an evaluated need were more likely to have utilized mental healthcare services (Williams, 2014). Additional research examining perceived need among college and graduate students indicated that perceived need appears to be a strong predictor of seeking mental health treatment (Ketchen Lipson et al., 2018). The majority of this sample was between the age of 18 and 22, but it also included adults over the age of 30. Evaluated and perceived need are strong predictors of whether an individual will seek mental health treatment (Ketchen Lipson et al., 2018; Williams, 2014). Thus, this belief held by some Black Americans that only people with serious mental illness seek help may decrease their perceived need and lessen their likelihood of seeking services. This decreased likelihood of seeking services lessens their ability to even receive a professional's perception of their need for mental healthcare services (i.e., evaluated need).

Public Stigma and Self (Internalized) Stigma. Informed by historic and present-day attitudes toward mental illness, there is both a public and personal stigma about mental illness and help-seeking for mental distress. Nadeem and colleagues (2007) found that U.S.-born Black women and immigrant Black women were more likely to report concerns about stigma and less likely to want to seek treatment, compared to U.S.-born White women (Nadeem et al., 2007). Similarly, in other samples with Black women and men, researchers have found that concerns about stigma have prompted Black adults to avoid or delay treatment (Alvidrez, Snowden, &

Kaiser, 2008). Once they were in treatment, they face stigmatized reactions (i.e., public stigma) within Black communities to revealing their mental health status (Alvidrez et al., 2008).

Consequently, many Black adults have voiced desires to keep issues of mental illness private and to not discuss these mental health stressors with anyone outside of the home (Alvidrez, 1999; Briggs et al., 2011; Campbell & Long, 2014; Conner et al., 2010; Logan et al., 2007; Mishra et al., 2009). For example, Conner and colleagues (2010) found that older African Americans, compared to older White Americans, were more likely to have negative attitudes toward seeking mental health treatment and to have experienced both public and internalized stigma. This belief of keeping mental illness private is often touted by older Black Americans (Conner et al., 2010), given their familiarity with the historical context of Black Americans' medical abuse at the hands of White providers. When Black adults consider seeking help for their mental health issues, it seems that they have to weigh their mental health against their social health (Campbell & Long, 2014; Mishra et al., 2009). Mishra and colleagues (2009) conducted focus groups with 42 African American individuals from the Baltimore area. They found that participants discussed concern about being "found out" as having mental health issues and that this disclosure could mean the loss of relationships and opportunities. Sometimes avoiding seeking help for mental health issues is due to the thought that seeking help means admitting that one has mental illness and they will have to live with that permanent tag for the rest of their life (Mishra et al., 2009).

There is some evidence that younger Black adults may be more open to seeking professional help for their mental distress than older Black adults (Ward & Mengesha, 2013). However, as adolescents mature into adulthood, they seek advice and guidance from their family and older trusted adults. Thus, the culturally held beliefs and norms of older Black family

members are still important in understanding barriers to mental healthcare utilization (Barksdale & Molock, 2009). Additionally, mental health stigma and self-concealment (i.e., self-stigma) have been found to be predictive of help-seeking attitudes in a sample of Black college students (Masuda, Anderson, & Edmonds, 2012). In their study, Masuda and colleagues (2012) also found that age was associated with more positive views of seeking professional help, such that older Black students were more likely to endorse those positive views.

Internalized stigma or self-stigma has been associated with more negative views of professional help seeking for psychological distress (Masuda et al., 2012). Some may perceive seeking professional help for their distress as a sign that the person is irreparably damaged (Sanders Thompson, Bazile, & Akbar, 2004). There is evidence that internalized stigma is predictive of attitudes toward treatment, with higher internalized stigma being associated with more negative attitudes toward mental health treatment and lower odds of help-seeking (Brown et al., 2010; Ketchen Lipson et al., 2018). Internalized stigma is not just associated with attitudes toward mental health treatment, but also self-esteem, self-efficacy, and recovery orientation (Drapalski et al., 2013). However, there is limited information on how public and personal stigma operate in the broader population of Black emerging adults.

Perceptions of Effectiveness of Therapy. Perceptions of the effectiveness of therapy or mental healthcare services may also influence attitudes toward mental health treatment and actual utilization rates (Sanders Thompson et al., 2004). Hines-Martin and colleagues (2003) found that one barrier to mental health treatment among Black adults was whether there were appropriate solutions and resources to address feelings of psychological distress. This suggests that Black adults may have concerns about the effectiveness of treatment and resources. Many Black Americans may feel marginalized by mental health professionals and feel that these

providers lack the training to engage with them and help them (Briggs et al., 2011). Additionally, Craft Defrietas and colleagues (2018) found that among Black college students, a more positive view of the effectiveness of a therapists' ability to treat mental illness was associated with factors that predict willingness to seek help, such as lower personal stigma (Craft Defreitas, Crone, Deleon, & Ajayi, 2018). There is still very little empirical work that examines Black American's perceptions of the effectiveness of counseling or other mental health services prior to utilization. However, the research that has been conducted found that Black Americans saw mental health services as ineffective or unacceptable (Logan et al., 2007; Neighbors, 1985).

Most of the limited research focusing on effectiveness is specifically focused on client perceptions of counselor effectiveness, rather than effectiveness of general mental health treatment. In a sample of Black men who had recently suffered an injury, some reported that they believed that therapy would not be helpful to them based on prior experiences; others reported that they did not believe that the mental healthcare providers had compassion for people, which contributed to their reluctance to seeking mental health treatment (Jacoby, Rich, Webster, & Richmond, 2018). However, there is some research that suggests that Black Americans may have concerns about the effectiveness of counseling given the lack of Black providers (Campbell & Long, 2014). Black Americans may believe that therapy will not be effective if they are not able to seek care from a mental health professional that looks like them and may have similar lived experiences.

Lack of Black Mental Healthcare Providers. Another reason that Black Americans may believe therapy is not effective for them is because of the scarcity of Black mental healthcare providers. A lack of Black mental healthcare providers is indicative of a lack of accessibility for Black clients who are interested in receiving care from a Black mental health

professional. Black Americans often report that they would rather see a healthcare provider of their same race; which is sensible given the history of mistreatment by other-race physicians in the medical system (Chen, Fryer, Phillips, Wilson, & Pathman, 2005; Jackson, 2001; Saha, Taggart, Komaromy, & Bindman, 2000). This can also be true for mental healthcare providers (Cabral & Smith, 2011), in that some Black adults have noted that they fear that White mental health professionals will not be able to understand them or their viewpoint and experiences (Campbell & Long, 2014; Sanders Thompson et al., 2004).

Given that only 4.0% of doctoral-level psychologists identify as Black or African American (American Psychological Association, 2018)², the reality for most Black Americans is that they will not be able to seek help from a mental healthcare provider that is also Black. Draucker (2005) examined the process by which adults aged 18 to 21 engaged with mental healthcare services when they were adolescents. She found that African American participants questioned whether they should seek help because they understood that the mental healthcare provider population was “mostly white” and they thought that White therapists could not understand their specific and unique experiences (Draucker, 2005). This suggests that Black Americans are aware of the lack of diversity of the mental healthcare provider population, and this may be a barrier to care. Some Black Americans may choose to seek mental healthcare services despite the lack of Black mental healthcare providers; there is some evidence that they have negative experiences while seeking care that may become additional barriers to continuing

² This study utilized the American Community Survey. Respondents were psychologists in the workforce and had professional or doctoral degrees (i.e., they had attended school for at least 23 years). This is an imperfect measurement of the number of mental health professionals that identify as Black or African American because licensed professional counselors and licensed clinical social workers also provide mental healthcare. However, there are very little data of national estimates of different racial groups for the wider group of mental health professionals.

care and utilizing mental healthcare services in the future (Constantine, 2007; Owen, Tao, Imel, Wampold, & Rodolfa, 2014).

Past Experience with Mental Healthcare Services. Generally, past utilization of mental healthcare services is associated with more positive attitudes toward seeking help and current use of mental healthcare services (Masuda et al., 2012; Wang et al., 2005). However, Black Americans who have had previous mental health treatment experiences that were negative may have unfavorable views toward mental health treatment (Sanders Thompson et al., 2004; Thompson, Dancy, Wiley, Perry, & Najdowski, 2011). Thompson and colleagues (2011) examined the experiences of African American mothers and their children in mental healthcare settings. They found that of 29 mothers, 14 reported they were generally satisfied, 6 were dissatisfied, and 9 were both satisfied and dissatisfied with the mental healthcare services that they received for themselves. Those that were satisfied said that the counselors were really engaging with them both in individual and group sessions. Those who were dissatisfied reported that they thought that the mental healthcare professional was not listening or invested in learning about their experiences, but just wanted to make them take medicine (Thompson et al., 2011). Some of these sentiments above were also seen in Black youths' report of their own satisfaction with the mental healthcare services they received.

In a national study, Diala and colleagues (2000) found that prior to utilizing a mental health service, compared to White Americans, Black Americans were more likely to report positive attitudes toward seeking professional help for their mental health problems. Additionally, they were more likely to be less embarrassed about their friends knowing that they were going to seek professional help for their psychological problems. However, after utilizing mental health services, Black Americans were more likely than White Americans to report

negative attitudes toward seeking help, less likely to report that they would return if their mental illness continued, and also less likely than White Americans to have positive attitudes toward their friends knowing that they had seen a mental health professional for help (Diala et al., 2000).

In contrast, Masuda and colleagues (2012) found that among Black college students, seeking help from professional mental health services was associated with more positive help-seeking attitudes and lower mental health stigma. They also reported age effects, such that older students reported more positive attitudes toward help-seeking for mental distress (Masuda et al., 2012). This suggests that within the Black emerging adult population, there may be systematic variation in help-seeking attitudes or willingness to utilize services based on prior use and age. Generally, Black adults may have negative attitudes toward seeking help, but some of these may be directly related to experiences of discrimination and/or concerns about discrimination in mental healthcare settings.

Discrimination in Healthcare Settings and Lack of Trust in Providers. Given the lack of diversity in the mental health provider population, Black adults may have significant concerns about discrimination and lack trust in providers. This is consistent with research that has shown that Black Americans historically and presently experience discrimination and racism in primary and mental healthcare settings (Burgess, Ding, Hargreaves, van Ryn, & Phelan, 2008; Constantine, 2007; Lee et al., 2009). The experience of racism in healthcare settings promotes widespread mistrust of physical and mental healthcare providers (Mishra et al., 2009). In some interviews, Black participants have stated clearly that they are treated differently in healthcare settings than people of other races and that this is primarily due to both implicit and overt racial prejudice (Campbell & Long, 2014). Constantine (2007) examined the relationship between racial microaggressions, the counseling working alliance, (i.e., this refers to the quality

and collaborative nature of the mental healthcare received by clients as well as the personal bond formed between clients and their therapists), perceptions of counselor's general and multicultural counseling competence, and counseling satisfaction among Black clients in cross-racial provider-client relationships. She found that higher numbers of perceived racial microaggressions were associated with lower perceptions of the therapeutic working alliance and White counselors' general and multicultural competence (Constantine, 2007). In addition, a greater number of perceived racial microaggressions were predictive of Black clients' lower satisfaction ratings (Constantine, 2007).

For a Black client seeking help with their mental distress, it might be especially difficult to cope with racial microaggressions in a relationship that is supposed to assist them with growth and healing, such as counseling (Constantine, 2007). Thus, Black therapy clients that experience discrimination (overt or subtle) may be discouraged from seeking care again after negative experiences and low satisfaction. Similarly, Lee and colleagues (2009) found that Black Americans, compared to White Americans, report more perceived provider discrimination and poorer health. Those with greater perceptions of provider discrimination were less likely to utilize healthcare services when they needed them (Lee et al., 2009).

Burgess and colleagues (2008) also examined the relationship between perceived discrimination and underutilization of medical and mental healthcare in a nationally representative sample. They found that 43.7% of U.S.-born Black Americans reported having experienced major discrimination in the past 12 months, compared to 11.7% of White Americans (Burgess et al., 2008). General perceived discrimination (from any source) was associated with a greater likelihood of underutilization of healthcare services. For U.S.-born Black Americans, the likelihood of underutilization was greater among those participants who reported experiencing

everyday discrimination (compared to major discrimination and discrimination specifically in the healthcare settings). Taken together, fears about discrimination may lead to an underutilization of healthcare services, and this may be particularly true for the use of mental healthcare services because of the sensitive nature of the topics discussed and stigma surrounding seeking help.

Importantly, Black emerging adults may face additional discrimination based on their education, income, or class status by healthcare providers (Kugelmass, 2016). In an audit study examining the effects of a potential client's race, class and gender on accessibility of therapists, Kugelmass (2016) found that middle class potential clients were offered appointments at rates almost three times higher than working-class potential clients. This suggests that the discrimination against Black and working-class help-seekers may begin at the initial stage of the help-seeking process and may continue into the first clinical encounter. Given the concerns about the lack of Black mental healthcare providers and discrimination in mental healthcare services coupled with the historical treatment of Black people in the mental healthcare system, Black adults developed a preference for seeking informal care.

Preference for Seeking Informal Care. Generally, Black adults tend to prefer seeking help from informal resources rather than a mental health professional (Avent & Cashwell, 2015; Ayalon & Young, 2005; Briggs et al., 2011; McMiller & Weisz, 1996). These informal resources may be family, friends, or their spiritual and religious communities (Avent & Cashwell, 2015). This is rooted in historical and present-day experiences of discrimination and maltreatment in medical and mental healthcare settings, as well as the family and church being safe havens from the rampant racism and mistreatment in the U.S (Avent & Cashwell, 2015).

Additionally, some Black Americans believe that if they go to a professional for help with their mental health, this will result in institutionalization, being medicated, or even losing

their children (Briggs et al., 2011; Copeland & Snyder, 2011; Snowden, 2001; Sussman et al., 1987). Thus, they developed a preference for seeking informal care to avoid the perceived consequences of seeking professional help. This trend to prefer to seek help from informal social support resources rather than formal, professional resources has also been evidenced in younger Black adults (Ayalon & Young, 2005). Ayalon and Young (2005) found that among community college students, Black students were more likely to use religious services, rather than psychological or social services, for help with psychological distress. These preferences for seeking informal care were due to experiences of discrimination and knowledge of historical treatment of Black people in the mental healthcare system.

Knowledge Gap in the Literature

To the extent that the mental health system is not perceived as inclusive to one's racial self-concept, it may not seem helpful to seek care (Smart Richman et al., 2007, p. 977).

In addition to the factors listed above, there is another potentially important factor that may inhibit Black emerging adults from utilizing needed mental healthcare services: perceived inclusivity of therapy services (i.e., the extent to which Black adults think that services are for them or people who look like them). Clearly, this construct is related to constructs reviewed above, such as perceptions of effectiveness, lack of Black providers, and public and personal stigma. However, it is still an independent construct as perceived therapy inclusivity is predicated on the fact that the mental healthcare system was designed for majority populations and, at one point in time, explicitly excluded populations of color. Thus, Black emerging adults may believe that mental health services are not inclusive because the system was not built for them. To my knowledge, there is no study that specifically investigates the role of perceptions of

the inclusiveness of therapy services in mental healthcare utilization among Black emerging adults.

Theoretical Framework: Critical Race Theory

I posit that critical race theory provides a useful framework to investigate how attitudes toward mental health services may have been formed by racism in the mental health system and the role that perceived therapy inclusivity may play in mental healthcare utilization among Black emerging adults. Critical race theory (CRT) emerged originally from the legal field and has been integrated into other fields like education and health. CRT states that racism is enmeshed in the culture of American life and that successfully combatting racism requires large changes and not incrementalism (Delgado & Stefancic, 2001; Ladson-Billings, 1998). In the past decade, public health researchers have been identifying ways to integrate CRT into public and population health research (Bridges, Keel, & Obasogie, 2017; Ford & Airhihenbuwa, 2010; Graham et al., 2011; Smedley, 2012). CRT integrates multiple methodologies and disciplines to “draw on theory, experiential knowledge, and critical consciousness to illuminate and combat root causes of structural racism” (Ford & Airhihenbuwa, 2010, pg. S31). In 2011, Graham and colleagues identified some of the CRT tenets applicable to population health research. Of particular interest to the current study are the tenets of dominant cultural orientation discrimination and contextual and historicized analysis.

The tenet of dominant cultural orientation discrimination suggests that inequalities exist and persist because of the constant privileging of majority cultural orientation over others (Graham et al., 2011). This tenet is directly applicable to the concept of perceived therapy inclusivity because therapy services privilege majority identities, as many measures of mental health disorders have been primarily normed with White individuals and clinicians, who are from

one cultural group. Thus, the use of the DSM classifications with a client from another cultural group may lead to misdiagnosis of the client if the provider is not familiar with the client's cultural context (American Psychiatric Association, 1994; Radloff, 1977; U.S. Department of Health and Human Services, 2001). As such, the tenet of dominant cultural orientation discrimination speaks to the core concept of therapy inclusivity as therapy services were not designed for people of color, and specifically excluded Black individuals from mental healthcare services in the past.

The tenet of contextual and historicized analysis suggests that it is imperative that data be contextualized and that the self-reported experiences of participants are highly influenced by history (Graham et al., 2011). This tenet is applicable to the concept of perceived therapy inclusivity and its measure because the history of Black Americans' experience in mental health services is important in our understanding of present-day attitudes and underutilization of mental health services (Logan et al., 2007). Taken together, by drawing on critical race theory, the current study seeks to address this knowledge gap in the literature and understand Black emerging adults' perspectives of therapy services by specifically privileging their voices.

Theoretical Foundation: Identity-Based Motivation

As mentioned above, CRT allows for the contextualization of how attitudes toward mental health services may have been formed by examining the roles of racism and ethnocentrism in the creation of mental health treatments, as well as the history of Black people's experiences in the mental health system. However, CRT does not address how individuals, within these cultural and historical contexts, make decisions to seek help to address mental health issues. I argue that Identity-Based Motivation (IBM) can address these individual-level processes underlying mental health help-seeking behaviors. According to IBM, people are more

motivated to behave in ways that are consistent with their social identities and are less motivated to engage in activities that are perceived to be inconsistent with their social identity (Oyserman et al., 2007, 2014). For example, students' experiences in school can be gendered such that boys believe that working hard is "not cool" and being organized is something that only girls do. In the IBM framework, boys will be less motivated to work hard or build organizational skills, as compared to girls, because those tasks are not congruent with their gender identity (Elmore & Oyserman, 2012).

IBM further suggests that social position and context influences behaviors through three aspects of identity-based motivation: dynamic construction, action and procedural readiness, and interpretation of difficulty (Oyserman et al., 2014). Dynamic construction refers to which identities are activated and what these activated identities mean (Oyserman et al., 2007). In the current example, when male students' gender identities are made salient, schemas are activated for what it means to be a boy (e.g., "Boys are cool and working hard is not cool; only girls can organize and since I am a boy, I cannot organize."). Action and procedural readiness refer to what cognitive resources are available to act, an individual's willingness to act, and whether there is a necessity to act urgently (i.e., whether the future feels near and thus action is necessary; Oyserman et al., 2007, 2014). In the context of the present example, young boys may not understand why it is important to work hard and stay organized and thus do not feel a need to act urgently. Finally, interpretation of difficulty can be further divided into two important subcategories: (1) whether difficulty means important or (2) whether difficulty means impossible. If the difficulty is interpreted as important, people persist in spite of the difficulty. In contrast, if the difficulty is interpreted as impossible, people disengage from the behavior (Oyserman et al., 2014). For example, if working hard and getting good grades is taught as an

important life skill for boys, they may persist despite the difficulty they face. If getting good grades is seen as impossible, boys will disengage from working hard because it is not possible for them to get good grades anyway.

Relevant to the current proposed research, IBM has also been used to better understand health-related behaviors. For example, Oyserman and colleagues (2007) found, compared to White American students, racial/ethnic minority students reported engaging in fewer health promotive behaviors, such as eating healthy, getting enough sleep, and exercising daily. Additionally, racial/ethnic minority students were more likely to view behaviors that promote health as White and middle class behaviors (Oyserman et al., 2007). I argue that seeking help for mental health issues is one specific type of health-promoting behavior. Black emerging adults are likely to perceive that seeking help for mental health issues through the mental healthcare system is for White Americans. This belief may result in a lower intention to seek help among Black emerging adults.

These findings from prior research suggest that it is critical to take into account variability in individuals' racial identity (i.e., the sense of collective identity based on an individuals' perceptions that they share a common heritage or background with a specific racial group; Chávez & Guido-DiBrito, 1999) when considering the role of IBM in health-promoting behaviors among Black emerging adults. Specifically, the relationship between perceived inclusivity of therapy services and willingness to utilize services may vary depending on the strength of two aspects of racial identity (i.e., racial centrality and private regard; see Figures 1 and 2). Centrality refers to the how significant race is in Black individuals' definitions of themselves. Private regard refers to the extent to which Black individuals feel positively or

negatively toward Black Americans and how positively/negatively they feel about being Black (Sellers, Rowley, Chavous, Shelton, & Smith, 1997).

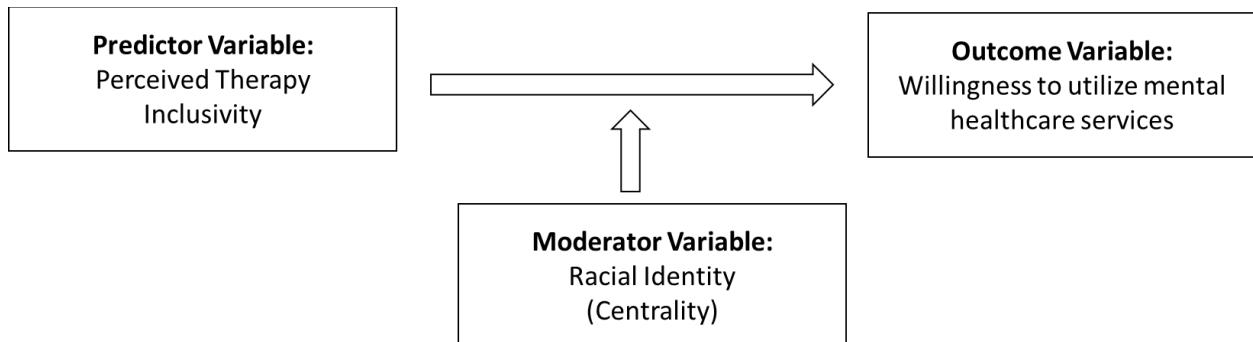


Figure 1. First Moderation Analysis (Racial Centrality as Moderator)

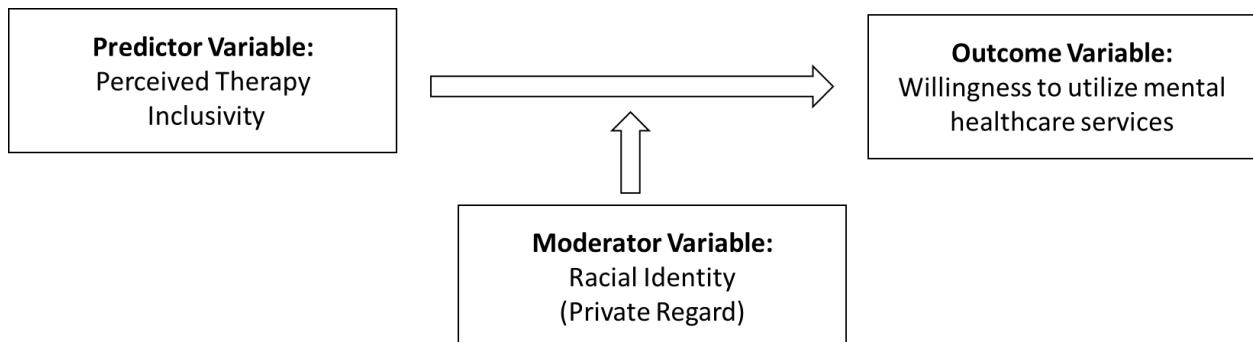


Figure 2. Second Moderation Analysis (Private Regard as Moderator)

Present Study

Findings from prior research strongly suggest that some Black emerging adults may believe that therapy is not for them or people who look like them; however, there is little empirical research examining this belief and its association with willingness to utilize services (Campbell & Long, 2014; Kaiser, 2008). Drawing on both critical race theory and identity-based motivation, the present study tested the hypothesis that lower levels of perceived therapy inclusivity would predict lower willingness to utilize mental health services among Black

emerging adults. It also examined whether two indices of racial identity (i.e., centrality and private regard) would moderate the association between perceived therapy inclusivity and willingness to utilize mental health services. It was hypothesized that if an individual has higher racial centrality, the relationship between perceived therapy inclusivity and willingness to utilize mental healthcare services would be strengthened. Specifically, if individuals perceived that therapy services *were* inclusive of Black people and had a higher racial centrality, they would be more willing to utilize services than those with lower centrality. Conversely, if an individual perceived that therapy services were *not* inclusive of Black people and had a higher racial centrality, they would be less willing to utilize mental health services. The same relationship was expected of private regard, such that with those with higher private regard that perceive therapy services to be inclusive would report a greater willingness to utilize mental healthcare services. These hypotheses and research questions were addressed by conducting an online survey. Findings from the current study will lay the foundation for future policy research that targets system-level indicators of inclusivity (e.g., lack of culturally-relevant treatments and lack of Black providers).

Method

Participants

A convenience sample of 304 self-identified Black emerging adults were recruited. Sixty participants (17.4%) were excluded from the study because they did not complete the entirety of the survey (i.e., lower than 99% progress). This resulted in 244 analyzable cases. To be eligible for this study participants had to: (1) be between 18-29 years of age and (2) self-identify as Black or African-American. Participants were recruited via the VCU Department of Psychology Research Participation System as well as flyers (Appendix E, pages 114-1117), which were

distributed through a variety of methods (e.g., social media, listservs, link distributed via emails using my professional networks, and physical flyers at places like black-owned restaurants and local community centers).

According to a power analysis conducted using G*Power 3.1 (Faul, Erdfelder, Lang, & Buchner, 2007), at least 160 participants were necessary to achieve .80 power with a small to medium effect size ($d = .07$), with two tested variables (i.e., perceived therapy inclusivity as a predictor and racial identity-centrality/racial identity-private regard as moderator variables), the two-way interaction of those predictors between the two variables, and six control variables (i.e., gender identity, public stigma, self-stigma, financial situation, mental health history, and previous mental health service utilization) for a total of nine predictors. The effect size was chosen based on a study examining stigma and attitudes toward mental health treatment (Clement et al., 2014; Craft Defreitas et al., 2018).

Procedure

All recruitment materials informed potential participants that the researchers were seeking Black emerging adults' perspectives on mental health and therapy services. Interested participants followed the link to complete an online prescreening survey, which assessed participants' age and race. Participants who met the eligibility criteria were directed to the full online survey, which lasted approximately 30-45 minutes. VCU college student participants utilized the SONA system to participate in the study with the same procedure. Non-VCU participants were compensated with an entry into a gift card raffle, where they could win one of eight \$100 gift cards to Amazon. VCU participants were awarded .75 research credits for their completion of the survey.

Measures

Predictor variable.

Perceived therapy inclusivity (PTI). PTI refers to a participant's perception of the extent to which therapy services are for them or people who look like them. A new scale was developed for this project to assess perceptions of therapy inclusivity. Sample items include: “*As a Black person, I feel welcomed in therapy spaces*” and “*Therapy services and treatments were designed for people who look like me.*” The full measure can be found in Appendix G, pages 121-122. These items were created based on findings from previous research that investigated the role of Afrocentric features in mental healthcare utilization and counselor preferences among Black college students (Dent, 2017), tenets of critical race theory (Delgado & Stefancic, 2001), and existing literature about barriers to mental healthcare (Graham et al., 2011; Hines-Martin et al., 2003; Jacoby et al., 2018). The scale ranges from 1 (Strongly disagree) to 5 (Strongly agree). The PTI scale demonstrated high internal consistency in this sample ($\alpha = .87$).

Outcome variable.

Willingness to utilize mental healthcare services. Willingness to utilize mental healthcare services was assessed via the help-seeking propensity subscale of the Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS; Mackenzie, Knox, Gekoski, & Macaulay, 2004). Sample items include: “*If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy*” and “*I would want to get professional help if I were worried or upset for a long period of time.*” There are eight items in the IASMHS help-seeking propensity subscale (See Appendix G, pages 120-121). Response options in the original scale ranged from disagree (0) to agree (4). However, to be consistent with other measures in the survey, we used a scale that ranges from 1 (Strongly

disagree) to 5 (Strongly agree). The IASMHS has been used before with a sample of Black adults and showed acceptable construct validity and internal consistencies, $\alpha = .73$ to $.81$ (Ward, Wiltshire, Detry, & Brown, 2013). An internal consistency in the current sample was consistent with the previous research ($\alpha = .75$).

Moderator variable.

Racial identity. Racial identity was assessed with two subscales of the Multidimensional Inventory of Black Identity (MIBI): racial centrality and private regard (Sellers et al., 1997). These two subscales were chosen, rather than the entire scale, because they are the most sensible in the identity-based motivation framework (Oyserman et al., 2007, 2014), and have been associated with utilization of mental health services (Smart Richman, Kohn-Wood, & Williams, 2007). The centrality subscale includes eight items ($\alpha = .77$; Sellers et al., 1997), such as “*In general, being Black is an important part of my self-image*” and “*I have a strong sense of belonging to Black people.*” The private regard subscale includes six items ($\alpha = .60$; Sellers et al., 1997), such as “*I feel good about Black people*” and “*I am happy that I am Black*” (See Appendix G, pages 125-126). Both subscales ranged from 1 (Strongly disagree) to 5 (Strongly agree). In this sample, internal consistencies were $\alpha = .75$ and $\alpha = .82$ for centrality and private regard, respectively.

Potential control variables.

The control variables were current financial situation, gender identity, self-stigma, public stigma, mental health utilization and mental health history, as these variables have been associated with mental health services use (Ketchen Lipson et al., 2018; Miranda, Soffer, Polanco-Roman, Wheeler, & Moore, 2015; Williams & Cabrera-Nguyen, 2016) or racial identity (Smart Richman et al., 2007) in previous studies.

Current financial situation. A participant's current financial situation was assessed with one item, "How would you characterize your current financial situation?" The response items ranged from 1 ("Very poor, not enough to get by") to 4 ("Well to do"). This item has been used with college students in the Healthy Mind Study that has been utilized at 60 different campuses (Ketchen Lipson et al., 2018). Financial concern is a common reason for not seeking mental health services in the emerging adulthood population (Miranda et al., 2015).

Gender identity. Gender identity was assessed with the following question: *How would you best describe your gender identity?* Response options included: Man (cisgender), Woman (cisgender), Transman, Transwoman, Non-binary/gender queer, and Not listed (Please Specify). Gender identity was included as a potential covariate because studies have found that Black American women are more likely to seek mental health services than Black American men, among the general Black population (Smart Richman et al., 2007; Williams et al., 2007). Among Black emerging adults, other studies have found a similar trend, indicating that Black women are more likely to seek services than Black men, even in emerging adulthood (Broman, 2012; Williams & Cabrera-Nguyen, 2016).

Public stigma. Public stigma was measured with the Perceptions of Stigmatization by Others for Seeking Help Scale (PSOSH; Vogel, Wade, & Ascherman, 2009). The PSOSH is a 5-item scale ($\alpha = .78\text{-.89}$), with response items ranging from 'Not at all' (1) to 'A great deal' (5). The scale prompt reads: "*Imagine you had an emotional or personal issue that you could not solve on your own. If you sought counseling services for this issue, to what degree do you believe that the people you interact with would _____.*" The items for this measure include: 1. *React negatively to you;* 2. *Think bad things of you;* 3. *See you as seriously disturbed;* 4. *Think of you in a less favorable way;* 5. *Think you posed a risk to others.* Emerging adults from racial/ethnic

minority backgrounds were more likely to cite fear of what others (not including friends and family) would think of them as a barrier to utilizing mental health treatment (Miranda et al., 2015). In this sample, the internal consistency was $\alpha = .91$.

Self-stigma. Self-stigma was measured with the 10-item “Self-Stigma of Seeking Help Scale (SSOSH, $\alpha = .86 - .90$; Vogel, Wade, & Haake, 2006). Sample items include: “*I would feel inadequate if I went to a therapist for psychological help*” and “*I would feel okay about myself if I made the choice to seek professional help.*” Response items range from 1 (Strongly disagree) to 5 (Strongly agree). Higher self-stigma is predictive of more negative attitudes toward mental health treatment (Masuda, Anderson, & Edmonds, 2012; Brown et al., 2010) and lower odds of help-seeking (Ketchen Lipson et al., 2018). An internal consistency in the current sample was consistent with the previous research ($\alpha = .83$).

Mental healthcare utilization. This measure was assessed with one item: “*Have you ever received counseling or therapy for your mental or emotional health from a mental health professional (psychologist, social worker, or licensed practicing counselor)?*” Response options were dichotomous: Yes or No. The item was taken from the Healthy Mind Study (Ketchen Lipson et al., 2018). Broman (2012) found that for the general emerging adult population, prior utilization of mental health services more than doubled the odds of current utilization; however, for Black emerging adults this trend was reversed. Black emerging adults who have received mental health services in the past were significantly less likely to utilize mental health services in the present (Broman, 2012). Consistent with these findings, Diala et al. (2000) found that Black adults had more positive attitudes than White adults prior to utilization of mental health services.

Mental health history (diagnosis). This variable was measured with one-item: *Have you ever been diagnosed with any of the following conditions by a health professional (primary care*

doctor, psychiatrist, psychologist, etc.)? Response options included: “Depression or other mood disorders,” “anxiety,” “attention disorder or learning disability,” “eating disorder,” “psychosis,” “personality disorder,” “substance abuse disorder,” “no, none of these,” and “don’t know.”

Participants were told to select all that apply. Responses were dummy-coded as (0) indicated no prior mental illness diagnosis and (1) indicated 1 or more prior mental illness diagnoses.

Williams and Cabrera-Nguyen (2016) found that a lifetime evaluated need for mental health services (i.e., need for services evaluated by a professional) was associated with higher likelihood of using services among Black emerging adults.

Other mental health variables.

Anxiety Symptomology. Anxiety was measured via the 7-item Generalized Anxiety Disorder Scale (GAD-7, $\alpha = .86 - .92$; Spitzer et al., 2006). This scale is utilized to screen for generalized anxiety disorder and assess its severity in both clinical and research settings.

Participants were asked to answer the following question: “Over the last 2 weeks, how often have you been bothered by the following problems?” Some of the items included: “Feeling nervous, anxious or on edge,” or “Being so restless that it’s hard to sit still.” Response items range from 0 (Not at all) to 3 (Nearly every day). Higher scores denote more severe anxiety symptomology. An internal consistency in the current sample was consistent with the previous research ($\alpha = .90$).

Depression Symptomology. Depression was assessed via the 9-item depression module of the Patient Health Questionnaire (PHQ-9, $\alpha = .89$, Kroenke, Spitzer, & Williams, 2001).

Participants were asked to answer the following question: “Over the last 2 weeks, how often have you been bothered by the following problems?” Some of the items included: “Little interest or pleasure in doing things” and “Feeling tired or having little energy.” Response items range

from 0 (Not at all) to 3 (Nearly every day). Higher scores denote more severe depression symptomology. In this sample, the internal consistency was $\alpha = .87$.

Flourishing. The flourishing scale was used to assess participants' social and psychological well-being ($\alpha = .86$; Diener et al., 2009). Participants were asked to indicate the extent to which they agree or disagree with eight statements. Example items include: "I lead a purposeful and meaningful life" and "my social relationships are supportive and rewarding." The original scale included 7 response options, but the current study utilized 5 response options (1-Strongly Disagree to 5-Strongly Agree) for consistency with other measures in the current study. Higher scores denote that participants view themselves as positively functioning across personal and social domains. In this sample, the internal consistency was $\alpha = .92$.

Analysis Plan

Prior to running the main analyses, descriptive statistics were conducted, and the data were examined for missing data, distribution issues, and outliers. Examinations of skewness, kurtosis, and distribution figures indicated that all but one variable were normally distributed. Specifically, skewness and kurtosis for each variable were: *skewness = -.150 (SE = .156)* and *kurtosis = .016 (SE = .311)* for PTI; *skewness = -.119 (SE = .156)* and *kurtosis = .002 (SE = .312)* for Willingness to Seek Help; and *skewness = -.322 (SE = .156)* and *kurtosis = .230 (SE = .310)* for Racial Identity-Centrality. The Racial Identity-Private Regard measure was non-normally distributed, with skewness of *-.2.133 (SE = .156)* and kurtosis of *4.972 (SE = .310)*. Because data transformations (square root, inverted square root, and log 10 transformations) did not substantially improve the skewness, the main analyses were carried with the original variable followed-up with two ancillary analyses, which is described in more detail below.

The nature of the relationships amongst the variables of interest were assessed with a series of bivariate correlations. Six potential control variables were identified (i.e., gender identity, public stigma, self-stigma, financial situation, mental health history, and previous mental health service utilization). Ultimately, all but one variable (i.e., financial situation) were selected as the covariates for the main analyses because of their significant correlations with the main predictor, outcome, or moderator variables. Thus, there were 5 final control variables (i.e., public stigma, self-stigma, mental health history, mental health utilization, and gender identity; see Table 1).

The goals of the current study were to: (1) test whether perceived inclusivity of therapy services predicts willingness to utilize mental healthcare services in a sample of Black emerging adults and (2) assess whether this relationship was moderated by racial identity-centrality or racial identity-private regard (Figures 1 and 2). To address these study goals, a moderation analysis was conducted for each moderator (i.e., Moderation 1: racial identity-centrality and Moderation 2: racial-identity-private regard) by using the PROCESS macro Model 1 (Hayes, 2012). Using PROCESS Model 1 allowed me to ascertain whether the overall model was significant and whether the predictor variable and moderator variables significantly predicted the outcome variable. These main analyses were further followed-up with two ancillary analyses in order to address the skewed racial identity-private regard variable. The first ancillary analysis treated the racial identity-private regard variable as dichotomous (0 = “Not Highest Score”; 1 = “Highest Score) because nearly half the sample (46.3%) scored the highest score (i.e., 5). The second ancillary analysis included only participants who scored below 5 and treated the racial identity-private regard variable as continuous.

Control variables found to be associated with the predictor, moderator, or outcome variables were first entered into the model as covariates (i.e., public stigma, self-stigma, mental health history, mental health utilization, and gender identity). For the main analyses and ancillary analyses, gender was dummy-coded and entered into the model (women as 0 and men as 1), excluding 4 participants who identified as transgender or non-binary. This approach to excluding an extremely small number of participants who identified as transgender/non-binary is consistent with prior research (Trujillo, Perrin, Elnasseh, Pierce, & Mickens, 2016). Public stigma and self-stigma were entered into the model as continuous variables. Mental health history (0 indicated no previous mental health diagnosis, and 1 indicated prior mental health diagnosis) and prior mental healthcare utilization (0 indicated no prior utilization, and 1 indicated previous utilization of mental health services) were both dummy-coded.

Table 1

Correlations among main variables

	1	2	3	4	5	6	7	8	9	10	
1. PTI Scale	—	.329**	-.194**	-.040	-.316**	-.206**	-.018	-.121	.038	.102	
2. Willingness to Seek Help		—	.206**	.231**	-.313**	-.427**	.110	.167**	.041	-.190**	
3. Racial identity- Centrality			—	.469**	-.128*	-.203**	-.016	.153*	-.056	-.269**	
4. Racial identity- Private Regard				—	-.303**	-.287**	-.177**	-.063	.006	-.136*	
5. Public Stigma					—	.416**	.126	.162*	-.127*	.124	
6. Self-Stigma						—	.055	-.109	.036	.232**	
7. Mental Health History (Diagnosis)							—	.493**	-.051	-.067	
8. Mental Healthcare Utilization								—	-.093	-.202**	
9. Financial Situation									—	-.120	
10. Gender										—	
	<i>M</i>	46.03	27.55	30.72	27.73	9.34	20.67	.25	.30	2.46	.25
	<i>SD</i>	10.57	5.37	5.65	3.41	4.65	6.76	.43	.46	.72	.43

Note. * indicates $p < .05$, ** indicates $p < .01$, and *** indicates $p < .001$.

Results

Participant Characteristics

Table 2 presents the means and frequencies of each main variable included in the analysis. The majority (80.5%) of the sample was from the VCU SONA population, and most (87.7%) of the sample were between the ages of 18-24. Additionally, 72.1% identified as U.S.-born Black adult or African American with their parents born in the U.S., and majority of the sample also identified as cisgender women (74%). Fifty-nine percent of the participants indicated that they made less than \$10,000 as their estimated yearly income and the majority (92.2%) were currently enrolled in school. Almost 90% of the sample indicated that they had health insurance. It should be noted that 53% of participants with health insurance indicated having private insurance provided by their employer, which seemed too high for this sample. It is possible that this health insurance question was misinterpreted by participants, such that their private insurance was provided by their *parents'* employers. However, there is no way to test this assumption empirically; thus, the finding should be interpreted with caution.

Turning to mental health status and mental healthcare utilization, approximately 37% of the sample reached the threshold for moderate depression on the PHQ-9 scale and 36.9% met the threshold for moderate anxiety on the GAD-7. On the flourishing scale, the mean for the sample was 30.5 (maximum of 40), indicating that the sample was comprised of people with many psychological resources and strengths. Approximately 67.5% indicated they were somewhat likely or extremely likely to seek help from a mental health professional if they were to experience mental health problems in the future, while about 23% of the sample had received a mental health diagnosis, and 29.9% had utilized counseling or therapy before. Of those who had

utilized counseling or therapy before, 80.6% noted that this experience was at least somewhat helpful.

Table 2

Study Population Demographics

Characteristics	M (SD) or N (%)	
Age		
18-24	214	(87.7%)
25-29	30	(12.3%)
U.S. Citizenship		
Yes	231	(94.7%)
No, but I have permanent residency/green card	12	(4.9%)
No, citizenship of another country	1	(0.4%)
Race and Origin		
U.S.-born Black adult or African American (parents born in the U.S.)	176	(72.1%)
U.S.-born Black adult or African American (parents born in an African nation)	35	(14.3%)
U.S.-born Black adult or African American (parents born in Caribbean)	14	(5.7%)
African-born Black adult	15	(6.1%)
Caribbean-born Black adult	4	(1.6%)
Gender Identity		
Woman (cisgender)	180	(73.8%)
Man (cisgender)	59	(24.2%)
Non-binary/gender queer	2	(0.8%)
Transman	1	(0.4%)
Transwoman	1	(0.4%)
Not listed	1	(0.4%)
Sexual Identity		
Heterosexual/Straight	207	(84.8%)
Bisexual/pansexual	15	(6.1%)
Gay or Lesbian	12	(4.9%)
Questioning	6	(2.5%)
Asexual	1	(0.4%)
Not Listed	3	(1.2%)
Personal Financial Situation		
Very poor, not enough to get by	22	(9.0%)
Had enough to get by but not many “extras”	99	(40.6%)
Comfortable	112	(45.9%)
Well to do	11	(4.5%)

Personal Estimated Yearly Income

Less than \$10,000	144	(59.0%)
\$10,000 to \$24,999	31	(12.7%)
\$25,000 to \$49,999	35	(14.4%)
\$50,000 to \$94,999	21	(8.6%)
\$100,000 or more	11	(4.5%)

Receiving Public Assistance

Yes	32	(13.1%)
No	212	(86.9%)

Personal Education

Did not finish High school	1	(0.4%)
High school diploma or GED	96	(39.3%)
Associate or junior college degree	15	(6.1%)
Vocational Degree	3	(1.2%)
Some College	91	(37.3%)
Bachelor's Degree (4-year degree)	17	(7.0%)
Graduate Degree (Masters, PhD, JD, MD, etc.)	21	(8.6%)

Currently enrolled in School

Yes	225	(92.2%)
No	19	(7.8%)

Current Educational Setting

2-year college	1	(0.4%)
4-year college	201	(89.3%)
Graduate School	22	(9.8%)
Not listed	1	(0.4%)

Current Employment Status

Employed Full-Time (40 hours or more/week)	29	(11.9%)
Employed Part-time (less than 40 hours/week)	78	(32.0%)
Unemployed	126	(51.6%)
Not Listed	11	(4.5%)

Currently have insurance

Yes	218	(89.3%)
No	26	(10.7%)

Source of Health Insurance

Medicaid	45	(20.6%)
Private Insurance (provided by your employer)	115	(52.8%)
Private Insurance (that you pay for)	20	(9.2%)
Private insurance (that your caregivers pay for)	6	(2.8%)
Other	28	(12.8%)

No Health Insurance	4	(1.8%)
Relationship Status		
Single	166	(68.0%)
In a relationship	69	(28.3%)
Married or partnered	8	(3.3%)
Divorced	1	(0.4%)
Living Arrangements		
Living alone	19	(7.8%)
Living with a partner	14	(5.7%)
Living with a roommate (that is not my partner)	165	(67.6%)
Living with parent or guardian/s	40	(16.4%)
Other	6	(2.5%)
Parental Status		
Not a caregiver	229	(93.9%)
Caregiver	15	(6.1%)
Mental Healthcare Diagnosis		
No	168	(68.9%)
Yes	56	(23.0%)
Don't know	20	(8.2%)
Mental Healthcare Utilization		
No	171	(70.1%)
Yes	73	(29.9%)

Descriptive Analyses

Table 1 shows means, standard deviations, and bivariate correlations among all major variables. Perceived therapy inclusivity was negatively associated with public stigma ($r = -.316$, $p < .01$) and self-stigma ($r = -.206$, $p < .01$), indicating that as perceived therapy inclusivity increased public stigma and self-stigma decreased. Consistent with some previous research (Nadeem et al., 2007; Vogel, Wade, & Hackler, 2007), perceived public stigma ($r = -.313$, $p < .01$) and self-stigma ($r = -.427$, $p < .01$) were negatively associated with willingness to seek help, indicating that as public stigma and self-stigma decreased willingness to seek help increased. Additionally, willingness to seek help was positively associated with prior mental health

utilization ($r_{pb} = .167, p < .01$). This suggests that willingness to seek help is greater among those who have sought help before. Consistent with previous research (Broman, 2012; Williams, 2014), women were more willing to seek help than men ($r_{pb} = -.190, p < .01$). Both indices of racial identity (centrality and private regard) were negatively associated with public stigma and self-stigma, indicating that as centrality and private regard increased, both perceived public stigma and self-stigma decreased.

Hypothesis Testing 1: Centrality as Moderator

The overall model predicting willingness to utilize mental health services was significant, $F(8, 208) = 12.65, MSE = 20.08, p < .001, R^2 = .3273$. Both the main effects of PTI ($B = .15, SE = .033, p < .001, CI [.0867, .2159]$) and racial identity-centrality ($B = .20, SE = .06, p = .001, CI [.0782, .3144]$) significantly predicted willingness to seek help. Specifically, higher PTI and higher centrality of racial identity were predictive of a greater willingness to seek help. Consistent with my prediction, this suggests that if participants perceive that therapy and mental health services are for them or people who look like them, they are more willing to utilize mental health services. However, unlike my prediction, the two-way interaction (Perceived Therapy Inclusivity X Centrality) was not significant, $F(1, 208) = 1.06, p = .3047, \Delta R^2 = .0034, CI [-.0158, .0050]$. This suggests that there is no evidence that racial identity-centrality moderates the relationship between PTI and willingness to seek help. That is, the relationship between PTI and willingness to seek help did not change at different levels of racial centrality. See Table 3 for detailed results.

Table 3

Hypothesis testing 1: Centrality as moderator

	<i>B</i>	<i>SE</i>	<i>t</i>	95% CI	
				Lower	Upper
Perceived Therapy Inclusivity (PTI)	.15***	.03	4.62	.0867	.2159
Racial Centrality	.20**	.06	3.28	.0782	.3144
Interaction Term (PTI x Centrality)	-.005	.01	-1.03	-.0158	.0050
Covariates					
Gender (Women vs. Men)	-.78	.76	-1.03	-2.2655	.7120
Public Stigma	-.13	.08	-1.65	-.2752	.0245
Self-Stigma	-.19***	.05	-3.71	-.2974	-.0911
Mental Health History (Diagnosis)	1.14	.82	1.38	-.4880	2.7586
Mental Health Utilization	1.61*	.81	2.00	.0210	3.2051
Constant	32.30	1.14	28.33	30.0534	34.5498

Note. * indicates $p < .05$, ** indicates $p < .01$, and *** indicates $p < .001$.

Hypothesis Testing 2: Private Regard as Moderator

The overall model predicting willingness to utilize mental health services was significant, $F(8, 208) = 12.34$, $MSE = 20.24$, $p < .001$, $R^2 = .3219$. The pattern of the results was the same as the first analysis. More specifically, the main effect of PTI was significant ($B = .15$, $SE = .033$, $p < .001$, $CI [.0860, .2171]$), such that higher PTI was predictive of a greater willingness to seek help. The main effect of racial identity-private regard was also significant ($B = .25$, $SE = .10$, $p = .009$, $CI [.0639, .4458]$), such that higher private regard was predictive of a greater willingness to seek help. However, the two-way interaction (Perceived Therapy Inclusivity X Private Regard) was not significant, $F(1, 208) = 3.85$, $SE = .01$, $p = .051$, $\Delta R^2 = .0126$, $CI [-.0484, .0001]$, suggesting that there is no evidence that racial identity-private regard moderates the relationship between PTI and willingness to seek help. See Table 4 for detailed results.

Table 4

Hypothesis testing 2: Private regard as moderator

	<i>B</i>	<i>SE</i>	<i>t</i>	95% CI	
				Lower	Upper
Perceived Therapy Inclusivity (PTI)	.15***	.03	4.56	.0860	.2171
Private Regard	.25**	.10	2.63	.0639	.4458
Interaction Term (PTI x Private Regard)	-.02	.01	-1.96	-.0484	.0001
Covariates					
Gender (Women vs. Men)	-1.11	.74	-1.50	-2.5834	.3490
Public Stigma	-.14	.08	-1.77	-.2897	.0158
Self-Stigma	-.19***	.05	-3.62	-.2963	-.0874
Mental Health History (Diagnosis)	1.13	.83	1.36	-.5055	2.7586
Mental Health Utilization	1.97*	.80	2.46	.3897	3.5556
Constant	32.37	1.18	27.55	30.0544	34.6874

Note. * indicates $p < .05$, ** indicates $p < .01$, and *** indicates $p < .001$.

Ancillary Analyses

To address non-normal distribution of the Racial Identity-Private Regard measure, the first ancillary analysis treated the variable as dichotomous. The pattern of the results was the same as in the main analyses. Specifically, the overall model predicting willingness to utilize mental health services was significant, $F(8, 208) = 12.07$, $MSE = 20.39$, $p < .001$, $R^2 = .3170$. Both the main effects of PTI ($B = .17$, $SE = .045$, $p < .001$, $CI [.0849, .2629]$) and dichotomous racial identity-private regard ($B = 1.48$, $SE = .62$, $p = .020$, $CI [.2373, 2.6973]$) significantly predicted willingness to seek help. However, the two-way interaction (Perceived Therapy Inclusivity X Private Regard [Dichotomous]) was still not significant, $F(1, 208) = 2.25$, $SE = .06$, $p = .13$, $\Delta R^2 = .0074$, $CI [-.2077, .0281]$. See Table 5 for detailed results.

Table 5

Ancillary analysis 1: Moderation with dichotomous private regard

	<i>B</i>	<i>SE</i>	<i>t</i>	95% CI	
				Lower	Upper
Perceived Therapy Inclusivity (PTI)	.17***	.05	3.85	.0849	.2629
Private Regard (Dichotomous)	1.47*	.62	2.35	.2373	2.6973
Interaction Term (PTI x Private Regard [Dich])	-.09	.06	-1.50	-.2077	.0281
Covariates					
Gender (Women vs. Men)	-1.31	.75	-1.76	-2.7848	.1571
Public Stigma	-.17*	.08	-2.19	-.3168	-.0163
Self-Stigma	-.20***	.05	-3.81	-.3051	-.0970
Mental Health History (Diagnosis)	.98	.82	1.19	-.6432	2.6086
Mental Health Utilization	1.87**	.80	2.32	.2833	3.4501
Constant	32.30	1.21	26.68	29.9108	34.6834

Note. * indicates $p < .05$, ** indicates $p < .01$, and *** indicates $p < .001$.

The results of the second ancillary analysis, which included only participants who scored lower than 5 on private regard and treated the variable as continuous, were partially consistent with the previous analyses. Specifically, the overall model predicting willingness to utilize mental health services was significant, $F(8, 105) = 4.13$, $MSE = 23.06$, $p < .001$, $R^2 = .2392$. The main effect of PTI was also significant ($B = .21$, $SE = .052$, $p < .001$, $CI [.1102, .3178]$). However, the main effect of racial identity-private regard was not significant ($B = .25$, $SE = .14$, $p = .08$, $CI [-.0327, .5411]$) although the direction of the relationship was similar to the main analyses and first ancillary analysis, such that higher private regard predicted greater willingness to seek help. This result may be due to the fact that this was a subset of the overall participant population and thus had a smaller sample size ($n = 114$) of those who did not score a 5 on the private regard subscale. Additionally, consistent with previous analyses, the two-way interaction (Perceived Therapy Inclusivity X Private Regard) was not significant, $F(1, 105) = .98$, $SE = .019$, $p = .32$, $\Delta R^2 = .0071$, $CI [-.0549, .0183]$. See Table 6 for detailed results.

Table 6

Ancillary analysis 2: Moderation with continuous private regard (among those who scored lower than 5)

	<i>B</i>	<i>SE</i>	<i>t</i>	95% CI	
				Lower	Upper
Perceived Therapy Inclusivity (PTI)	.21***	.05	4.09	.1102	.3178
Private Regard	.25	.14	1.76	-.0327	.5411
Interaction Term (PTI x Private Regard)	-.018	.02	-.99	-.0549	.0183
Covariates					
Gender (Women vs. Men)	-1.62	1.12	-1.44	-3.8437	.6068
Public Stigma	-.083	.12	-.68	-.3246	.1587
Self-Stigma	-.086	.08	-1.02	-.2522	.0811
Mental Health History (Diagnosis)	1.44	1.31	1.10	-1.1589	4.0437
Mental Health Utilization	.98	1.20	.82	-1.3911	3.504
Constant	29.11	1.83	15.84	25.4629	32.7487

Note. *** indicates $p < .001$.

Discussion

Previous research has shown that Black emerging adults underutilize mental health services (Broman, 2012). Although several factors have been identified as contributors to the underutilization of mental healthcare services among Black emerging adults, very little research has examined Black emerging adults' perceptions of therapy inclusivity (i.e., whether Black adults perceive that therapy services are for them or people who look like them). The goals of this study were to examine whether: (1) perceived therapy inclusivity predicted willingness to utilize mental healthcare services and (2) the relationship between perceived therapy inclusivity and willingness was moderated by two indices of racial identity (i.e., centrality and private regard).

Across multiple analyses, perceived therapy inclusivity consistently predicted willingness to utilize mental health services. Specifically, when Black emerging adults perceived greater inclusivity of therapy services, they were more willing to utilize mental health services. This was the case after controlling for multiple factors, including gender, public stigma, self-stigma,

mental health history, and previous mental healthcare utilization. These findings suggest that Black emerging adults may be more willing to utilize mental health services and engage with the mental healthcare system if they perceive that mental health services are for them. Additionally, these models explained a large portion (ranging from 24% to 33%) of the overall variance in willingness to utilize mental health services among Black emerging adults.

The present study failed to provide evidence that the association between perceived therapy inclusivity and willingness to utilize mental health services was moderated by either index of racial identity (i.e., centrality and private regard). One potential reason for the null result may be related to the measurement of perceived therapy inclusivity. According to IBM, understanding perceived group norms and personal relevance is important when predicting individuals' behaviors (Altschul, Oyserman, & Bybee, 2006; Oyserman et al., 2007). In the context of present study, the perceived group norm is mental healthcare utilization (e.g., whether Black adults utilize mental health services or not) and personal relevance is racial identity (e.g., whether individuals strongly or weakly identify with their racial group [centrality]). The combination of perceived group norms and personal relevance determine the likelihood of engaging in certain behaviors (e.g., mental healthcare utilization). However, some items included in the measure of perceived therapy inclusivity assessed both perceived group norms (i.e., norms of their racial group) and personal relevance (e.g., racial identity) concurrently. One example item is: *"Therapy services and treatments were designed for people who look like me."* Participants who do not view their racial identity as central to their sense of self may not label themselves in terms of their race. Another example is the item: *"As a Black person, I feel welcomed in therapy spaces."* Participants who have lower racial centrality, may answer that they disagree regardless of whether they believe that generally Black people are welcomed in

therapy spaces. Such conflation of these two variables may have made it difficult to parse the moderating effects of racial identity (i.e., centrality and private regard) on the relationship between perceived therapy inclusivity and willingness to utilize mental health services leading to the null finding. A next step from this study could be to conduct cognitive interviews in order to better understand how participants are interpreting the items of the perceived therapy inclusivity measure. Additionally, specific subscales could be created that measure perceived group norms and personal relevance separately.

Another potential explanation for the null finding may be that seeking mental health services is not a meaningful part of Black racial identity. According to IBM, the strength of adherence/non-adherence to a certain behavior can be predicted by the strength of individuals' racial identities only when the behaviors are meaningful to their racial group (Oyserman & Destin, 2010; Oyserman, Kemmelmeier, Fryberg, Brosh, & Hart-Johnson, 2003). Because of historical and current-day mistreatment of Black people in U.S. healthcare systems generally, seeking professional help may not be a meaningful or desirable course of action within Black communities. The present study did not directly assess whether Black emerging adults consider mental health help-seeking to be part of their Black identity.

The lack of evidence supporting the moderating effects of racial identity has an important implication for designing interventions. Specifically, the finding that greater perceptions of perceived therapy inclusivity directly predict greater willingness to utilize mental health services among Black emerging adults suggests that general interventions to improve perceptions of inclusivity may be effective in increasing utilization of mental healthcare services in this population without having to be tailored for individuals with different levels of racial identity. One viable way to increase perceived therapy inclusivity may be to target structural level

indicators of inclusiveness. The following section introduces several evidence-based strategies for antiracist interventions and structural changes to the mental healthcare system that would help to create a better, more inclusive system in order to increase perceptions of inclusivity among Black emerging adults.

Implications for the Mental Healthcare System

Develop Trainings and Workshops. The American Psychiatric Association (APA) recently released a position statement acknowledging the impact of racism on mental health. In this statement, the APA encourages “mental health professionals to be mindful of the existence and impact of racism and racial discrimination in the lives of patients and their families, in clinical encounters, and in the development of mental health services” (American Psychiatric Association Council on Minority Mental Health and Health Disparities, 2018, pg. 1). However, the APA does not provide recommendations on how mental health professionals can incorporate this into their interactions with their clients. Thus, I argue that mental health agencies should create activity-based trainings and workshops to educate mental health professionals on the history of Black people’s experiences in the mental health system, the current-day impact of racism on the lives of their clients, and how to best use this information to inform their interactions with Black clients and their communities (Hamilton-Mason & Schneider, 2018; The People’s Institute for Survival and Beyond, 2018).

This strategy has already been employed at Massachusetts General Hospital. Because of the advocacy of medical residents, the Division of Public and Community Psychiatry at Massachusetts General Hospital created a didactic course, “Racism, Justice, and Community Mental Health,” as a part of the Massachusetts General Hospital/McLean Psychiatry residency program (Medlock et al., 2017). By the end of the required training module (comprised of four

50-minute interactive lectures), attendees are expected to be able to define racism and explain how different levels of racism impact access to mental health services for Black clients.

Attendees also leave the training module able to describe the ways that racial bias impacts both the diagnosis and treatment of Black clients, and to suggest approaches to combat racial biases in the mental healthcare system (Medlock et al., 2017).

Trainings like this are a necessary first step, but I posit that these trainings should go one-step further to help providers better understand how to engage with clients about these topics. For example, providers could ask Black clients to describe (negative) therapy encounters they may have had in the past and use this information to better serve them (Hankerson, Suite, & Bailey, 2015). Engaging clients and communities in this way will improve their perceptions of inclusivity because a provider is taking the time to incorporate their previous experiences into better treatment (Hankerson, Wells, et al., 2018). Additionally, in order to for the effects to be sustainable, trainings such as these should anticipate potential challenges mental health professionals may face in the developmental process of learning to engage in antiracist action (e.g., confrontation of people perpetrating racism) and prepare to provide instruction on coping strategies for navigating such challenges (Malott, Schaeffle, Paone, Cates, & Haizlip, 2019). After initial trainings like this above, mental health service organizations should begin to examine their outreach and relationship building efforts with Black communities.

Outreach (Building relationships). Mental health service organizations also need to examine whether and how they reach out to Black communities and whether Black Americans are involved in the development of outreach and advertising materials and research being conducted in their communities (Mance, Mendelson, Byrd, Jones, & Tandon, 2010; Woods, 2009). The community-based participatory research framework provides a good background for

how mental health service organizations may go about building relationships and partnerships with Black communities (Woods, 2009). Some questions that organizations can ask themselves are: “*What kind of relationship does our organization have with Black communities (historically and present-day)?*” ‘*How have we replicated or maintained systems of oppression that harm Black communities (i.e., White supremacy, anti-Black racism)?*’ “*How can we build relationships with Black communities in our metro area?*” “*What are the ways that we do specific outreach to Black communities?*” “*How accessible is our information?*” and “*Who is featured on our outreach materials?*”

These questions, along with community-based interventions, will encourage interrogation of current outreach practices and building of genuine relationships. Building partnerships with Black communities where Black adults’ voices are heard and valued and creating community-based interventions are both strategies that have been used by social workers to raise awareness of mental health conditions, promote help seeking, build trust, and decrease perceptions of stigma (Williams, Gorman, & Hankerson, 2014). These interventions that focused on changing attitudes toward mental health treatment and similar interventions could also potentially increase Black adults’ perceptions of the inclusiveness of the mental healthcare system.

One example of a way to partner with Black communities is through church-based health promotion (Hankerson, Wong, & Polite, 2018). Church-based health promotion strategies have primarily focused on medical conditions, such as diabetes, cancer and cardiovascular disease, but there is opportunity to collaborate with Black churches and gain pastoral support for mental health services. By collaborating with Black churches, mental health service organizations can increase perceptions of therapy inclusivity among Black adults because they are incorporating an important part of their identity into mental health awareness and treatment.

Develop and provide culturally responsive treatments. Little empirical research documents treatment strategies that are specific to Black Americans (Jones, Huey Jr, & Rubenson, 2018). However, there are some recommendations on topics that clinicians may want to address in their sessions with Black clients, including “addressing experiences of racism, supporting positive racial/ethnic identity development, and incorporating clients’ spiritual and/or religious values into treatment” (Jones et al., 2018, pg. 561). Additionally, there are mental health interventions that have been culturally tailored to be more harmonious with the cultural values and beliefs of Black Americans.

One example of a culturally-specific treatment is *Nia*, an intervention for African American women who been impacted by intimate partner violence and had symptoms of suicidality (Taha et al., 2015). *Nia* emphasized important Afrocentric values (Corneille, Ashcraft, & Belgrave, 2005), such as spirituality and collectivism, and used culturally-specific information, including positive African American female mentors and heroines and African proverbs (Taha et al., 2015). Wider use of culturally-adapted and/or tailored interventions and treatments are imperative in improving the mental health system and Black adults’ perceptions of inclusivity. These interventions have Black mental health professionals involved in the development and implementation. Interventions similar to the one detailed above will indicate to Black emerging adults that their culture and values are important and can be incorporated into their mental health treatment, which may in turn increase their perceptions of inclusiveness of the therapy services.

Increase Black adults’ representation in clinical staff and leadership. In order to implement culturally tailored interventions and treatments, Black mental health professionals experience and backgrounds are a necessity as Black clients frequently report preferring to seek

care from a Black mental health professional (Cabral & Smith, 2011; Goode-Cross & Grim, 2016). In one study, Black clients who sought care from Black therapists reported greater perceptions of understanding and acceptance from therapists as well as a greater belief in use of therapeutic strategies (Sanders Thompson & Alexander, 2006). Thus, another structural change that is recommended is the development of a diverse pipeline to the mental health workforce and the targeted recruitment of Black mental health professionals to work at public mental health agencies and university counseling centers.

However, it is not enough to purely have representation at the clinician level, but also in director positions and other leadership roles (Clark, 2018; Huang & Holliday-Moore, 2019). In 2019, the SAMHSA recognized three leaders who made a substantial impact on the mental and behavioral health of their communities. Dr. Altha Stewart is the first African American to lead the American Psychiatric Association and one of her main goals is “to be a leading voice for diversity and inclusion in medicine and mental health.” (Huang & Holliday-Moore, 2019, pg. 1). This representation at both the clinician- and director-levels could increase Black adults’ perceptions of therapy inclusivity because they can see people who look like them that are both treating them and advocating for them on a national level (Cook & Glass, 2015; Sanders Thompson & Alexander, 2006).

Tailor interventions to Black emerging adult population. The interventions described above are based on the broader Black adult population. Thus, interventions would need to be tailored to account for the unique characteristics of the Black emerging adult population. Said differently, when beginning to build relationships, researchers, clinicians, and interventionists should specifically engage the Black emerging adult population (Mance et al., 2010). This may include piloting the interventions in different settings that Black emerging adults frequent, such

as social media interventions (Clarke, Kuosmanen, & Barry, 2014), Black young professional organizations (National Urban League, 2019), and youth and young adult ministries in Black church communities (Snell, 2009). Bringing mental health promotion programs and services into Black emerging adult communities could improve their perceptions of therapy inclusivity by providing programming in spaces where they feel safe and comfortable.

Implications for College Campuses

The strategies discussed above are applicable to the general Black population. Although Black college students share many experiences with the general population, they may experience stressors specific to their experience as a student on campus (Greer & Brown, 2011; Mushonga, 2019). Their access to mental healthcare is also unique in that they have greater access to mental health services for free or reduced costs, compared to the general Black adult population because of the health promotion and counseling services on college campuses in the U.S. (Gallagher, 2014). Importantly, students who have utilized mental health services on campus have reported that counseling services helped them improve their academic performance and stay in school (LeViness, Bershad, Gorman, Braun, & Murray, 2019). This emphasizes the necessity of students having access to equitable mental health service, not only for their mental health and well-being, but also for their retention on college campuses.

One suggestion for college faculty is to provide information on mental health resources on campus not only at the beginning of the semester during syllabus review, but also continually throughout the semester, especially at high stress moments (e.g. midterms and finals). Additionally, university counseling centers should be engaging in tailored outreach and messaging about positive mental health to their Black student population (Mushonga, 2019). Tailored outreach should include partnering with various Black student organizations and

facilitating mental health promotion programs in Black student housing and other spaces where Black students feel relaxed and comfortable (Harper & Quaye, 2007). This tailored outreach could improve Black students' perceptions of therapy inclusivity and encourage them to utilize mental healthcare services.

Limitations and Future Directions

This study is not without limitations. The first limitation is that the current study examines an intention (i.e., willingness to utilize mental health services) rather than the actual behavior (i.e., utilization of mental health services). There is evidence that intentions predict actual behaviors under certain circumstances (McEachan, Conner, Taylor, & Lawton, 2011; Webb & Sheeran, 2006; Wood et al., 2016), but it is tenuous. For example, a meta-analysis found that there is small-to-medium positive effect ($d = .36$) of intention on actual behavior (Webb & Sheeran, 2006). However, most of the studies in this analysis were focused on physical health behaviors (e.g., condom use or exercise), and no studies were focused on behaviors specifically related to mental health. This suggests that willingness to seek mental health services may predict actual utilization of mental health services, if the trend is similar to that seen among physical health behaviors. Because very few studies have examined the intention-behavior link among mental health behaviors, future research should examine whether perceived therapy inclusivity predicts willingness to seek mental health services and actual mental health help-seeking behaviors.

The second limitation concerns the current sample. The majority of the sample is currently enrolled at a university either at the undergraduate or graduate level. There is evidence that emerging adults that are enrolled in college are more likely to utilize mental health services than emerging adults who are not in college (Broman, 2012). Thus, these results may not be

generalizable to emerging adults that are not a part of the college student population. Because of the amount of mental health resources on college campuses, college students most likely have more access to mental health services for free or reduced costs, compared to their non-college peers (Gallagher, 2014). Therefore, it is possible that college students may have overall higher perceptions of inclusivity and greater willingness to utilize services. Additionally, the current sample was mostly women (74%). Black men are often underrepresented in mental health research (Campbell & Allen, 2019; Hammond, 2012) and are less likely to utilize mental health services (Williams et al., 2007; Williams & Cabrera-Nguyen, 2016). Consistent with these previous findings, the results of the current study showed that men are less willing to seek help and report lower utilization of mental health services. These results suggest that the current results may not be generalizable to a population of Black men between the ages of 18 and 29. For example, it is possible that though Black men may perceive that therapy services are for their race, they may not think that therapy services and treatments are for both their race and gender, due to the lack of services that are both culturally appropriate and specific to their gender identity (Watkins & Neighbors, 2007). Given the intersection of race and gender of Black men, the association between perceived therapy inclusivity and willingness may be weaker for Black men than Black women. Future research should examine potential differences in perceived therapy inclusivity and willingness among college and non-college emerging adult populations with greater gender diversity.

The third limitation is that order effects may have been introduced due to the predictor, moderator, and outcome measures not being randomized. The current order of the measures was as follows: (1) willingness to seek help (2) perceived therapy inclusivity and (3) indices of racial identity (i.e., centrality and private regard). This order was chosen so that participant responses

to the willingness to seek help questions would not be influenced by their perceptions of therapy inclusivity. It is possible that because participants completed the perceived therapy inclusivity measure before the racial identity measure, they may have been primed to think about their racial identity given that most items in the perceived therapy inclusivity measure began with the statement, “as a Black person.” This may have led to the higher scores on the private regard and centrality measures. Future research should randomize the order of measures to address this limitation.

The last limitation is related to the definition and measurement of perceived therapy inclusivity. As defined in the current study, perceived therapy inclusivity is solely focused on inclusivity based on racial group membership. There are other social identities that are important to Black emerging adults, such as sexual orientation, religious affiliation, caregiver status, and shared first language. For example, Black emerging adults who identify as lesbian, gay, bisexual, transgender or questioning (LGBTQ) may feel that services are not inclusive for their set of identities (race and sexual orientation) (National LGBT Health Education Center, 2019). Additionally, the perceived therapy inclusivity measure was developed for the current study. Although the internal consistency was high, the current study lacked additional information about the psychometrics of the scale, including test-retest reliability, discriminant validity, and concurrent validity. Thus, validation of the perceived therapy inclusivity scale by employing the multi-trait multi-method approach and using large samples is essential for further investigations of the role of perceived therapy inclusivity in mental healthcare utilization. Taken together, future research should take a more intersectional approach and specifically examine perceptions of therapy inclusivity among Black sexual and gender minority adults and conduct rigorous psychometric test of the measure of perceived therapy inclusivity.

Conclusion

Critical race theory states that racism is embedded in the very nature of our social systems (Delgado & Stefancic, 2001), and the mental healthcare system is no exception to this. Due to this historical and cultural context, the current mental health system in the U.S. is centered on the experiences of the White majority population and excludes people of color. This study was the first to measure perceived therapy inclusivity (i.e., the extent to which Black adults perceive that therapy services are for them or people who look like them) and provided strong evidence that perceptions of inclusiveness of therapy services is one important factor associated with willingness to utilize mental health services among Black emerging adults. In her manuscript, “Separate and Unequal: The Legacy of Racially Segregated Psychiatric Hospitals,” Vanessa Jackson (2001; pg. 9) states that “the development of genuinely culturally competent services is premised on the examination and elimination of the institutional racism that served as the foundation for the development of organized mental health services for African Americans.” Taken together, the present study and this quote emphasize the necessity of implementing structural changes to the mental healthcare system in order to create a better, more inclusive system for all Black adults, increase perceived therapy inclusivity and willingness to seek care, and ultimately, improve mental health outcomes within Black communities.

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Appendix A

SONA Advertisement

Study Name: Black Mental Health Study

Brief Abstract: This is an online survey study in which you will be asked to complete a series of measures that are designed to assess your perceptions of and attitudes toward mental healthcare services.

Detailed Description: If you meet the eligibility criteria, you will be redirected to the online survey (approximately 30-40 min.). In the online survey, you will complete a series of measures that are designed to assess your perceptions of and attitudes toward the current mental healthcare services in the US. You will receive .75 research credits upon completion of the study.

Study length: 35 minutes

Amount of credits: .75

Appendix B

TelegRAM Announcement for Black Mental Health Study

Title: Black Mental Health Study- Seeking Survey Participants

The Black Mental Health Study is seeking Black emerging and young adults' (aged 18-40) perspectives on mental health and therapy services. Compensation may be available. To participate, please go to: <https://bit.ly/2Mogjq6>

If you have any questions or concerns, please contact Randl Dent, dentr@vcu.edu.

Appendix C

(SONA) RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM

STUDY TITLE: Black Mental Health Study

VCU INVESTIGATOR: Nao Hagiwara, Associate Professor, (804) 828-6822

ABOUT THIS CONSENT FORM

You are being invited to participate in a research study. **It is important that you carefully think about whether being in this study is right for you and your situation.**

This consent form is meant to assist you in thinking about whether or not you want to be in this study. **Please ask the investigator or the study staff to explain any information in this consent document that is not clear to you.**

Your participation is voluntary. You may decide not to participate in this study. If you do participate, you may withdraw from the study at any time. Your decision not to take part or to withdraw will involve no penalty or loss of benefits to which you are otherwise entitled.

AN OVERVIEW OF THE STUDY AND KEY INFORMATION

Why is this study being done?

Black/African Americans are less likely to utilize mental health services compared to White Americans, even though they are both affected by mental health problems at similar rates. This trend may also occur during emerging and young adulthood. Because of the important life changes occurring during emerging adulthood (ages 18 to 29) and young adulthood (30-40), it is important to examine Black emerging and young adults' mental health and perceptions of therapy services.

There has been some research investigating factors that may influence mental and physical healthcare utilization in the emerging adult population, such as health insurance status, financial costs, and personal and public stigma. However, the racial disparities reported in the mental healthcare utilization literature suggest that there may be unidentified barriers that contribute to the underutilization of mental healthcare services among Black emerging adults.

The purpose of this research study is to find out about Black emerging and young adults' perceptions of therapy services. We think that gaining insight into Black emerging and young adults' perceptions of therapy services will allow us to identify barriers and facilitators to utilizing mental health services. This study will allow us to learn more about it. These hypotheses will be

addressed by utilizing an online survey. Findings from the proposed research will lay the foundation for future policy research.

What will happen if I participate?

In this study, you will be asked to do the following things:

1. Take a survey and answer questions about your current mental health, history of utilizing mental health services and perceptions of therapy services.

Your participation in this study will last between 30-40 minutes. You are free to take the survey wherever is most comfortable for you.

What alternative treatments or procedures are available?

You can receive extra credit without being in the study by completing another assignment as determined by the professor of the class for which you are achieving extra credit.

What are the risks and benefits of participating?

Risks and Discomforts	Benefits to You and Others
<ul style="list-style-type: none">• Participation in research might involve some loss of privacy. There is a small risk that someone outside the research study could see and misuse information about you.• The study questionnaires ask questions that are sensitive and personal in nature and may make you feel uncomfortable. You may refuse to answer any question that makes you feel uncomfortable.• You may learn things about yourself that you did not know before and that could affect how you think about yourself.	<ul style="list-style-type: none">• There is no guarantee that you will receive any benefits from being in this study. However, possible benefits include an opportunity to voice your opinions on therapy services and a written list of resources about mental health services specific to Black/African American adults. We hope the information learned from this study will provide more information about Black emerging and young adults' perceptions of therapy services.

Will I be paid to participate in the study?

Upon completion of the study, you will receive .75 credits of extra credit. You will also receive a [resource list](#).

Can I stop being in the study?

You can stop participating in this research study at any time. You are able to skip any questions that make you feel uncomfortable or that you do not want to answer.

Your participation in this study may be stopped at any time by the investigator without your consent. The reasons might include:

- you are found to not be eligible for the study
- you have not followed study instructions

How will information about me be protected?

VCU and the VCU Health System have established secure research databases and computer systems to store information and to help with monitoring and oversight of research. Your information may be kept in these databases but are only accessible to individuals working on this study or authorized individuals who have access for specific research related tasks.

Identifiable information in these databases are not released outside VCU unless stated in this consent or required by law. Although results of this research may be presented at meetings or in publications, we will not release any information that could identify you.

In the future, after all identifiable information has been removed, data collected from this study could be used for other research studies by this study team or another researcher without asking you for additional consent.

Personal information about you might be shared with or copied by authorized representatives from the following organizations for the purposes of managing, monitoring and overseeing this study:

- Representatives of VCU and the VCU Health System

In general, we will not give you any individual results from the study. If you provide your email address for the drawing for a gift card, once the study has been completed, we may send you a summary of all of the results of the study and what they mean.

Whom should I contact if I have questions about the study?

The investigator and study staff named below are the best person(s) to contact if you have any questions, complaints, or concerns about your participation in this research:

Dr. Nao Hagiwara

Department of Psychology

808 West Franklin Street, Room 301

804-828-6822

nagiwara@vcu.edu

OR

Randl Dent

Department of Psychology

dentr@vcu.edu

If you have general questions about your rights as a participant in this or any other research, or if you wish to discuss problems, concerns or questions, to obtain information, or to offer input about research, you may contact:

Virginia Commonwealth University Office of Research

800 East Leigh Street, Suite 3000, Box 980568, Richmond, VA 23298

(804) 827-2157; https://research.vcu.edu/human_research/volunteers.htm

Statement of consent

I have been provided with an opportunity to read this consent information carefully. I understand the information about this study. All of the questions that I wish to raise concerning this study have been answered. By clicking the button below, I have not waived any of the legal rights or benefits to which I otherwise would be entitled. By clicking the button below, I freely consent to participate in this research study.

Appendix D

(NON-SONA) RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM

STUDY TITLE: Black Mental Health Study

VCU INVESTIGATOR: Nao Hagiwara, Associate Professor, (804) 828-6822

ABOUT THIS CONSENT FORM

You are being invited to participate in a research study. **It is important that you carefully think about whether being in this study is right for you and your situation.**

This consent form is meant to assist you in thinking about whether or not you want to be in this study. **Please ask the investigator or the study staff to explain any information in this consent document that is not clear to you.**

Your participation is voluntary. You may decide not to participate in this study. If you do participate, you may withdraw from the study at any time. Your decision not to take part or to withdraw will involve no penalty or loss of benefits to which you are otherwise entitled.

AN OVERVIEW OF THE STUDY AND KEY INFORMATION

Why is this study being done?

Black/African Americans are less likely to utilize mental health services compared to White Americans, even though they are both affected by mental health problems at similar rates. This trend may also occur during emerging and young adulthood. Because of the important life changes occurring during emerging adulthood (ages 18 to 29) and young adulthood (30-40), it is important to examine Black emerging and young adults' mental health and perceptions of therapy services.

There has been some research investigating factors that may influence mental and physical healthcare utilization in the emerging adult population, such as health insurance status, financial costs, and personal and public stigma. However, the racial disparities reported in the mental healthcare utilization literature suggest that there may be unidentified barriers that contribute to the underutilization of mental healthcare services among Black emerging adults.

The purpose of this research study is to find out about Black emerging and young adults' perceptions of therapy services. We think that gaining insight into Black emerging and young adults' perceptions of therapy services will allow us to identify barriers and facilitators to utilizing mental health services. This study will allow us to learn more about it. These

hypotheses will be addressed by utilizing an online survey. Findings from the proposed research will lay the foundation for future policy research.

What will happen if I participate?

In this study, you will be asked to do the following things:

2. Complete an online screening survey to determine your eligibility for the study.
3. Take a survey and answer questions about your current mental health, history of utilizing mental health services and perceptions of therapy services.

Your participation in this study will last between 30-40 minutes. You are free to take the survey wherever is most comfortable for you.

What are the risks and benefits of participating?

Risks and Discomforts	Benefits to You and Others
<ul style="list-style-type: none">• Participation in research might involve some loss of privacy. There is a small risk that someone outside the research study could see and misuse information about you.• The study questionnaires ask questions that are sensitive and personal in nature and may make you feel uncomfortable. You may refuse to answer any question that makes you feel uncomfortable.• You may learn things about yourself that you did not know before and that could affect how you think about yourself.	<ul style="list-style-type: none">• There is no guarantee that you will receive any benefits from being in this study. However, possible benefits include an opportunity to voice your opinions on therapy services and a written list of resources about mental health services specific to Black/African American adults. We hope the information learned from this study will provide more information about Black emerging and young adults' perceptions of therapy services.

Will I be paid to participate in the study?

Upon completion of the study, you will be asked if you would like to enter a drawing to receive one of 16 \$50 amazon cards. If you would like to enter the drawing, you will be asked to provide your email address. Your email address will not be linked in any way to your responses on the survey. You will also receive a [resource list](#).

Can I stop being in the study?

You can stop participating in this research study at any time. You are able to skip any questions that make you feel uncomfortable or that you do not want to answer.

Your participation in this study may be stopped at any time by the investigator without your consent. The reasons might include:

- you are found to not be eligible for the study
- you have not followed study instructions

How will information about me be protected?

VCU and the VCU Health System have established secure research databases and computer systems to store information and to help with monitoring and oversight of research. Your information may be kept in these databases but are only accessible to individuals working on this study or authorized individuals who have access for specific research related tasks.

Identifiable information in these databases are not released outside VCU unless stated in this consent or required by law. Although results of this research may be presented at meetings or in publications, we will not release any information that could identify you.

In the future, after all identifiable information has been removed, data collected from this study could be used for other research studies by this study team or another researcher without asking you for additional consent.

Personal information about you might be shared with or copied by authorized representatives from the following organizations for the purposes of managing, monitoring and overseeing this study:

- Representatives of VCU and the VCU Health System

In general, we will not give you any individual results from the study. If you provide your email address for the drawing for a gift card, once the study has been completed, we may send you a summary of all of the results of the study and what they mean.

Whom should I contact if I have questions about the study?

The investigator and study staff named below are the best person(s) to contact if you have any questions, complaints, or concerns about your participation in this research:

Dr. Nao Hagiwara

Department of Psychology

808 West Franklin Street, Room 301

804-828-6822

nagiwara@vcu.edu

OR

Randl Dent

Department of Psychology

dentr@vcu.edu

If you have general questions about your rights as a participant in this or any other research, or if you wish to discuss problems, concerns or questions, to obtain information, or to offer input about research, you may contact:

Virginia Commonwealth University Office of Research

800 East Leigh Street, Suite 3000, Box 980568, Richmond, VA 23298

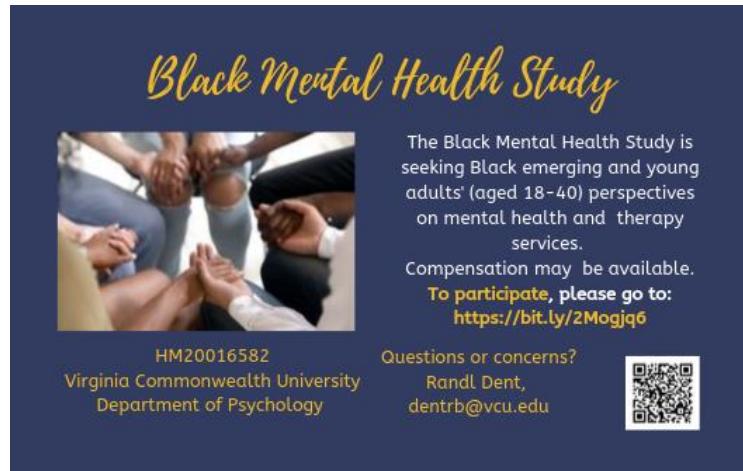
(804) 827-2157; https://research.vcu.edu/human_research/volunteers.htm

Statement of consent

I have been provided with an opportunity to read this consent information carefully. I understand the information about this study. All of the questions that I wish to raise concerning this study have been answered. By clicking the button below, I have not waived any of the legal rights or benefits to which I otherwise would be entitled. By clicking the button below, I freely consent to participate in this research study.

Appendix E RECRUITMENT FLYERS

3x5 flyer (Print)



8 ½ X 11 flyer (Print)



Twitter Flyers:

Black Mental Health Study

The Black Mental Health Study is seeking Black emerging and young adults' (aged 18-40) perspectives on mental health and therapy services.

Compensation may be available.

To participate, click the link in the tweet!

HM20016582
Virginia Commonwealth University
Department of Psychology

Questions or concerns?
Randi Dent,
dentrb@vcu.edu



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The Black Mental Health Study is seeking Black emerging and young adults' (aged 18-40) perspectives on mental health and therapy services.

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To participate, click the link in the tweet!

HM20016582
Virginia Commonwealth University
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Questions or concerns?
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To participate, click the link in the tweet!

HM20016582

Virginia Commonwealth University
Department of Psychology

Questions or concerns?

Randl Dent,
dentrb@vcu.edu



Instagram Flyer:



Black Mental Health Study

The Black Mental Health Study is seeking Black emerging and young adults' (aged 18-40) perspectives on mental health and therapy services.

Compensation may be available.

To participate, go to: <https://bit.ly/2Mogjq6>

HM20016582
Virginia Commonwealth University
Department of Psychology



Questions or concerns?
Randi Dent,
dentr@vcu.edu

Appendix F Resource List

Black Mental Health Resource List

General Resources:

- [Mental Health Disparities: African Americans](#)
- [How Churches Are Addressing the Mental Health Needs of the Black Community](#)
- Black Mental Health Alliance: [Blackmentalhealth.com](#)

Getting Started with Therapy:

- [Basics of Therapy- Psychology Today](#)
- [Find a Therapist- Psychology Today](#)
- [Guide to getting started with Therapy](#)
 - Includes Tracking List and questions to prepare for first session.
- [What to expect in your first session](#)

Resources specific to Black men:

- [Brother, You're on My Mind](#)
 - Brother, You're on My Mind is a partnership between National Institute for Minority Health and Disparities (NIMHD) and the Omega Psi Phi Fraternity, Inc. The initiative is intended to raise awareness of the mental health challenges associated with depression and stress that affect African American men and their families.
- [Henry Health](#)
 - About HenryHealth: “Our goal at Henry Health is to make access to mental health care easy and convenient, removing all barriers to seeking treatment and we aim to support men in achieving optimal health.”
- [#YouGoodMan: Black Men and Mental Health](#)

Resources specific to Black women:

- <https://www.therapyforblackgirls.com/>
 - “Therapy for Black Girls” has articles, podcasts, and a therapist directory that you can sort by State AND Insurance!
- [Black Women: Mental Health Treatment is for Us Too](#)
- [What keeps some black women from seeking mental health care — and how therapists are working to change that](#)
- <https://www.teenvogue.com/story/why-i-need-a-woman-of-color-therapist>

Resources specific to Black (and people of color) LGBTQ individuals:

- [National Queer & Trans Therapists of Color Network](#) (NQTCN)
- [NQTCN's List of Hotline, Online and Organization Resources](#)
- [The Therapy for Black Girls Podcast \(Episode 58: GLBTQ Affirmative Spaces\)](#)
- [2019 Black & African American LGBTQ Youth Report](#)

Apps/Videos:

- The Safe Space: A Minority Mental Health App geared towards the Black Community.



- <https://www.facebook.com/TheSafePlaceTSP/>
- [iOS App Store](#)
- [Changing views on mental health in the Black community](#)
- [Black Mental Health Matters](#)
- [Black Churches and Mental Health](#)

Hotlines:

- National Suicide Prevention Lifeline: (800) 273-8255
- National Domestic Violence Hotline: (800) 799-7233
- Family Violence Helpline: (800) 996-6228
- National Hopeline Network: (800) 784-2433
- Self-Harm Hotline: (800) 366-8288
- Planned Parenthood Hotline: (800) 230-7526
- Alcoholism & Drug Dependency Hope Line: (800) 622-2255
- National Crisis Line, Anorexia and Bulimia: (800) 233-4357
- LGBT Hotline: (888) 843-4564
- Trevor Crisis Hotline: (866) 488-7386

Appendix G

FULL SURVEY MEASURES

Intention to seek professional psychological help

Response Options: Very Unlikely (1) to Very Likely (5)

1. If you were to experience mental health problems in the future, how likely is that you would seek help from a mental health professional to help with your symptoms?
2. (Branched question): You answered *insert answer here*, why did you choose that response? (open-ended)

Willingness to Utilize Mental Health Services (IASMHS)

Adapted version Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS; Mackenzie, Knox, Gekoski, & Macaulay, 2004)

Instructions: Please rate on a scale of 1 (Strongly disagree) to 5 (Strongly agree) how much you agree with the following statements. In the statements below, mental health professionals are referring specifically to psychologists, licensed clinical social workers, and licensed practiced counselors.

Response Options: Strongly disagree (1) to Strongly agree (5)

Psychological openness:

1. There are certain problems which should not be discussed outside of one's immediate family.
4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.
7. It is probably best not to know everything about oneself.
9. People should work out their own problems; getting help from a mental health professional should be a last resort.
12. Psychological problems, like many things, tend to work out by themselves.
14. There are experiences in my life I would not discuss with anyone.
18. There is something admirable in the attitudes of people who are willing to cope with their conflicts and fears without resorting to help from a mental health professional.
21. People with strong characters can get over psychological problems by themselves and would have little need for help from a mental health professional.

Help-seeking propensity Subscale

2. I would have a very good idea of what to do and who to talk to if I decided to seek help from a mental health professional for psychological problems.
5. If good friends asked my advice about a psychological problem, I might recommend that they see a mental health professional.

8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in therapy.
10. If I were to experience psychological problems, I could get help from a mental health professional if I wanted to.
13. It would be relatively easy for me to find the time to see a mental health professional for psychological problems.
15. I would want to get help from a mental health professional if I were worried or upset for a long period of time.
19. If I believed I were having a mental breakdown, my first inclination would be to get attention from a mental health professional.
22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.

Indifference to Stigma:

3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.
6. Having been mentally ill carries with it a burden of shame.
11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.
16. I would be uncomfortable seeking help from a mental health professional for psychological problems because people in my social or business circles might find out about it.
17. Having been diagnosed with a mental disorder is a blot on a person's life.
20. I would feel uneasy going to a mental health professional because of what some people would think.
23. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up."
24. I would be embarrassed if my neighbor saw me going into the office of a mental health professional who deals with psychological problems.

Perceived Therapy Inclusivity

these 16 items were randomized

Instructions:

Mental health professionals are referring specifically to psychologists, licensed clinical social workers, and licensed practiced counselors.

Therapy services and treatments include making an appointment to talk with a mental health professional or having attended sessions with a mental health professional.

Response Options: Strongly disagree (1) to Strongly agree (5)

1. Therapy services and treatments were not designed with Black individuals in mind. (R)
2. Therapy services and treatments were designed for people who look like me.
3. As a Black person, I feel welcomed in therapy spaces.
4. As a Black person, I do not feel like I belong in therapy spaces. (R)
5. Therapy services and treatments are primarily for White people. (R)
6. Therapy services and treatments are not effective for Black adults. (R)
7. Therapy services offer resources (e.g., readings, referral information, websites, apps, etc.) specific to Black people.
8. Therapy services do not offer culturally relevant services and treatments for Black people. (R)
9. Therapy services reflect my values and beliefs as a Black person.
10. Therapy services do not incorporate factors that are important to me as a Black person (e.g., religion, family, immigrant status, etc.). (R)
11. Therapy services and treatments do not reflect my experiences as a Black person. (R)
12. Mental health professionals cannot relate to me as a Black person. (R)
13. Mental health professionals can understand my experiences as a Black person.
14. Mental health professionals can relate to my experiences as a Black person.
15. Therapy services have culturally competent mental health professionals.
16. Therapy services lack mental health professionals who look like me. (R)

Perceived Efficacy of Professional Help

Citation: Kessler RC, Ustun TB (2004) The World Mental Health (WMH) Survey Initiative Version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI). Int J Methods Psychiatr Res 13:93–121

Response Options: Answers could vary between 0 and 100%.

1. Of the people in general who see a mental health professional for serious emotional problems, what percent do you think are helped? Answers could vary between 0 and 100%.



2. Of those with serious emotional problems who do not get help from a mental health professional, what percent do you think get better even without it? Answers could vary between 0 and 100%.



Perceived Effectiveness of therapy services

Please rate on a scale of 1 (Strongly disagree) to 5 (Strongly agree) how much you agree with the following statements.

Response Options: Strongly Disagree (1) to Strongly Agree (5)

1. Therapy services and treatments would be effective for all Black people (including me).
2. Therapy services and treatments would be effective for me, **but not** other Black people.
3. Therapy services and treatments would be effective for other Black people, **but not** for me.
4. Therapy services and treatments would **not** be effective for Black people at all (including myself).

Mental Health Symptoms

Depression (PHQ-9)

Response Options: 1=Not at all sure; 2=Several days; 3=Over half the days; 4= Nearly every day

Over the last 2 weeks, how often have you been bothered by the following problems? (1=Not at all sure; 2=Several days; 3=Over half the days; 4= Nearly every day)

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual
9. Thoughts that you would be better off dead or of hurting yourself in some way

Anxiety (GAD-7)

Response Options: 1=Not at all sure; 2=Several days; 3=Over half the days; 4= Nearly every day

Over the last 2 weeks, how often have you been bothered by the following problems?

1. Feeling nervous, anxious, or on edge
2. Not being able to stop or control worrying
3. Worrying too much about different things
4. Trouble relaxing
5. Being so restless that it's hard to sit still
6. Becoming easily annoyed or irritable
7. Feeling afraid as if something awful might happen

Positive Mental Health (Modified Flourishing Scale)

Ed Diener and Robert Biswas-Diener, January 2009

Response options were original 1-7, for the current study, 1-5 (strongly disagree to strongly agree)

Instructions: Below are 8 statements with which you may agree or disagree. Using the 1-5 scale below, indicate your agreement with each item by indicating that response for each statement.

1. I lead a purposeful and meaningful life.
2. My social relationships are supportive and rewarding.
3. I am engaged and interested in my daily activities.
4. I actively contribute to the happiness and well-being of others.
5. I am competent and capable in the activities that are important to me.
6. I am a good person and live a good life.
7. I am optimistic about my future.
8. People respect me.

Perceived Need

Adapted from the Health Minds Study (Ketchen Lipson et al., 2018).

Response Options: 1 (Strongly Disagree) to 5 (Strongly Agree)

1. In the past 12 months, I needed help from a mental health professional for emotional or mental health problems such as feeling sad, blue, anxious or nervous.
2. Did you receive help for emotional or mental health problems? (Yes/No)?
 - a. (If no, will answer): I should you have received help from a mental health professional for emotional mental health problems that I identified (1: Strongly Disagree to 5:Strongly Agree)

Knowledge of Resources

From the Health Minds Study (Ketchen Lipson et al., 2018).

Response Options: 1(Strongly Disagree) to 5 (Strongly Agree)

1. If you needed to seek professional help for your mental or emotional health, you would know where to go.
2. Where would you go to seek help for your mental or emotional health?(open-ended)

Diagnosed mental health condition/Impairment

Adapted from Health Minds Study (Ketchen Lipson et al., 2018). Will be coded 0=None; 1=any

1. Have you ever been diagnosed with any of the following conditions by a health professional (primary care doctor, psychiatrist, psychologist, etc.)? (Evaluated Need)
 - a. Depression or other mood disorders;
 - b. Anxiety;
 - c. Attention disorder or learning disability;
 - d. Eating disorder;
 - e. Psychosis;
 - f. Personality disorder;

- g. Substance abuse disorder;
 - h. No, none of these;
 - i. Don't know
2. In the past 4 weeks, how many days have you felt that emotional or mental difficulties have hurt your daily activities (e.g., interacting with friends or family, academic or work performance, etc.)?
- a. **Response options:** None, 1-2 days, 3-5 days, 6 or more days (0-4)

Mental Health Care Utilization

Adapted from Health Minds Study (Ketchen Lipson et al., 2018).

1. Have you ever received counseling or therapy for your mental or emotional health from a mental health professional (psychologist, social worker, or licensed practicing counselor)? (Yes/No)
2. How helpful, overall, do you think therapy or counseling was or has been for your mental or emotional health?
 - a. Very Helpful
 - b. Helpful
 - c. Somewhat Helpful
 - d. Not at all helpful
3. Have you ever received counseling or therapy for your mental or emotional health from your primary care doctor? (Yes/No)
4. How do you feel about seeking help from a mental health professional? (open-ended)
5. What are the reasons you would seek help from a mental health professional? (open-ended)
6. What are the reasons you would choose ***not*** to seek help from a mental health professional? (open-ended)
7. (If they have sought help): What were your past experiences like seeking help from a mental health professional? (open-ended)

Family/Close Friends History of Utilization

Adapted from Health Minds Study (Ketchen Lipson et al., 2018).

1. As far as you know, how many of your close friends or family have ever sought professional help for an emotional or mental health problem?
 - a. **Response Options:** 0, 1 or 2, 3 or more (0-3)
2. How do your close friends and family feel about seeking help from a mental health professional?

Racial Identity

Multidimensional Inventory of Black Identity (MIBI; Sellers et al., 1997)

these items were randomized

Racial Identity Centrality (1= Strongly disagree to 5= Strongly agree):

1. Overall, being Black has very little to do with how I feel about myself. (R)
2. In general, being Black is an important part of my self-image

3. My destiny is tied to the destiny of other Black people.
4. Being Black is unimportant to my sense of what kind of person I am (R)
5. I have a strong sense of belonging to Black people.
6. I have a strong attachment to other Black people.
7. Being Black is an important reflection of who I am.
8. Being Black is not a major factor in my social relationships. (R)

Racial Identity Private regard (1= Strongly disagree to 5= Strongly agree):

9. I feel good about Black people.
10. I am happy that I am Black.
11. I feel that Blacks have made major accomplishments and advancements
12. I often regret that I am Black. (R)
13. I am proud to be Black.
14. I feel that the Black community has made valuable contributions to this society.

Discrimination

Combination of Branscombe et al. (1999) and Levin et al., (2002).

these items were randomized

Response Options: 1 (Strongly disagree) to 5 (Strongly agree)

Personal-Level

1. I experience discrimination because of my race.
2. I feel that I am discriminated against because of my race.
3. I feel like I am personally a victim of society because of my race.
4. I consider myself a person who is deprived of opportunities that available to others because of my race.
5. I personally have been a victim of racial discrimination.

Group-Level

1. Other members of my race experience discrimination.
2. My racial group is discriminated against.
3. My racial group has been victimized by society.

Adapted from Health Minds Study (Ketchen Lipson et al., 2018).

1. When seeking help from a mental health professional, have you been treated unfairly because of your race, ethnicity, or cultural background?
 - a. Response options range from 1 (Never) to (5) Almost All of the time.

Treatment Barriers

Adapted from Health Minds Study (Ketchen Lipson et al., 2018).

Have you had a need for mental health services in the last 12 months? (Yes/No)



In the past 12 months which of the following explain why you have not received therapy for your mental or emotional health or have received fewer services than you would have otherwise received?

1. “I have not had any need for mental health services”
2. “I haven’t had the chance to go but I plan to”
3. “I prefer to deal with issues on my own”
4. “There are financial reasons (too expensive, no insurance)”
5. “The location is inconvenient”
6. “The hours are inconvenient”
7. “I don’t have time”
8. “The number of sessions is too limited”
9. “The waiting time until I can get an appointment is too long”
10. “I am concerned about privacy”
11. “I worry about what others will think of me”
12. “I worry that my actions will be documented on my academic record”
13. “I worry that my actions will be documented in my medical record”
14. “I worry that someone will notify my parents”
15. “I fear being hospitalized”
16. “People providing services aren’t sensitive enough to cultural issues”
17. “People providing services aren’t sensitive enough to sexual identity issues”
18. “I have a hard time communicating in English”
19. “I question the quality of my options”
20. “I question whether medication or therapy is helpful”
21. “I have had a bad experience with medication and/or therapy”
22. “The problem will get better by itself”
23. “I question how serious my needs are”
24. “I don’t think anyone can understand my problems”
25. “Stress is normal at my age”
26. “I get a lot of support from other sources, such as family and friends”
27. “Other”
28. “There have been no barriers that I can think of”

Public Stigma

Public Stigma (1= Not at all; 5= A great deal) (Modified Perceptions of Stigmatization by Others for Seeking Help Scale[PSOSH]; Vogel et al., 2009).

“Imagine you had an emotional or personal issue that you could not solve on your own. If you sought therapy services for this issue, to what degree do you believe that the people you interact with would _____.”

1. React negatively to you;
2. Think bad things of you;
3. See you as seriously disturbed;
4. Think of you in a less favorable way;

5. Think you posed a risk to others.

Self-Stigma

Self-Stigma (Self-Stigma of Seeking Help Scale [SSOSH]; Vogel et al., 2006; 1= strongly disagree to 5=strongly agree)

1. I would feel inadequate if I went to a mental health professional for psychological help.
 2. My self-confidence would NOT be threatened if I sought help from a mental health professional.
 3. Seeking help from a mental health professional would make me feel less intelligent.
 4. My self-esteem would increase if I talked to a mental health professional.
 5. My view of myself would not change just because I made the choice to see a mental health professional.
 6. It would make me feel inferior to ask a mental health professional for help.
 7. I would feel okay about myself if I made the choice to seek help from a mental health professional.
 8. If I went to a mental health professional, I would be less satisfied with myself.
 9. My self-confidence would remain the same if I sought help for a problem, I could not solve.
 10. I would feel worse about myself if I could not solve my own problems.
-
1. I would be fearful that my parents or caregivers would find out if I utilized mental health services. (1= strongly disagree to 5=strongly agree)

Informal Care-Seeking

From Health Minds Study (Ketchen Lipson et al., 2018).

1. In the past 12 months have you received counseling or support for your mental or emotional health from any of the following sources?:
 - a. Roommate;
 - b. Friend (who is not a roommate);
 - c. Significant other;
 - d. Family member;
 - e. Religious counselor or other religious contact;
 - f. Support group;
 - g. Other non-clinical source;
 - h. None of the above

Preference for seeking informal care

Response Options: Strongly Disagree (1) to Strongly Agree (5)

1. I would rather seek care from the sources above rather than going to a mental health professional.

Knowledge of Black Americans Experience in the Mental Healthcare System

Response Options: Strongly Disagree (1) to Strongly Agree (5)

1. In the past, Black people have been mistreated by mental health professionals.

Misconceptions about mental illness and help-seeking

Response Options: Strongly Disagree (1) to Strongly Agree (5)

1. Black people don't experience mental health problems.
2. Only people with a severe mental health problem go to therapy.
3. Black people are too strong to experience mental health problems, like depression and anxiety.
4. If someone seeks help for mental health problems, they could lose their job.
5. Only White people suffer from mental illness.
6. If someone seeks help for mental health problems, they could lose their custody of their children.

Conceptions of strength

Response Options: Strongly Disagree (1) to Strongly Agree (5)

7. Black people are expected to show strength at all times.
8. Black people have to show strength in the face of difficult times.

Group-Based Medical Mistrust

Adapted from Shelton et al.'s (2010) version of the Group-Based Medical Mistrust Scale that was validated among urban Black men

Response Options: Strongly Disagree (1) to Strongly Agree (5)

1. Black people cannot trust mental health professionals.
2. Black people should be suspicious of modern medicine.
3. Black people should be suspicious of information from mental health professionals.
4. Black people should not confide in mental health professionals because it will be used against them.
5. Mental Health professionals treat Black people like guinea pigs.
6. Black people receive the same mental health care from mental health professionals as people from other groups.
7. Black people are treated the same as people of other groups by mental health professionals.
8. In most mental healthcare settings, people of different ethnic groups receive the same kind of care.
9. Mental Health Professionals have the best interests of Black people in mind.
10. Mental Health Professionals sometimes hide information from Black people.
11. I have personally been treated poorly or unfairly by mental health professionals because of my race and/or ethnicity.

Trust in Mental Health Professionals Measure

Adapted measures from Anderson and Dedrick (1990) Trust in Physicians Scale

Response Options: Strongly Disagree (1) to Strongly Agree (5)

If I attended therapy services...

1. I doubt that mental health professionals would really care about me as a person.
2. Mental health professionals would be considerate of my needs and puts them first.

3. I would trust mental health professionals so much and try to follow their advice.
4. I would trust mental health professionals' judgments about my mental health care.
5. I would not trust mental health professionals to do everything they should for my mental health care.
6. I would trust mental health professionals to put my mental health needs above all other considerations when treating my mental health problems.
7. I would trust that the mental health professionals responsible for my care would be a real expert in taking care of mental health problems, like mine.
8. I might sometimes worry that mental health professionals may not keep the information we discuss totally private.

Knowledge about Lack of Black Mental Healthcare Providers

1. What percentage of mental health providers do you believe identify as Black/African-American?

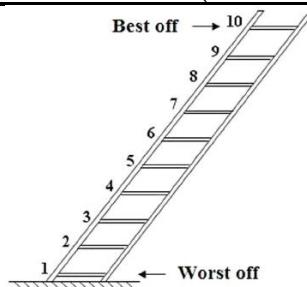


Counselor Preferences

2. What would your preferred race of your mental healthcare counselor be? (open-ended)
 - a. How likely do you think it would be that you could seek care from a counselor of your preferred race?
 - i. 1: Not at all likely to 5: Extremely Likely
3. What would your preferred gender of your mental healthcare counselor be? (open-ended)
 - a. How likely do you think it would be that you could seek care from a counselor of your preferred gender?
 - i. 1: Not at all likely to 5: Extremely Likely
4. If you could seek care from any mental health professional, what would be their ideal characteristics. Please include race, gender, religion, sexuality or other characteristics that would be important to you. (open-ended)
5. Are there any other identities (other than your racial identity) that may impact your feelings towards utilizing therapy services? (open-ended)

Demographics

Subjective Social Status (MacArthur Scale)



1. "Think of this ladder as showing where people stand in the United States. At the top of the ladder are the people who are best off – those who have the most money, the best education, and the most respected jobs. At the bottom are the people who are worst off – those who have the least money, the least education, and the least respected job or no job. The higher up you are on this ladder, the closer you are to the people at the top; the lower you are, the closer you are to the people at the bottom. Where would you place yourself on this ladder? Place an "X" on the rung where you think you stand at this time of your life relative to other people in the United States."

Financial Background

1. Which of the following best describes your family's financial situation growing up?
 1. "Very poor, not enough to get by"
 2. "Had enough to get by but not many 'extras'"
 3. "Comfortable"
 4. "Well to do"

Current financial situation

1. How would you characterize your current financial situation?
 1. "Very poor, not enough to get by"
 2. "Had enough to get by but not many 'extras'"
 3. "Comfortable"
 4. "Well to do"
2. What is your personal estimated yearly income?
 1. Less than \$10,000
 2. \$10,000 to \$14,999
 3. \$15,000 to \$24,999
 4. \$25,000 to \$34,999
 5. \$35,000 to \$49,999
 6. \$50,000 to \$74,999
 7. \$75,000 to \$99,999

8. \$100,000 to \$149,999
9. \$150,000 or more

2. Are you currently receiving any public assistance? (Yes/No)

Insurance

1. Do you currently have health insurance? (Yes/No)
2. What is the source of your health insurance? (Choose One)
 - a. Medicaid
 - b. Private insurance (provided by your employer)
 - c. Private insurance (that you pay for)
 - d. Private insurance (that your caregivers pay for)
 - e. Other
 - f. No health insurance
3. Do you know if your health insurance plan would provide any coverage for a visit to a mental health professional (psychologist, clinical social worker, etc.)?
 - a. Response Options: (1) "I have no idea to " (5) 'Yes, it definitely would,'
4. Is the insurance coverage enough that you could afford to have regular sessions with a mental health professional? (yes/no/ I don't have insurance)

Education:

3. What is your personal highest level of education?
 1. Did not finish High School
 2. High School Diploma or GED
 3. Associates Degree (2-year degree)
 4. Vocational Degree
 5. Some College
 6. Bachelor's Degree (4-year degree)
 7. Graduate Degree (Masters, Ph.D., JD, MD, etc.)
 8. Other (Please specify)
4. What is the highest level of education your mother or Guardian 1 has achieved?
 1. Did not finish High School
 2. High School Diploma or GED
 3. Associates Degree (2-year degree)
 4. Vocational Degree
 5. Some College
 6. Bachelor's Degree (4-year degree)
 7. Graduate Degree (Masters, Ph.D., JD, MD, etc.)
 8. Other (Please specify)
 9. Not Applicable
5. What is the highest level of education your father or Guardian 2 has achieved?
 1. Did not finish High School
 2. High School Diploma or GED
 3. Associates Degree (2-year degree)
 4. Vocational Degree

5. Some College
 6. Bachelor's Degree (4-year degree)
 7. Graduate Degree (Masters, Ph.D., JD, MD, etc.)
 8. Other (Please specify)
 9. Not Applicable
6. Are you currently enrolled in school? (Yes/No)
 1. If yes (choose one):
 - i. GED program
 - ii. Trade skills training program
 - iii. 2- year college
 - iv. 4- year college
 - v. Graduate School
 - vi. Not Listed: Please Specify
 2. Are you a full time student? (Yes/No)
 7. What is your current employment status? (Mark all that apply)
 - a. Employed Full-Time (40 or more hours/week)
 - b. Employed Part-Time (less than 40 hours/week)
 - c. Not in Labor Force (stay at home parent, etc.)
 - d. Unemployed
 - e. Not Listed: Please Specify
 2. How are you paid?
 - a. I am paid by the hour/day
 - b. I receive a weekly, monthly, or annual salary
 - c. Other
 3. Do you get paid sick leave from your employer? (Yes/No)
 4. Do you get unpaid sick leave from your employer? (Yes/No)
 5. If you need medical care, how easy or difficult is it to take time off from work?
 - a. (1: Very easy to 5: Very Difficult)
 6. Marital Status?
 - a. Which of the following best describes you?
 - i. Single
 - ii. In a relationship
 - iii. Married or Partnered
 - iv. Divorced
 - v. Separated
 - vi. Widowed
 - vii. Other
 7. Which one of the statements below best describes your living arrangements?
 - a. Living alone
 - b. Living with a partner
 - c. Living with a roommate (that is **not** my partner)
 - d. Living with parent or guardian/s
 - e. Other: (Please Specify)

8. Which one of the statements below best describes your personal responsibilities regarding dependent children?
 - a. I am not a caretaker for any dependent children
 - b. I am the prime caretaker of a dependent child/children
 - c. I am a caretaker of a dependent child/children but someone else is the prime caretaker
 - d. I equally share the care of a dependent child/children
9. How many children do you have?
 - a. 0
 - b. 1
 - c. 2
 - d. 3
 - e. 4 or more

Biological Sex/ Gender Identity:

1. What is your sex assigned at birth (i.e., the sex listed on your birth certificate)?
 - a. Male
 - b. Female
 - c. Not listed: (Specify)
2. Which term best describes your gender identity? For your information, cisgender is a term for people whose gender identity matches the sex that they were assigned at birth.
 - a. Man (cisgender)
 - b. Woman (cisgender)
 - c. Transman
 - d. Transwoman
 - e. Non-binary/queer
 - f. Not listed: (Specify)
3. How would you best describe your sexual identity?
 - a. Heterosexual or straight
 - b. Bisexual/Pansexual
 - c. Gay or Lesbian
 - d. Questioning
 - e. Not Listed (Specify)

Race/Ethnicity:

1. With which race do you most closely identify?
 - a. White or Caucasian
 - b. Black or African American
 - c. Black and Other Race (please specify)
 - d. Arab/Middle Eastern
 - e. Asian
 - f. American Indian/Alaskan Native
 - g. Multiracial/Other
 - i. If Multiracial/Other was chosen, please indicate here _____
2. Please choose the response that best describes you.

- a. U.S.-born Black adult or African-American (parents born in the U.S)
 - b. U.S. born Black Adult or African-American (parents born in the Caribbean)
 - c. U.S. born Black Adult or African-American (parents born in an African Nation)
 - d. Caribbean-born Black adult
 - e. African-born Black adult
3. Are you Hispanic or Latino? (Yes/No)
 4. How would you best describe your racial/ethnic background in your own words?
 5. Are you a citizen of the United States?
 - a. Yes
 - b. No, but I have permanent residency/green card.
 - c. No
 - i. List your country of citizenship

Age:

1. How old are you?
 - a. 18-24
 - b. 25-29
 - c. 30-35
 - d. 36-40
 - e. Over 40
2. What is your birth date (including year XX/XX/XXXX)?

Zip code:

1. What is your zip code of your current address?

Found study:

1. How did you find about this study?
 - a. SONA
 - b. Facebook
 - c. Instagram
 - d. Twitter
 - e. Flyer (specify where they found it)
 - f. Other: specify where.

Share Anything: If there is anything else you would like to share about Black mental health or your experiences with therapy services, please do so here!

Thank you message:

Thanks! Thank you so much for taking the time to complete the Black Mental Health Study. Your contribution to our understanding of Black adults' perceptions of therapy services is greatly appreciated and will help lay the foundation for future mental health policies.

I encourage you to share this link with your friends and family so that we can get as many responses as possible and ensure a broader, more holistic understanding of Black adults' perceptions of therapy services.

If you would like to be entered into the raffle for a \$50 amazon gift card (you have 16 chances to win!), first click this link to the Drawing Survey, then click the response below to submit your completed survey.

Appendix H

Drawing Survey (in no way linked to main survey)

If participant, chooses yes, they would like to enter the drawing for a gift card, they are redirected to a new survey and will complete the questions below.

“Thank you again for taking the Black Mental Health Survey. If you are interested in being entered for the drawing for a \$50 amazon gift card (you have 16 chances to win!), please answer the following questions.

You may only enter the drawing once. Any additional entries will lead to disqualification.”

1. Please enter your full name.
2. Please enter your email address.
3. Would you like to be notified about the results of the study or future publications?
(Yes/No)

Vita

Randl Dent was born August, 20, 1993 in Baltimore, MD. She graduated from Northern High School, Owings, Maryland in 2011. Randl received her Bachelor of Arts in Psychology from Washington and Lee University, Lexington, Virginia in 2015. She received a Master of Science Degree in Psychology from Virginia Commonwealth University, Richmond, Virginia in 2017. Randl's research interests are primarily focused on the mental health of Black Americans, their attitudes toward and utilization of mental health care and the mechanisms by which racial mental health disparities are created and maintained, with a particular focus on Black emerging adults (aged 18-29). Her graduate education was funded by the National Science Foundation (NSF) as she was a recipient of the NSF Graduate Research Fellowship. During the course of her graduate education, Randl was also an NSF-funded behavioral health equity research intern at the Virginia Department of Behavioral Health and Developmental Services.