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Presenting image/presenting symptoms : clinicians' diagnoses of Black women in the therapeutic space

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Presenting Image/Presenting
Symptoms: Clinicians' Diagnoses of
Black Women in the Therapeutic
Space

ABSTRACT

This was a mixed methods study that used both random and non-random purposive snowball convenience sampling. The purpose of the study was to investigate whether clinicians issue more severe psychotic DSM diagnoses (schizophrenia and schizoaffective disorders) to Black female clients than to White female clients when implicitly primed with cultural archetypes unique to Black women. The research questions were, "Do clinicians issue more severe and stereotype-consistent diagnoses to Black female clients than they do to White female clients;" and "Is there a difference in reaction time in clinician diagnosis of severe psychotic disorders between a clinically-identical Black female vignette and a White female vignette?" Two hypotheses were tested for this study: (1) Despite identical symptomatology, the Black female clinical vignette will be assigned more severe psychotic diagnoses than the White female clinical vignette; and (2) Clinicians diagnosing the Black female clinical vignette with a severe psychotic diagnosis will demonstrate quicker reaction times than clinicians diagnosing the White female clinical vignette with a severe psychotic diagnosis, which shows an implicit bias. The study's most significant findings were: (1) Data did not yield significant evidence to show that more diagnoses of psychotic disorders were assigned to the Black female vignette than to the White female vignette; and (2) Although clinicians were found to spend more time diagnosing the White female clinical vignette than the Black female vignette, the difference was not significant. The study consisted of 48 participants.

PRESENTING IMAGE/PRESENTING SYMPTOMS: CLINICIANS' DIAGNOSES OF

BLACK WOMEN IN THE THERAPEUTIC SPACE

A project based upon independent investigation, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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CHAPTER I

Introduction

This study, Presenting Image/Presenting Symptoms: Clinicians' Diagnoses of Black Women in the Therapeutic Space, investigated the assumption that clinicians are susceptible to stereotypes of Black females and that this susceptibility is transferrable to Black female clients, which ultimately compromises their clinical treatment. The primary research question was, "Do clinicians issue more severe and stereotype-consistent diagnoses to Black female clients than they do to White female clients?" In particular, "Are clinicians more likely to issue more severe Diagnostic Statistical Manual (DSM) code diagnoses to a Black woman when presented with a case vignette embedded with racially and sexually coded language stereotypic of cultural archetypes unique to Black women?" The second research question was, "Is there a difference in reaction time in clinician diagnosis of severe psychotic diagnoses between a clinically-identical Black female vignette and White female vignette?" This study utilized a mixed methods design that allowed clinicians to complete an online survey, which tested the merit and soundness of these research questions. A quantitative assessment was used to more easily make comparisons with other relevant research literature and the addition of an open-response format added a qualitative element to this study's survey. It was added for several reasons: to lessen the disadvantage of utilizing highly structured assessment tools that force clinicians to categorize their responses in a way that less accurately reflects why they respond as they do; to expand upon, clarify and explain their answers and diagnoses; and to unveil subtleties and nuances that would be difficult to uncover in a purely quantitative design.

This study also gathered demographic data, utilized response latency data and the Cross Cultural Counseling Inventory-Revised (CCCI-R) scale (LaFromboise, Coleman, & Hernandez, 1991). The CCCI-R scale is a self-report assessment scale, which requires clinicians to assess their own cross-cultural counseling competencies, multicultural awareness, knowledge, and skill; and thereby renders a more explicit self-report measure of bias as opposed to an implicit measure. Cultural competency is defined as a collection of consistent behaviors, attitudes, and policies that combine and meet in a system, agency, or among professionals and facilitates the ability of that system, agency and professionals to work effectively in cross cultural situations (Cross, Bazron, Dennis, & Isaacs, 1989). To counter clinicians' propensity towards inflated positive self-reports of cultural competency, response latency data (i.e., the response time of actions in milliseconds –converted to minutes in this study), was also collected. Qualtrics was used to measure implicit bias from the time stamp data on the time it took to answer particular questions in the survey.

This research consisted of two hypotheses that examined the impact of stereotypic cultural archetypes of Black women that can lead to bias in the therapeutic space.

Hypothesis 1:

Despite identical symptomatology, the Black female clinical vignette will be issued more severe psychotic diagnoses than the White female clinical vignette.

Hypothesis 2:

Clinicians diagnosing the Black female clinical vignette with a severe psychotic diagnosis will demonstrate quicker reaction times than clinicians diagnosing the White female clinical vignette with a severe clinical diagnosis, which shows an implicit bias.

Many clinicians today are aware of the impact of clinician and client difference in race, gender, sexual orientation and class on the therapeutic relationship. The field of social work has adopted the stance of cultural competence in recognition of how various forms of prejudice and oppression (i.e., racism, sexism, homophobia, ableism, xenophobia, ethnocentrism, etc.) can impede the formation of a therapeutic relationship, or lead to ruptures and impasses in the therapeutic alliance once formed with clients belonging to an oppressed group. Many social work programs offer courses in cultural competency, awareness, knowledge, and skills as part of their course curricula. While the adoption of cultural competency suggests that social workers recognize that bias which remains unrecognized and unchallenged becomes more rather than less potent, the field of social work may still be underestimating the potency of the subtle and soft power of racial appeals via implicit priming of stereotypes (or implicit stereotyping) as opposed to the blatant, intense, and naked power of racist appeals via explicit priming of stereotypes (or explicit stereotyping).

Priming, which refers to studies in which participants' responses to a behavioral task are influenced by exposure to other stimuli, may reveal that clinicians are underestimating how much their unconscious is hogtied by unconscious bias and stereotyping and are engaging in self-deception while overestimating their socially desirable behavior. They may also be overestimating the effects of cultural competency and diversity training as providing an immune defense to unconscious clinical bias. This immune defense may be porous because cultural competency and diversity training do not directly challenge white supremacy. Unexamined

implicit bias might explain some of the lasting power of stereotypic cultural archetypes of Black women even among clinicians of the same race due to internalized racism, which is, "the acceptance, by marginalized racial populations, of the negative societal beliefs and stereotypes about themselves" (Williams & Williams-Morris, 2000, 255), as well as internalized racialism, which is the internalization of negative and positive stereotypes of innate, immutable characteristics (Cokley, 2002). This study argues that from a critical lens perspective of intersectionality, cultural competency may be inadequate in addressing how oppression and hierarchy are replicated in the clinical space. While the issue of race of clinician is important to the cross-cultural and cross-racial clinical relationships, the current study did not examine race of clinician as a factor in the diagnostic process, but rather chose to focus solely on client race.

CHAPTER II

Literature Review

This chapter illustrates the absence of Black women in mental healthcare studies and examines the sociohistorical context of the stereotypic cultural archetypes of Black women that lead to explicit and particularly, implicit bias; discusses findings on the implicit priming of various cultural archetypes; reviews the literature on clinical cultural competence; and closes with a review of the literature on the theory of intersectionality as a challenge to the reliance of clinical social workers on cultural competency alone.

Black Women Occupying the Marginalized Intersecting Space of Mental Healthcare

There is a wealth of literature suggesting that diagnoses are not uninhibited by bias and that clinicians show bias based on race/ethnicity and gender, which suggests that racial and ethnic minorities and women are issued more severe diagnoses as well as racially and gender-stereotypical diagnoses in a reflexive manner (Cook, Warnke, & Dupuy 1993; Garb, 1997; Iwamasa, Larrabee, & Merritt, 2000). These studies, however, did not consider the intersectionality of gender, race and class. Although women experience differential treatment based on gender, the issue may be complicated further when race and other aspects of Black women's identities are part of the equation.

As Black women occupy the overlapping space between the different subjectivities of Black (male) and White (female), they are marginalized in the sphere of mental health. Research on gender differences with regard to mental illness is contextual (Barbee, 1992) depending upon

intertwining identities. Contextualizing Black women's relationship with mental illness and the

mental health care system involves discussing and deconstructing aspects of oppression and

discrimination imposed by the multiple binds of racism, sexism, heterosexism, classism, etc.

While there are common socialization factors for Black women and White women, there are risk

factors for Black women that are not present to the same degree for White women. The same

can be said of Black women and Black men. In full acknowledgement of the power that

diagnostic labels have on colonizing Black women, it is difficult to judge the extent to which this

occurs due to the invisibility factor of Black women in research on the incidence and prevalence

rates of mental illness (Taylor, 1999).

Diagnostic divergence or differential diagnosis appears to suggest gender bias and the

pathologizing of women. For example, women are diagnosed more often with personality

disorders (PDs) due to conceptions of traditional feminine stereotypes as a function of certain

traits being gendered, such as dependency and emotionality, which are key words in the criteria

of certain PDs (Cosgrove & Riddle, 2004; Garb, 1997; Brown, 1992; Rivera, 2002; Gibson,

2004; Walker, 1993; Cook, Warnke, and Dupuy 1993; Ali, Caplan, & Fagnant, 2010). Hamilton,

Rothbart & Dawes (1986) revealed that even when males and females have the same symptom

presentation, women are diagnosed differentially with histrionic personality disorder based upon

their gender. Likewise, women are diagnosed with depression at rates at least twice that of men

(Sparks, 2002).

We see the same diagnostic divergence based upon race. African Americans may be at

higher risk for misdiagnosis. The concern over misdiagnosis emanates from research

(Adebimpe, 1981; Adebimpe, 1982; Adebimpe, Klein, & Fried, 1981; Bell and Mehta, 1980;

Bell and Mehta, 1981) — research that demonstrates that although African Americans have

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higher incidences of depression, they are less likely diagnosed with this disorder and more likely to be diagnosed with schizophrenia, antisocial and paranoid personality disorders, and anxiety disorders (particularly phobias); whereas, mood disorders are more likely to be diagnosed among White Americans (Garb, 1997; Neighbors, Trierweiler, Ford, & Muroff, 2003; Neighbors, Trierweiler, Munday, Thompson, Jackson, Binion, & Gomez, 1999; Neighbors & Williams, 2001; Pavkov, Lewis, & Lyons, 1989; Iwamasa et al., 2000). Mukherjee, Shukla, and Woodle (1983) found that African Americans were more likely to be misdiagnosed with schizophrenia when they were actually suffering from bipolar affective disorder.

Even considering research in which African Americans were the target population, the prevalence rates of many mental illnesses among African American women is indeterminate due to the scarcity of empirical research. For instance, despite the racial bias that both African American females and African American males face, studies show that low-income African American girls reported higher depressive symptoms than African American boys (Grant, Landis, Cho, Scudiero, Reynolds, Murphy, and Bryant, 1999). Overall, the epidemiological research that has been done regarding prevalence and incidence rates among Black women have included under represented samples of Black women, which causes limited generalizability to Black women (Hunn & Craig, 2009).

There are consistent gender differences in the rates of depression among women and in symptoms of psychological distress (Nolen-Hoeksema, 1990, 1995; Nolen-Hoeksema & Girus, 1994) in comparison to men despite ethnicity/race. However, African American women are more likely to report depressive symptoms (Schiller, Lucas, Ward, & Peregoy, 2012) and have greater risk of depression (Barbee, 1992). With respect to schizophrenia, research indicates that there are some differences in men and women that consistently apply in general across ethnic

and cultural lines (Goldstein 1988; Culbertson, 1997; Test & Berlin, 1981a; Test & Berlin, 1981b).   However, findings that schizophrenia is often over diagnosed among African Americans and that mood disorders are underdiagnosed among African Americans may or may not hold for Black women as compared to White women who present the same or vastly similar symptomologies. In any case, the paucity of literature to date makes it difficult to ascertain the extent to which racial, gender, and class biases are operating in the diagnosis and treatment of Black women for mood disorders and schizophrenia. However, it would seem naïve to assume that intersectionality exerts no differential influence for Black women.

The Sociohistorical Context of Cultural Archetypes Unique to Black Women

The historical roots of femininity and masculinity in the United States have associated the former with Whiteness and the latter with Blackness, isolating Black women from the ranks of the "cult of true womanhood" (hooks, 2015). As early as 1851 at the Women's Convention in Akron, Ohio, Sojourner Truth's words in a rebellious oration, now known as "*Ain't I a Woman*?" were an early precursor to the importance of intersectionality in understanding the cultural, political and economic challenges specific to Black women in this country at that time and beyond.   Further, Black women's marginalization from the cult of true womanhood and as a subgroup further marginalized them among Blacks and has given rise to stereotypic archetypes wholly unique to Black women.

This dualism of the meaning of the feminine or womanhood is illustrated by the development, intractability, and persistence of the multiple stereotypical cultural archetypes that have come to be associated with Black women. These archetypes include the Mammy, the Jezebel, the Video Vixen, the Angry Black Woman, the Strong Black Woman, the Superwoman, the Overachiever, the Sapphire, the Baby Mama, the Chickenhead, the Welfare Queen/Mother,

the Matriarch, and the Hoochie Mama (Morgan, 1999; Collins, 1990, 2000; Jewell, 1993; Cowan & Campbell, 1994; Morton, 1991; Sims-Wood, 1988; Wyatt, 1982; West, 1995; Taylor, 1999; Speight, Isom, & Thomas, 2012; hooks, 1981). Some of these stereotypes have deep historical roots while others have only recently emerged. Each cultural archetype encapsulates specific character traits that isolates Black women from the cult of true womanhood. Independently, the archetypes seem to lend credence, testimonial and anecdotal evidence supporting the position that Black women as a group do occupy a particular sector of intersectional space. Yet, studies have not taken into account how these cultural archetypes affect the way Black women are seen and diagnosed by clinicians.

Black Means Male, Female Means White: The Isolation of Black Females from the Cult of True Womanhood

Dating back to the 1930s, investigations were conducted on the way that Blacks were seen by the dominant society. These investigations unveiled negative images that declined from the 1930s to the 1970s, then rose slightly in the 1980s (Stephan and Rosenfield, 1982). Results from the 1980s revealed that Whites thought of Blacks as lazy, sly, aggressive, very religious, loyal to family ties and intelligent (Clark and Pearson 1982). These traits may or may not have been equally ascribed to Black women and Black men. Even as there is evidence of media representations of Black women being depicted in stereotypical ways that are archetypal (Littlefield, 2008; Baker, 2005; Coltrane & Messineo, 2000), the examination of how these cultural archetypes affect clinical judgments of Black women has been remiss. When Black means male and female means White, many intersectional identities are left out including the target group of Black women.

A study by Landrine (1985) was an exception to the rule that challenged the assumption underlying studies that Black women are no different from Black men and no different from White women. In a small survey of 44 middle class White undergraduates on the popular images of Black and White women and how they think society views Black women and White women, Landrine found that Black and White women were rated similarly on certain characteristics. Both were ascribed the traits of happy, inconsiderate, irresponsible, and self-confident. Each group was also ascribed unique traits. The White participants rated Black women as being popularly perceived as significantly more dirty, hostile, and superstitious; whereas, they rated White women as being popularly perceived as significantly more passive, dependent, emotional, intelligent, competent, warm, vain, suggestible, and talkative. The survey's participants reported that they only slightly disagreed with these ratings.

In realizing and amending a serious methodological flaw, Weitz and Gordon (1993) uncovered racialized opinions that may have otherwise gone undetected. Weitz and Gordon (1993) found that the Katz/Braly (1933) traits list, a list constructed to examine racial stereotypes in America, was an inadequate research instrument to detect stereotypes for certain populations, such as Black women. Simply put, its signifiers or adjectives were too androcentric in their imagery. The investigators revised the Katz/Braly traits list into a more gender-appropriate version. Once the questionnaire was completed, the researchers asked 256 non-Hispanic White college undergraduates at Arizona State University to select 5 of 81 traits from the revised Katz/Braly traits list that they believed best described or were associated with each of the following groups of women—American, Native American, lesbian, Black, Jewish, disabled, Mexican, Japanese. The investigators found that the students' images of African American women differed substantially from those of other American women. According to Weitz and

Gordon (1993), negative stereotypical descriptions flourished regarding images of Black women in comparison to other American women in the minds of the White students who participated in the survey. Whereas the White students were generous in extending positive traits to American women overall who were more frequently attributed as being sensitive, attractive, sophisticated tied with emotional, materialistic, intelligent in addition to other attributes of ambitious, independent, imaginative, kind, career-oriented, they were more parsimonious in extending these same positive traits to Black women. African American women were more commonly perceived as loud, aggressive, talkative, intelligent, straightforward in addition to argumentative, stubborn, quick-tempered, bitchy, too many children, threatening, and disorderly. Given that some respondents probably dissembled to avoid giving socially undesirable answers, the results may have been understated.

Gender research has revealed and confirmed repeatedly that women are categorically seen differently than men; women are perceived as more emotionally expressive, sensitive, warm, nice and aware of others' feelings, while men are considered to be more instrumental, active, dominant, independent, and competent (Broverman, Vogel, Broverman, Clarkson, & Rosenkrantz, 1972; Plant, Hyde, Keltner, & Devine, 2000; Spence & Buckner, 1995, 2000; Williams & Best, 1990a, 1990b). The concepts of femininity and masculinity are tied together in an equation of proportionality in that one is feminine if one possesses more female traits and low levels of male traits (Spence and Buckner, 1995) and vice versa. When studies of gender stereotypes do not consider race or racialized gender stereotypes, then the dominance of Whiteness in our society suggests that the participants in these studies default to White women (Fiske, 1998).

The dominant view of femininity is to be pious, pure, submissive, and domestic (Collins, 2004) even unto contemporary times and across cultures (Spence & Buckner, 1995, 2000; Williams & Best, 1990). As Sojourner Truth's oration of "Ain't I a Woman" in 1851 pointed out, Black women have not been historically perceived as belonging to the cult of womanhood as White women have. During slavery, Black women were often perceived as strong, mule-like creatures that did fieldwork alongside men. Even during contemporary times, Black women continue to be seen as strong and this perception of strength as a central characteristic may be leading to differential treatment in certain professions. For instance, Black women firefighters are often excluded and treated hostilely even as they are expected to shoulder heavy loads and chores (Yoder & Berendson, 2001). Sojourner Truth's 5 syllable refrain of "Ain't I a Woman?" confronts and disputes the notions of European feminine beauty, the conflation of femininity with Whiteness and the eradication of Black womanhood from the cultural landscape. This conflation of Blackness and masculinity and Whiteness with femininity continues today. If the enactment of femininity is being perceived as possessing proportionally more female than male traits, then as long as Black women are plagued by racialized gender stereotypes, they will not be perceived as stereotypically feminine.

Colonizing, Calculated, and Perverse Images: Stereotypic Archetypes of Black Women and Mental Health

> Intersecting oppressions of race, class, gender, and sexuality could not continue without powerful ideological justifications for their existence …As part of a generalized ideology of domination, stereotypical images of Black womanhood take on special meaning. Because the authority to define societal values is a major instrument of power, elite groups, in exercising power, manipulate ideas

about Black womanhood. They do so by exploiting already existing symbols, or

creating new ones … These controlling images are designed to make racism,

sexism, poverty, and other forms of social injustice appear to be natural, normal,

and inevitable parts of everyday life (Collins, 2000, 69).

Diagnostic labels can lead to the colonization of the images of Black women by serving

as oppressive, stigmatizing mechanisms in mental healthcare (Taylor, 1999). As Comas and

Greene (1994) identify colonization, it involves the systemic repudiation of the colonized,

negating the value of the self, resulting in inescapable identity conflicts. Neo-colonizing,

calculated, and perverse images animate the converging oppressions of Black women. With one

foot in the past and another foot in the present, a myriad of cultural archetypes are re-birthed in

contemporary skins and times. Historically, "sexist-racist Americans tend to see the [B]lack

male as representative of the [B]lack race" (hooks, 2015, 66). However, as bell hooks also notes,

contrary to Black women who were masculinized as they labored in the fields alongside Black

men, Black men were not regarded as "femininized" as few worked as domestics in White

households beside Black women (hooks, 2015). From the beginning, Black women were

objectified as the subordinated domestic worker, mules of the earth, and yet also as emotional,

passionate sexual creatures.   But controlling the image of the Black woman had larger

implications for all womanhood. "According to the cult of true womanhood that accompanied

the traditional family ideal, 'true' women possessed four cardinal virtues: piety, purity,

submissiveness, and domesticity. Propertied White women and those of the emerging middle

class were encouraged to aspire to these virtues" (Collins, 2000, 72). Black women's "virtues"

were a combination of White women's "virtues," that is, to be submissive and domestic and

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domesticated. However, Black women had other attributes that placed them not only in opposition to White women, but also in opposition to everyone else.

While other groups define their normality by comparison to Black women's binary, oppositional and undomesticated abnormality, Black women are perceived as the ultimate objectified Other, deserving of occupation at the bottom of the political, economic and cultural hierarchy of domination, exploitation, and manipulation (Collins, 2000, 70). The "psychological warfare to enforce the ideal of [W]hite supremacy" (hooks, 2015, 60) is committed through the "systematic devaluation of [B]lack womanhood" (hooks, 2015, 59) and fought by sustaining the myths of cultural archetypes and imprinting these upon the psyches of all, including the targets. As Athena sprang from the forehead of Zeus these stereotypic cultural archetypes sprang from the forehead of elite White men.

The Mammy is one of the oldest cultural archetypes.   She is marginalized by her fatness and blackness in the construction of her gender identity (Shaw, 2005) in comparison to the Jezebel and White women, therefore, completely non-threatening to White women. In addition to being dark-skinned and obese and therefore asexual, the Mammy is domestic, compliant, nurturing, and self-sacrificial (Collins, 2000; Romero, 2000)—establishing an ideal Black female rapport to oppressive institutionalized structures and the White elite (Collins, 2000). Her maternal urges were redirected towards the White family she cared for and outside of that, she seemed devoid of other attachments.   Her fierce faithfulness and protectiveness of the masters and mistresses she served ultimately justified the original economic exploitation of Black women (Taylor, 1999; West, 1985).

The Mammy's nurturing nature is found within the general stereotype of women. And yet, she remains in contrast to White women's femininity because of her asexuality or

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hypofemininity. The Mammy is best represented by Hattie McDaniel's portrayal of the character of the same name, Mammy, in *Gone with the Wind*. Many of the other images of Black women penalize them for not being like the Mammy, for being sexual, strong, aggressive, etc. The Mammy was encouraged to pass on to the next generation the deferent behavior with which she was forced to convey (Collins, 2000) towards first her White masters and mistresses during slavery and later as household, domestic help after slavery. The compliance and obedience of the Mammy stereotype and the internalization of this image may lead mental health care providers to deny Black women access to knowledge and services and control information provided to them, which can simultaneously lead Black women to provide "informed consent" for treatments out of obsequiousness (Taylor, 1999; Barbee & Little, 1993) to the mental health provider who is usually either White and male or White and female.

The Jezebel dates back to the 17th century and stands in stark contrast to the Mammy. The Jezebel along with her offspring cultural archetypes (the Hoochie Mama, the Chickenhead, the Video Vixen, etc.) is representative of the controlling image of the sexually derogated Black woman (Collins, 2000). The myth of Black women as morally depraved, loose, faithless with a bestial sexuality and the initiators of sexual relationships with men has its roots in the sexual exploitation during slavery and beyond (hooks, 2015). The veracity of this stereotype was supported by pseudo-scientific observations of the Black female body's protruding buttocks and hanging genitalia, the Hottentot Venus, Saartjie Bartmann. The Jezebel's deviant hypersexual heterosexuality provides justification for White male sexual exploitation, the molestation and rape of enslaved Black women (Collins, 2000; West, 2008). "Gender ideology also draws upon the [J]ezebel image—a devalued [J]ezebel makes pure White womanhood possible. Overseeing

these relationships are nation-state policies that because they implicitly see Black women as [J]ezebels, deny Black women equal treatment under the law" (Collins, 2000, 142).

As noted, the aggressively sexual image of the Jezebel and her descendent stereotypes are used to denigrate Black women in a way that ignore or minimize sexual assaults and abuse in contemporary times (Barbee, 1993; Taylor, 1999). Sexual violence is a risk factor for poor mental health. West (1995) notes that the hypersexuality of the Jezebel may lead to diagnoses of sexual dysfunctions. Black women may either be perceived as asexual (akin to the Mammy) and therefore pathological or hypersexual (akin to the Jezebel and her descendent archetypes) and therefore pathological.

The primary cultural archetype that counters the Jezebel is in the images of Black women depicted as the "long suffering, religious, maternal figure whose most endearing characteristic is her self-sacrificing and self-denial for those she loves" (hooks, 2015, 66), is the Matriarch cultural archetype. Hooks (2015) notes that Black women tried to become a part of the cult of true womanhood by shifting the focus away from their sexuality, by emphasizing their commitment to motherhood and demonstrating that they were self-sacrificial in providing for their families. Although this was a way that Black women sought to reclaim their dignity, even this self-sacrificial icon was cast in a negative light. In other words, it was another myth created and maintained to dishonor the contributions and characteristics of Black women (hooks, 2015). The title of Matriarch is a misnomer as it is incongruous with the historical meaning of the Matriarch and her privileges and rights particularly over her own body and the local, national, cultural, economic, and political plight of Black women in the United States and in the African-descent diaspora.

The Matriarch as the single female head of household has been blamed for insecure family structures and was epitomized in the 1960s government report, *The Negro Family: The Case for National Action*, by then Senator Patrick Moynihan (Moynihan 1965) as partially responsible for the plight of the Black family and by extension the Black community, and responsible for the intergenerational passage of Black poverty and cultural deficiency (Collins, 2000). The Matriarch symbolizes the maternal figure in the Black home rather than the White home—the bad mother and a "failed Mammy" (Collins, 2000, 73/75) who raises sons to be criminals and daughters, creatures who can't control their wild sexuality. Supposedly, the self-reliance, strength of will, power and resourcefulness of these *newly minted* Black Matriarchs deprived Black men of their masculinity and their status in the family. And the Matriarch's failings as women and single mothers became the cause of the demise of the Black family overall. Hence, virtues were transformed into character flaws. Further, "Using images of bad Black mothers to explain Black economic disadvantage links gender ideology to explanations for extreme distributions of wealth that characterize American capitalism" (Collins, 2000, 76).

Though the Matriarch and Mammy are hypo-feminine, often dark-skinned, and motherly/grandmotherly figures, the Matriarch's hypofemininity is a consequence of an emphasis or overemphasis on her chief character attributes of non-traditional gender appropriate behavior, such as strength, toughness, domination, aggression, with a type of feminized gruffness and full of potency that resembles the type of potency that is thought masculine. All of these characteristics serve to minimize the nurturing aspect of her character even as she is often portrayed as playing a centrifugal force in trying to hold the Black family together, and yet fails to do so according to the negative stereotype. As with the Matriarch, the Welfare Queen, another archetype, also stands in contrast to the Mammy as another failed Mammy.

As with many of the archetypes, class also plays a prominent role in the identity of the Welfare Queen. The Welfare Queen is characterized as a lazy breeder, who is sexually irresponsible, and a single mother who has too many children out of wedlock, materialistic, manipulative and constantly living on the government payroll. The Welfare Queen confirms that Black women are natural breeders. However, fertility outside of White tamed fertility is again dangerous for passing on a terrible work ethic (Collins, 2000), again justifying the positioning of Blacks at the bottom of the socioeconomic hierarchy. The uncontrollable breeding represented by the Welfare Queen cultural archetype could be used as a justification for involuntary sterilization programs for Welfare mothers in the 1960s and 1970s and more recent endeavors to control prenatal substance abuse, elucidating the link between race, class and reproduction (Roberts 1997; Wilson, 1996).

As with the Matriarch, the Welfare Queen is not only the cause of her own poverty but also a fountainhead of multigenerational poverty, again deploying the strategy of "blame the victim" by shifting the gaze away from institutional racism (Collins, 2000) and cramming it within the individual. The cultural stereotypic archetype of the Welfare Queen confers ample accountability for the impoverishment of the Black family on the Black female, particularly the Black mother.

Davis (2014) uses the feminization of poverty, the racialization of poverty, and the cultural stereotypic archetype of the Welfare Queen to examine how capitalism operates via the co-constitutive categories of race, gender and class. When Ronald Reagan took the story of a woman in Chicago who committed welfare fraud, exaggerated it and adorned it with propagandistic appeal to make it more salacious (discounting the fact that the fraud did not raise the woman above the poverty level), he was propagating the myth of the Welfare Queen, who

cannily reproduces for the sake of taking more than she needs from government social programs. The Welfare Queen was tactically deployed to sully big government and the redistributive policies via social programs conferred by liberal politicians in favor of redistributive policies (Bridges, 2014).

As with Davis (2014), Bridges (2014), from a legal critical race and anthropological perspective, associates the controlling image of the [W]elfare [Q]ueen with the twenty-first century American political economy of gender and race. Bridges (2011) recounted in her book, *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization*, how the hospital staff at "Alpha," a hospital in New York City that predominantly serves vulnerable populations, used the social constructions of the wily patient, i.e., "a health-care seeking subject whose crushing stupidity is matched only by her formidable duplicity" (Bridges, 2014, 287) and the Welfare Queen "raced as Black" to discredit and disparage the Black women in their care and simultaneously absolve themselves of racism (Bridges, 2014). By drawing forth the social construction of the purportedly unraced or race neutral wily patient construction, the staff at Alpha could claim a rhetoric of color-blindness while also implicitly racializing the wily patient such that it is the code-word for race (Bridges, 2014).

The Sapphire too stands in contrast to the Mammy. The Sapphire was born in the late Jim Crow era of the 1940s and 1950s. She was epitomized by the character in the radio and television show *Amos 'n' Andy* of the same name (Sapphire Stevens) who was depicted as an outrageous, sassy, angry, shrill, pushy, loud, hostile, aggressive, no-nonsense, bossy shrew, domineering in general and particularly nagging, overbearing, verbally emasculating and berating to her husband (Kingfish Stevens) (Thomas, Witherspoon, & Speight, 2004; West,

2008). The Sapphire and the Matriarch archetypes are linked to domineering masculinity as opposed to caring femininity (Donovan, 2011).

"The Sapphire has been projected onto any [B]lack, woman who overtly expresses bitterness, anger and rage about her lot" (hooks, 2015, 86). Black women either embraced it as defensive armor and source of strength or avoided it out of fear of being perceived as bitchy Sapphires (hooks, 2015).

> The image of the Sapphire as bitchy and hateful fit within the script of females as inherently evil. "Christian mythology depicted women as the source of sin and evil; racist-sexist mythology simply designated [B]lack women as the epitome of female evil and sinfulness. White men could justify their de-humanization and sexual exploitation of [B]lack women by arguing that they possess inherent evil demonic qualities. Black men could claim that they could not get along with [B]lack women because they were so evil. And [W]hite women could use the image of the evil sinful [B]lack woman to emphasize their own innocence and purity. Like the biblical figure Eve, black women became the scapegoats for misogynist men and racist women who needed to see some group of women as the embodiment of female evil" (hooks, 2015, 85).

The myth that Black women are more aggressive likely contributes to the idea that they are more accustomed to violence, and this same aggressive nature contributes to them being seen as more violent and more likely to resist domestic violence (Harrison & Esqueda, 1999). Women are seen as more culpable as victims of domestic violence based on whether or not they resist domestic violence and whether they are single as is the case with a number of cultural archetypes associated with Black women (Harrison & Esqueda, 1999). Black women are also

viewed more negatively and blamed more when victims of acquaintance rape (Foley, Evanic, Karnick, King, & Parks, 1995; Willis, 1992). The imposition of strength and aggression is also harmful to Black women in other ways as it contributes to Black women, the victims of more gender harassment and sexual harassment, as being responsible (Donovan & Williams, 2002; Berdahl & Moore, 2006; Mecca & Rubin, 1999). The Sapphire along with the Matriarch and their domineering, loud, tough, strong manner may also contribute to the belief that they are blamed more when victimized (Browne & Misra, 2003; Esqueda & Harrison, 2005; Willis, 1992). Hence, they could not truly be victims of domestic violence or gender and sexual harassment as they are not seen as vulnerable.

The strength of Black women is paradoxically turned against them as it fuels the idea that Black women are provocateurs of the violence done to them by those who have a more traditional ideology of gender role stereotypes as opposed to those with an egalitarian ideology of gender role (Esqueda & Harrison, 2005). The Sapphire archetype may lead mental healthcare workers to diagnose Black women as out of control and aggressive and thereby pathological and even issue more severe diagnoses like schizoaffective disorders in comparison to milder diagnoses such as depression or bipolar disorder.

The above has introduced the possible diagnostic implications of stereotypic archetypes being endorsed by the dominant culture. "Diagnosis is essential to the process and control of [mental] illness (i.e., curing). Unfortunately, under the influence of labels, the meanings of even normal behavior are transformed and easily misinterpreted, and there exists the possibility that labels/diagnoses reinforce less privileged social positions, reproduce systems of oppression (i.e., racism, classism, sexism), and transmit practices and knowledge that contribute to poor [mental] health" (Taylor, 1999, 38). In addition, they may be transmitting stigma associated with mental

illness diagnoses because diagnoses further objectify the individual and amplifies their "Otherness" status.

Implicit Bias: Its Role in Priming Cultural Archetypes and Cultural Competency

Contributing to the mental health burden shouldered by African American women is the extent to which unconscious implicit bias permeates the micro and macro configuration of the mental healthcare system and impedes culturally competent clinical care. Those clinicians "who hold a worldview different from that of their client and are unaware [not consciously aware] of the basis for this difference are most likely" to impute negative and stereotypical traits on their clients (Sue & Sue, 1990, 137). In other words, those clinicians' whose worldviews go unexamined and unchecked at the conscious level are more susceptible to and at risk of implicit bias.

The following section will explain the difference between implicit and explicit bias, the Implicit Association Test (IAT) and priming as ways to activate implicit bias, the IAT test effect and response latency data as measures of implicit bias. Finally, I review previous research studies—priming stereotypic cultural archetypes and cultural competency studies—that used these methodologies.

Implicit and Explicit Bias: Gathering the Data

Greenwald and Banaji (1995) proposed the application of implicit and explicit bias to social constructs as separate and distinct ways of assessing how attitudes and actions are influenced. Explicit bias is intentional, expressed via conscious information and conscious processing (Boysen, 2009). Explicit bias is gathered by self-reports and is therefore, vulnerable to social desirability bias, one's desire to give the most socially desirable answers. On the other hand, implicit bias is defined by automatically activated evaluations, actions or judgments

outside the "performer's awareness of that causation" (Greenwald, McGhee, and Schwartz, 1998, 1464). While implicit bias has been a focal concept in the discipline of psychology, it does not have such centrality in the discipline of clinical social work and upon literature regarding multicultural competency. Boysen's (2009) review of the literature found that explicit bias has been pursued almost exclusively in counseling literature in relation to cultural competency (Boysen, 2009). This is troubling considering the presence of diagnostic divergence between implicit and explicit measures of bias and in light of clinical diagnoses that appear to be based upon racial and gender bias. As racism and racial bias have gone incognito by secreting themselves in the unconscious of Americans, it is all the more reason to study the implications that implicit bias or implicit stereotyping have on clinical diagnoses. As implicit bias operates automatically on social judgments and attitudes at the unconscious level, it is measured without inquiring about them directly (Greenwald & Banaji, 1996; Fazio & Olson, 2003) by response latency data and the IAT effect.

Activating and Measuring Implicit Bias: Gathering the Data

The IAT, a measure of implicit bias created by Greenwald, et al. (1998), is a memory-oriented and categorization task designed to eliminate or minimize the problem of social desirability bias and self-deception. Typically, participants must either briskly categorize sequential tasks or associate two target pairings with characteristics or concepts. The IAT utilizes words or pictures. Several pen and paper versions of the IAT exist. However, the original IAT was a computerized version in which pictures of African American and White American faces were shown while words denoting good and bad characteristics flashed at the bottom of the screen. The intent of the researchers was to obtain the gut reaction, i.e., implicit

reaction, by gathering response latency data, measuring the amount of time it took for the participants to react when given only milliseconds to respond until the screen changes.

The categorizations are either congruent or incongruent. An example of the former would be pairing White with hardworking and Black with lazy because the stereotype is that Blacks are lazy in comparison to Whites. An incongruent categorization would be the opposite. An IAT effect is evident when the reaction times are significantly faster for the congruent categorization as opposed to the incongruent categorization. The pairings that elicit a faster response are interpreted as being more strongly associated in memories of the participants. That is, when participants with significant rapidity consistently categorize Black with negative attributes like lazy or angry, the interpretation is that the participants are responding to a memory of these pairings as being more congruent or stereotype-consistent. Stereotype-consistent pairing and categorization is a result of cognitive shortcuts that allow participants to rely upon cognitive reserves and therefore, elicit quicker responses to stereotype-consistent pairing and categorization. The stereotype-inconsistent pairings are pairings that seem unlikely or improbable and therefore require more cognitive exertion causing participants to respond slower. When specific stereotype consistent pairings are repeatedly associated with a particular stereotype with rapidity, I contend that this represents a stereotypic cultural archetype.

Although commonly used in psychology, priming is less well known as a concept in other disciplines. As with the IAT, priming is used to activate implicit bias and is intended to reduce the hazard of social desirability bias, which stubbornly attaches itself to self-report measures of explicit bias. Whereas the IAT procedure explicitly categorizes by race, priming does not. Priming presents race information in a way that doesn't resonate consciously, making it more difficult for participants to alter their responses in order to appear less biased. Priming is

based on the assumption that subliminally presented information about a social category inertly, and unconsciously effects the response of participants, i.e., their affect and behavior (Bargh and Chartrand, 2000; Devine, 1989; Graham and Lowery, 2000). This method also assumes that the participants already have built-in cognitive shortcuts to a pathway with a reservoir of stereotypes that structure their responses towards marginalized groups. Participants who undergo (subliminal) priming are more likely to deliver more stereotypical responses because it stimulates implicit racial-ethnic and other biases (Stepanikova, 2012).   Priming produces the suspected results because racial and gender bias are so widespread among the American population (Nosek, Banaji, & Greenwald, 2007; Greenwald & Banaji, 1995; Devine, 1989; Bargh, Chen & Burrows, 1996; Chen and Bargh, 1997; Payne, 2001; Dovidio, Kawakami, Johnson, Johnson & Howard, 1997; Dovidio, Kawakami, & Gaertner, 2002; Fazio, Dunton, Jackson, & Williams, 1995).

Priming is an implicit memory-oriented task wherein exposure to one stimulus, a.k.a. the prime stimulus, impacts the response to another stimulus, a.k.a. the target stimulus when the prime stimulus precedes the target stimulus via exposure to words or pictures. Meyer and Schvaneveldt (1971) demonstrated that individuals reacted quicker in deciding a string of words when those words followed an associatively or semantically related word. From this research and others came the theory of activation spreading, i.e. related words facilitating lexical or verbal decision tasks. According to the priming procedure, decision-making or execution of the appointed task is reflective of the cognitive processing of the priming stimuli as it is related to the target stimuli since the prime and the target stimuli share features and are from the same semantic category. Again as with the IAT, priming can utilize response latency data and the pairing of concepts is categorized as either stereotype-consistent or as stereotype-inconsistent.

Previous Findings from Implicit Priming of Archetypes

A few studies have demonstrated the accuracy of priming cultural archetypes utilizing implicit measures of bias. A study by Givens and Monahan (2005) compared direct self-reports of participants versus indirect measurements of participants' responses via response latency data. Givens and Monahan (2005) examined how exposure to mediated stereotypic images of the Mammy and the Jezebel would activate stereotype-consistent perceptions of unrelated African American women in social situations. They hypothesized that response times would be faster to stereotype-consistent adjectives after participants observed the stereotypic image of the African American woman as opposed to the White American woman. Respondents began by viewing one of three images of a video: a Mammy, Jezebel, or non-stereotypic video image. They subsequently viewed a mock employment interview featuring either an African American or White woman. Lastly, the respondents rated the job interviewee via implicit and explicit measures. As the interviewees were trained together, followed the same fictional script, and similarly dressed, these confounding factors were negated as explanatory factors.

As hypothesized, the subjects attributed the African American interviewee more quickly with negative terms like aggressive (stereotype-consistent) and less quickly with positive terms like sincere (stereotype-inconsistent) and vice versa with regard to the White American interviewee. Again as hypothesized, those who observed the Jezebel video and who also observed the African American interviewee rated her more quickly with Jezebel-related terms (e.g.., sexual) rather than positive, negative, or Mammy-related terms (e.g., maternal). In comparing the African American and White interviewees, there was no significance in between-group differences or priming differences revealed in the explicit measures, i.e., the self-reported findings among the job-suitability items. Priming differences were only surmised via the

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response times for adjective associations, which is consistent with researchers who argue that direct, explicit measures of racial attitudes are inadequate as the participant must be willing to reveal their own socially undesirable biases (Wittenbrink, Judd, & Park, 1997; Fazio et al. 1995; Greenwald and Banaji 1995).

Surprisingly, in the Givens and Monahan (2005) study, the participants primed with the Jezebel prime condition who were asked to evaluate the African American interviewee reacted significantly quicker to Jezebel-associated adjectives than to those primed with Mammy-associated adjectives. Despite the fact that the relationship for those participants primed with the Mammy condition was in the expected direction, the association proved insignificant. The authors provide two explanations for these null findings for the Mammy prime as opposed to significant findings for the Jezebel prime. They proposed that the Mammy stereotype was not as readily familiar as the Jezebel stereotype for college students. Monahan, Givens and Shtrulis' (2003) study of the same population using within-group stereotyping, supported this explanation. In their study the participants had the most difficulty describing and identifying the representation of the Mammy archetype. The authors suggested that an upgrade of the Mammy stereotype, perhaps a single, African American woman working in a profession, such as a social worker, wherein she supports others as she would her own, might have provided a more successful prime for participants. The second potential explanation for the null findings are the body type of the African American female interviewee, which was young, thin, and attractive, as similar to the White American female interviewee as possible to eliminate confounding factors. But these are not the physical characteristics usually associated with the image of the Mammy. Hence, the participants may not have found this body type at all fitting with the Mammy stereotype.

Such was not a problem with the Welfare Queen stereotypic archetype in a study by

Monahan, Shtrulis, and Brown-Givens (2005). Again, the researchers hypothesized that specific

stereotype portrayals of the Mammy, the Jezebel and the Welfare Queen would produce

stereotype-consistent judgments made of other African American women in a mock interview.

Utilizing response latency data, the researchers found that the participants consistently responded

quicker to the stereotypic adjectives associated with the video priming the particular stereotypic

archetype to which they had just been exposed. There were a host of other significant findings.

First, they found that the participants were most knowledgeable and familiar with the Welfare

Queen stereotype. Second, participants who were primed with the Welfare Queen responded

quicker than those primed with the other two stereotypic archetypes. Third, the only stereotypic

archetype to produce significant effects for the direct measures was the Welfare Queen. Fourth,

when using indirect measures to uncover the quickest responses to stereotypic-consistent

adjectives, participants were quickest with associating all three stereotypic archetypes with their

stereotype-consistent adjectives. But the strongest and most positive indirect effects were for the

Welfare Queen. Fifth, in the video clip where the participants were primed with the Welfare

Queen video clip, the Black interviewee was assigned positions in fast food restaurants, Wal-

Mart, and stuffing envelopes. Monahan, et al. (2005) suggested that these findings speak to the

Welfare Queen as being the stereotypic archetype most salient and accessible in their memories.

The speculation is that this occurred because the participants who were college students were

growing up watching television wherein the Welfare Queen is prominently displayed such as

Jerry Springer and even the *Nightly News* (Gilliam, 1999).

Cultural Competency and Previous Findings of Divergence between Implicit and Explicit Bias

Cross, Bazron, Dennis, and Isaacs (1989) developed a thorough definition of cultural competence: "A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals, and enable that system, agency, or those professionals to work effectively in cross-cultural situations. The word 'culture' is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial ethnic, religious or social group. The word competence is used because it implies having the capacity to function effectively" (13). Sue, Arrendondo, & McDavis (1992) noted that culturally competent individuals are aware of racial prejudice and actively seek a nonracist identity. The culturally competent counselor/therapist has self-awareness, sensitivity, appreciation and knowledge of other cultures and a skill set to match. This development of self-awareness is pivotal to the development of the culturally competent clinical social worker. Otherwise there is the probability that the treatment of ethnically, racially, religiously, etc. diverse clients will be compromised; hence the necessity for emphasis on multicultural competence training.

A plethora of studies found a significantly positive relationship between multicultural training and multicultural competencies, i.e., awareness, knowledge and skills (D'Andrea, Daniels, & Heck, 1991; Neville, Heppner, Louie, Thompson, Brooks, & Baker, 1996; Sodowsky, 1996; Kuo-Jackson, Richardson, & Corey, 1998). Yet, it is demonstrated in empirical research that implicit racial bias has an effect on a counselor's judgment (Gushue, 2004). And, literature suggests that there is divergence between implicit and explicit measures of bias. Greenwald, et

al. (1998) found that even as the majority of White Americans supported positive or neutral attitudes toward African Americans when responses were measured explicitly, their responses when measured implicitly were shown to support negative attitudes toward the same target group of African Americans.

Abreu's (1999) study also lent credence to the perspective that therapists are susceptible to being influenced by African American stereotypes. Utilizing response latency data, Abreu (1999) randomly assigned therapists to 1 of 2 priming conditions who were then primed with African American stereotypes or neutral words. Next, participants were tasked with assessing the target, Mr. X, an African American man, on hostility-related and unrelated attributes. The participants who were primed with the stereotype rated Mr. X significantly less favorably (i.e., a positive association) on hostility-related attributes and significantly more favorably (i.e., a negative association) on hostility-unrelated attributes.

Katz and Hoyt (2014) examined whether cultural sensitivity could predict therapists' bonding and prognosis with African American clients compared to White clients. Katz and Hoyt (2014) utilized three measures of cultural sensitivity: the IAT (Greenwald, et al., 1998) to measure automatic prejudice specifically towards Blacks, the Multicultural Counseling Inventory to measure global multicultural competence (MCI; Sodowsky, Taffe, Gutkin & Wise, 1994), and a new self-report measure of anti-Black clinical prejudice created specifically for this study. In addition, they used a Working Alliance Inventory (WAI Bond Scale; Horvath & Greenberg, 1989) to assess the quality of the therapeutic alliance. Finally, they included the Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1984) to control for socially desirable responding. Their study gathered data from an online survey of 173 participants of varying professional disciplines and experience. Each participant was given two case vignettes of one

Black client and one White client either depicting features of anxiety or depressed mood. The race of the client for each case type and the order of the cases were counterbalanced across participants. The participants were asked to rate each case study as if they were the client's therapist. Katz and Hoyt (2014) found no statistically significant differences on the basis of participant ethnic identification; therefore, they decided not to include this factor in subsequent analyses. They found that automatic prejudice as gathered from the IAT was the strongest predictor of racial bias in bond expectations; however, the test-reliability rating was low compared to expectations. They also found that their self-created self-report measure did predict anti-Black bond expectancies, intimating that the MCI is not a sufficient measure of prejudicial attitudes among clinicians.

Boysen and Vogel (2008) suggested that there was a relationship among level of training, implicit bias, and multicultural competency (MCC) among counselor trainees. They assessed MCC as gathered by self reports from the CCCI-R to assess explicit bias towards African Americans, gays and lesbians using a pen and paper version of the IAT to assess implicit bias towards these under-represented groups. They had 4 hypotheses: (1) They hypothesized that counselor trainees would report high levels of MCC; (2) They hypothesized that counselor trainees would possess significant levels of implicit bias; (3) They hypothesized that MCC would vary by level of training; and, (4) They hypothesized that implicit bias would not vary by level of training. Boysen and Vogel (2008) found that despite counselor trainees' high self-reported multicultural competency on the CCCI-R scale, implicit bias was still present. Also, although self-reports of MCC varied by level of training, implicit bias did not vary regardless of level of training. A year later Boysen (2009) performed a review of counseling literature that again found a divergence between self-reports of bias and implicit bias among counselors. Boysen and

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Vogel (2008) and Boysen (2009) research was contradicted by Castillo, Brossart, Reyes, Conoley, and Phoummarath (2007). Castillo et al. (2007) also used counselor trainees as participants. Using response latency data and the racial IAT, they found that taking a multicultural counseling course did statistically increase cultural awareness and ameliorated implicit racial bias.

Even as clinicians continue to rate low in levels of explicit bias on self-reports of cultural competence, studies still demonstrate implicit bias, indirectly measured. The problem has not been a failure to document bias in multicultural competency research and literature, rather an exclusive focus on explicit bias to the exclusion of the role of implicit bias as the Boysen (2009) review of the literature revealed, leaving one to question whether clinical cultural competency and training are enough to counter this implicit bias? The current study argues that we need to move beyond cultural competency and look towards intersectionality in order to confront implicit bias.

The Challenge from the Quarters of Intersectionality

The longevity of cultural archetypes, that are most potent when implicitly primed, is all the more reason to vigorously mount a challenge to multicultural competence from the quarters of intersectionality. The concept of multicultural competence has been incorporated in the field of social work in a way that intersectionality has not, as this thesis agues, to the detriment of marginalized groups. In the words of Andersen (2005), "seeing race, class and gender as merely descriptive demographic variables that speak to diversity and a plurality of experiences and viewpoints reproduces the system of privilege and domination" (445). Instead, analyzing these variables "must be about the hierarchies and systems of domination that permeate society" (Andersen, 2005, 446). I posit that the importance of intersectional identities on the mental

health and well being of Black women is not given due regard or appreciation through the stance of multicultural competency. Cultural competency is too much about seeing the individual through a lens of plurality and the inclusion of diversity and too little about seeing the client as existing within and challenging the system of White supremacy where marginalized groups continue to be pathologized under the medical model.

The National Association of Social Workers' (1996) Code of Ethics delineates social workers' responsibility to understand and recognize strengths in all cultures, to demonstrate competence in providing services, and to seek to understand the nature of diversity and oppression, in short, cultural competence. The Council on Social Work Education (CSWE), the accrediting and governing body for social work education emphasizes a respect for diversity in the content of social work programs "that emphasizes the interlocking and complex nature of culture and person identity" in recognition that "social services meet the needs of groups served and are culturally relevant …" (2004, 9). Such statements show the aspirations of the CSWE, but do these aspirations lead to cultural competence; and does cultural competence truly address the "the interlocking and complex nature of culture and personal identity" holistically? According to Murphy, Hunt, Zajicek, Norris, & Hamilton (2009), social work has undergone somewhat of a developmental sweep along several perspectives with regard to the way individuals and particularly at-risk populations are seen.

Contemporary social workers strive towards cultural competency. In 1978, the CSWE published "The Dual Perspective: Inclusion of Ethnic Minority Content into the Social Work Curriculum", which promotes cultural competency via the lens of the dual perspective (Norton, 1978). According to the dual perspective, individuals possess two self images that develop through two systems: one, the nurturing system that cultivates the individual's personal self-

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image developed through the individual's family and community and two, the sustaining system, which supports the individual's social self image developed as a result of society's political, economic, and educational systems (De Hoyos, De Hoyos, & Anderson, 1986). The assumption underlying this model is that greater cultural knowledge on the part of the social worker would lead to more competence (Murphy, et al., 2009). However, a focus on diversity underscores the difficulties related to minority status, instead of perspectives and experiences (Murphy, et al., 2009). The ecological perspective, which spread in the 1980s, was meant to address this failing. It is also known as the person-in-environment theory in social work, wherein the focus shifted away from the individuals and instead emphasizes that human beings are by-products of their support systems, communities and daily interactions (Murphy, et al., 2009) or lack thereof. However, the failing of this perspective is that it simply recruits social workers to help individuals cope under oppressive social structures in a way that perpetuates the systems of social control (Murphy, et al., 2009).

The third perspective, the sociological perspective, similar to the ecological perspective focuses on an external force that influences the contours of the lives of marginalized clients, but this time the focus is culture (De Hoyos et al., 1986). While this perspective helps social workers understand why clients act in ways that are in opposition to the expectations of the dominant culture (Murphy et al., 2009), it ignores a detail, that the motivations, standards and expectations under which Whites function and maneuver *are* cultural. In other words, marginalized groups and numerical minorities are not the only ones who have "culture." By ignoring this, it places White mores and expectations as the objective norm. The sociological perspective was also lacking in its failure to acknowledge the effect of the multiple layering of

varying identities in molding the experiences of marginalized populations (Murphy et al., 2009).

Feminist thought and gender-based perspectives began to address this gap.

Social work's application of a feminist perspective focused on attaining political rights within the prevailing political structure (Sands & Nuccio, 1992). But, gender-based perspectives challenge social work's theoretical base, its ways of working and ways of structuring relationships between service providers and clients and its indiscriminating acceptance of the oppressive legal, political and organizational structures under which women operate (Dominelli, 1992). But even as the social work discipline has applied feminist thought to subjects such as domestic violence, sexual assault, child abuse, and eating disorders (Murphy et al., 2009), social work scholarship and practice, particularly clinical social work, continues to individualize social problems and relegate structural problems to the individual client's own responsibility. In other words, the structural causes largely become invisible, as does the marginalization of the marginalized populations.

Much of social work's theoretical underpinnings come from the fields of medicine and psychology wherein the interventions that have emerged have mostly been 'proven' with an unrepresentative segment of the population (Murphy et al., 2009). This critique of social work did not only emerge out of women's studies but also out of cultural studies; hence the incorporation of an ethnic-centered framework in the 1990s, most prominently, Afrocentrism (Murphy et al., 2009). Afrocentric-centered perspectives emphasize how Eurocentric mores, patriarchy, and capitalism create and are, themselves, oppressive systems of control that feed into and are perpetuated by social injustice. Specifically, there has been a dearth of attention given to the experiences of Black women whose unique marginality remains largely invisible in social work scholarship and practice. The attraction and revolutionary appeal of intersectionality is that

represents a paradigm shift as it places the inclusion of intersectional identities with all the concomitant complexities as an imperative in direct and policy practice, social work research and education. Considering the complexity of lived experience, intersectionality is particularly well poised to help social workers develop "the values and skills needed to capture the depth and breadth of the human experience" and "to evaluate the expressions of power within [our] subconscious and actions" (Murphy et al., 2009, 45).

Intersectionality is conceptualized as many things: as a theoretical perspective and critical social theory, as a mechanism for social change (Association for Women's Rights in Development (AWID, 2004), as a policy framework (Crenshaw, 1991), as a methodology (in the way it crafts and uses social theory; Brah & Phoenix, 2014), and structural analysis that studies how multiple dimensions of difference (Dill, Nettles, & Weber, 2001) or various axes of identity and their political and economic derivatives are mutually co-constitutive (wherein the intrinsic logic of each single axis identity is shaped by others; Rothenberg, 2001) and historically entrenched on multidimensional and simultaneous levels that interrelate to create an oppressive social hierarchy. Crenshaw (2014) places this in perspective:

> To use a metaphor of an intersection, we first analogize the various axes of power—i.e., race, ethnicity, gender, or class—as constituting the thoroughfares which structure the social, economic or political terrain. It is through these avenues that disempowering dynamics travel. These thoroughfares are sometimes framed as distinctive and mutually exclusive axes of power, for example racism is distinct from patriarchy, which is in turn distinct from class oppression. In fact, the systems often overlap and cross each other, creating complex intersections at which two, three or four of these axes meet. Racialized women are often

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positioned in the space where racism, xenophobia, class and gender meet. They

are consequently subject to injury by the heavy flow of traffic traveling along all

these roads. Racialized women and other multiply burdened groups who are

located at these intersections by virtue of their specific identities must negotiate

the "traffic" that flows through these intersections. This is a particularly

dangerous task when the traffic flows simultaneously from many directions.

Injuries are sometimes created when the impact from one direction throws victims

into the path of oncoming traffic while in other occasions, injuries occur from

fully simultaneous collisions. These are the contexts in which intersectional

injuries occur—disadvantages or conditions interact with preexisting

vulnerabilities to create a distinct dimension of disempowerment (Crenshaw,

2014, 17-18).

An intellectual fountainhead of the theory of intersectionality lies in the critical legal

scholarship of Kimberle Crenshaw who first coined the term intersectional theory in 1989. The

above quote signifies Black women's positionality in society as experiencing discrimination and

prejudice on occasion in ways that resemble White women's experience [and the experiences of

women of other races and ethnicities], at other times that resemble Black men's experiences, and

yet at other times that resemble Black women's experiences that are not derivatives of either

White women's [or the experiences of women of other races and ethnicities] nor Black men's

experiences (Grzanka, 2014). The simultaneity of an individual's identity, that an individual

belongs to multiple identities in every given moment, can oppress and privilege the same

individual depending on circumstance, and even oppressions can be weighted differently

according to circumstance (Landry, 2006).

As Grzanka (2014) notes, there is more than one origin story to intersectionality. Intersectional thinking predated the term intersectional theory. The idea of intersectionality entered sociological scholarship and was borne of the Black feminist movement in the 1960s and 1970s, and sprang from the historical exclusion of Black women's experiences from the largely White feminist movement. This continued from the civil rights movement as Black feminists recognized that their racial, gender, class nor sexual identities were mutually exclusive in their experience of oppression. The term also has theoretical links to the Combahee River Collective Statement of 1977 in Boston, Massachusetts that addressed the simultaneity of the influences of race, gender, sexuality, and class in shaping oppression. And even earlier, in 1851 when Sojourner Truth delivered her famous, "Ain't I a Woman?" speech that challenged the exclusion of Black women from the White feminist movement and from the concept of womanhood. Since Sojourner Truth's speech, intersectionality has become a key concept in critical feminist analysis in "decentering … the normative subject of feminism" (Brah & Phoenix, 2014, 310).

Intersectionality gained further prominence with the work of sociologist, Patricia Hill Collins, who posited that there is a matrix of domination. This is a sociological paradigm that dismisses the dichotomous categorizations of descriptive demographic variables and emphasizes that Black women are beset by "a distinctive set of social practices that accompany our particular history … characterized by intersecting oppression" (Collins, 2000, 26). According to Collins, marginalized groups gain the status of "an other" whose domination involves objectification or the "devaluation of the subjectivity of the oppressed" (Collins, 1986, S18).

Ultimately, the foundation for intersectionality was built in the house of Black feminist epistemology and feminists of color, as a challenge to traditional feminist perspectives (Collins, 1993; Crenshaw, 1991; King, 1988; Baca Zinn & Dill, 1996). They challenged the seemingly

discrete social identities or single-axis categorical analysis such as ability, race, class, gender, immigration and national status, i.e., perspectives, methods and modes of analysis that privilege one dimension of inequality and posit that the experiences of all members of a categorical group are essentially the same (Grzanka, 2014, xv), in favor of a position that emphasizes that a person's social location is actually social locations that are composed of various identities. This captures the complexity of multiple systems of power, privilege and domination. Black feminist epistemology or an Afrocentric feminist epistemology is both specialized knowledge created by Black women that reflects the unique standpoint of African American women and a theoretical framework for understanding those unique lived experiences and perspectives (Collins, 1990) of Black women who have traditionally stood outside the institutions where knowledge was produced and synthesized. This Afrocentric feminist epistemology emphasizes the need to use and promote an alternative intersectional framework where identities are conceptualized as organic, active, evolving and interdependently socially constructed identities, which can encompass other marginalized populations; hence, leading to its social justice appeal.

For most of its history, as a critical social theory, Black women's thought or epistemology has not been recognized as such or at all in academia. As elite White men have controlled knowledge validation processes in Western and Eurocentric epistemologies such as credentialing, their interests permeate the themes, paradigms and epistemologies of traditional scholarship and any admission into traditional scholarship and the canon (Collins, 2000). Consequently, Black women's epistemology is subjugated knowledge as it has been customarily dismissed and disregarded from what counts as knowledge, expertise, credibility, truth and interpretations no less so because it's critique represents an upstart epistemology. Critical social theory theorizes about "the social in defense of economic and social justice. As critical social

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theory, Black feminist thought encompasses bodies of knowledge and sets of institutional

practices that actively grapple with the central questions facing U.S. Black women as a group.

Such theory recognizes that U.S. Black women constitute one group among many that are

differently placed within circumstances of injustice. What makes critical social theory "critical"

is its commitment to justice, for one's own group and for other groups" (Collins, 2000, 35). The

justification and basis of Black feminist epistemology is founded on the existence of the

subordination of intersecting oppressions of Black women buoyed by White supremacy and male

superiority. Despite individual standpoints conferred by differences in age, sexual orientation,

social class, region, religion, skin tone, ethnicity, national origin, etc., Black women have faced

collective encounters with institutionalized racism, diasporic historical challenges with White

supremacy and patriarchy and "recurring patterns of differential treatment" in housing,

education, employment, etc. that present challenges to their well being, mental and physical

health (Collins, 2000, 29).

Summary of the Literature

Racial disparities in mental healthcare can be traced back to historical and contemporary

economic, legal and political inequalities. This is no less true for Black women. The multiple

binds of oppression for Black women have created a web of sociocultural factors that range from

social demographic stressors to physical environmental stressors to stressors imposed by cultural

expectations, such as violent victimization, sexual and physical abuse (Copeland & Butler,

2007), attenuated social networks and social support systems (Dressler, 1985), higher rates of

single motherhood than White women (Dressler, 1985), the lack of mate availability and high

incarceration rates of Black men (Hunn & Craig, 2009), role strain for caretakers and

multigenerational caregivers (Chadiha & Brown, 2002), environmental living conditions such as

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inadequate housing and poor neighborhood conditions (Cutrona, Russell, Hessling, Brown, & Murry, 2000; Levanthal & Brooks-Gunn, 2003), low income, low employment and poverty (Chadiha & Brown, 2002), and perceived gender and racial discrimination (Copeland & Butler, 2007; Kessler, Mickelson, & Williams, 1999; Klondoff, Landrine, & Ullman, 1999; Kwate, Valdimarsdottir, Guevarra, & Bovbjerg, 2003). Psychopathology is shaped by Black women's multiple intersecting identities and oppressions.

The importance of intersectionality to the field of social work is the presumption that social workers may do more harm than good when not taking the intersectional identities of their clients and seemingly extraneous factors into account. Social workers must adjust their approaches accordingly, and one of these approaches is cultural competency. As intersectionality is a relational critique of systems of oppression, it is also a critique of cultural competency. Intersectionality is self reflexive in that it "imagines alternative ways of knowing and doing in the interest of forging efficacious tools for social justice" (Grzanka, 2014, xix). Discourses that make use of intersectionality have been critical of claims of truth as 'truth' has been used as instrumental in maintaining systems of oppression. Such a positivist approach to reality, that is, "an approach to create scientific descriptions of reality by producing objective generalizations" (Collins, 2000, 273) dismisses the lived experiences of Black women and "asks Black women to objectify ourselves, devalue our emotional life, displace our motivations for furthering knowledge about Black women, and confront in an adversarial relationship those with more social, economic, and professional power" (Collins, 2000, 274). The "truth" of stereotypic archetypes of the Mammy, the Sapphire, the Jezebel, etc. becomes "controlling images" (Collins, 2000) in the public cultural sphere and the private sphere of Black women's lives. The cultural competency stance is too often seen as "rigid categories of knowledge, skills, and attitudes"

rather than "the continuous critical refinement and fostering of a type of thinking and knowing

… of self, others, and the world" (Kumagai & Lypson, 2000, 783). By taking the critical stance

that intersectionality takes and applying it to social work, social work can then recognize that

challenging these controlling images and the power of implicit priming requires a dynamic

challenge and a revolutionary stance.

CHAPTER III

Methodology

Study Purpose and Research Questions

The purpose of this study was to investigate whether clinicians issue more severe psychotic DSM diagnoses (schizophrenia and schizoaffective disorders) to Black female clients than to White female clients when primed with clinically identical stereotype-consistent vignettes. This study was based upon the assumption that clinicians issue more severe psychotic DSM diagnoses in a stereotypic manner to Black female clients when implicitly primed with cultural archetypes unique to Black women. Two research hypotheses were tested for this study: (1) Despite identical symptomatology, the Black female clinical vignette will be assigned more severe psychotic diagnoses than the White female clinical vignette; and (2) Clinicians diagnosing the Black female clinical vignette with a severe psychotic diagnosis will demonstrate quicker reaction times than clinicians diagnosing the White female clinical vignette with a severe psychotic diagnosis, which shows an implicit bias.

Research Design

This study used a mixed methods approach and utilized both qualitative and quantitative elements. A survey was created to answer two research questions: (1) Is there a difference in the type of DSM diagnoses issued by clinicians to the Black female clinical vignette and White female clinical vignette, that is, do clinicians issue more severe and stereotype-consistent

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psychotic diagnoses to the former; and, (2) Is there a difference in the reaction times when clinicians diagnose the Black female clinical vignette and the White female clinical vignette? Clinicians were asked to read clinical case vignettes of an African American woman and a White American woman that were diagnostically and demographically identical except for race to eliminate confounding factors, and then to issue a DSM diagnosis. Clinicians were also asked to complete a multicultural competency, self-report measure (the CCCI-R survey) to ascertain explicit bias.

This survey was created with Qualtrics and contained both quantitative and qualitative questions. Open response dialogue boxes offered participants the opportunity to expand upon, clarify and explain their answers, which included their diagnoses, in an effort to reveal subtleties and nuances that would be difficult to discover in a purely quantitative design.

The CCCI-R survey instrument was also used in this study. This instrument rates high in both reliability and validity tests (LaFromboise, et al., 1991). There were no reliability and validity tests conducted on the two case vignettes. However, the case vignettes were approved by both the thesis research advisor and by the Human Subjects Review Committee to be both diagnostically identical and diagnostically ambiguous to warrant multiple diagnoses.

Sample

The inclusionary criteria for participants in the study were: (1) licensed clinical social workers: and (2) experience in diagnosing mental illness according to DSM criteria. To screen out ineligible participants, all individuals were asked to confirm that they matched these two criteria at the beginning of the survey before moving to the remainder of the survey. This study used simple random sampling and purposive snowball convenience sampling. Because this was an online survey study, access to the Internet was an exclusionary factor for the sample.

Recruitment

The participants were recruited among members of the National Association of Social Workers (NASW), the American Group Psychotherapy Association (AGPA), and the Clinical Social Workers Association (CSWA). Hence, the sampling frame was the current roster of clinical social workers affiliated with the NASW, the AGPA and the CSWA. The recruitment process consisted of the following: (1) the NASW *News* classified advertisement in both paper and online versions of the newsletter (Appendix D), (2) Recruitment letter posted to the Facebook pages of the NASW and the Clinical Social Work Associations, and sent out via email listserv to the NASW national and state chapters (Appendix E), and (3) the recruitment flyer sent to the national membership of the AGPA (Appendix F). Each of these methods included a link to the survey and a brief synopsis of the study. I also used purposive snowball convenience sampling and used professional and personal contacts to further disseminate the survey. Recruitment took place from February 1, 2016 to March 29, 2016. The survey and all associated files were removed from Qualtrics on April 18, 2016 and stored in compliance with research standards.

Limitations

The survey was administered online and therefore only individuals with access to the Internet could participate. The small sample size of 48 precludes this study from being generalized to the greater population of licensed clinical social workers who use the DSM-V Manual.

Ethics and Safeguards

The thesis proposal was submitted and approved by the Human Subjects Review Committee at Smith College School for Social Work (Appendix A) to ensure all efforts be taken to maintain anonymity and confidentiality and ethical safeguards for participants. Protocol change forms were also submitted to the HSR Committee (Appendices B and C) as methodological modifications were warranted.

The informed consent page (Appendix G) outlined the study, included the potential benefits and risks of participation and the ethical safeguards to protect confidentiality and anonymity. All participants included in the data analysis agreed to the informed consent. The potential benefits of participation were that clinicians would become more aware of the possibility of diagnostic inconsistency among clinicians when relying upon the DSM to diagnose clients, and thereby remain and/or become more mindful in diagnosing according to DSM criteria, and that this would contribute to and improve practitioner knowledge regarding diagnostic inconsistency for themselves and for their profession. There are some risks involved in all research. However, the probability and magnitude of harm, distress or discomfort anticipated in this study were no greater than those risks ordinarily encountered in daily life or when individuals undergo routine self-examination, assessments, and evaluations. Therefore, there were no reasonable, foreseeable risks.

The online survey was administered by Qualtrics, which does not collect any identifiable information including names, email addresses or IP addresses. Therefore, I was not able to collect any information on the participants and their anonymity and confidentiality were protected. Their responses were only available to the researcher via the use of password protection. Participants were asked to refrain from disclosing any identifying information in the

open-response questions to further protect their anonymity. I reviewed all open-responses and removed any identifying information of participants before allowing anyone else to view the data. Once the coding was completed by the software survey and I removed all identifying information from the open-response section, the research advisor and research statistician consultant had access to the data. The informed consent page stated that in any publications or presentations, the data would be presented in brief illustrative quotes or vignettes, with no data identifying participants' identities. All research materials including recordings, transcriptions, analyses and consent/assent documents have been electronically stored in a secure password protected and encrypted location and will be kept for three years in compliance with federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. Participants were told that if they chose to participate, they could skip questions or withdraw from the survey at any point. But once they submitted their survey, it would be impossible to withdraw from the study, as their survey data was anonymous.

There was an ethical complication of not telling the participants upfront the complete purpose of the study. However, to do so would have alerted participants to the specific purpose of the study and potentially contaminate and alter their responses. Therefore, I deliberately hid the intent of the complete purpose of the study by giving participants a more general and camouflaged description.

Data Collection

This mixed methods study was an anonymous online study that was constructed and managed using the Qualtrics online survey program. The study requested participants to take an online survey that consisted of several components and took no more than an average of 30

minutes to complete. Once participants indicated that they met the inclusionary criteria by clicking the "I agree that I meet BOTH of these criteria" button, they proceeded to the introduction of the survey and to the informed consent page. If they did not meet the study's criteria, they were directed to the disqualification or consolation page.

Part One of the survey collected demographic data from the participants, i.e., age, ethnicity, gender, socioeconomic status, years of professional practice, theoretical orientation, training in multicultural competency, etc. During part two of the survey each participant was given 1 of 2 clinical case vignettes, written to present clinical features ambiguous enough to warrant a more or less severe clinical diagnosis. Participants were told that there was no correct or incorrect diagnosis. Rather, the study allowed exploration of whether clinical uncertainty led clinicians to rely more upon implicit race, gender and class biases to influence their clinical judgment, and contended that diagnostic ambiguity would lead clinicians to rely more upon their gut instincts or reactions. I chose symptoms that would either elicit a less severe disorder, bipolar disorder, Type 1, or a more severe disorder, schizoaffective disorder or schizophrenia. These selections were made because Blacks are often "underdiagnosed" with bipolar disorder and "over-diagnosed" with schizophrenia. The computer program randomly assigned clinicians to one of the two clinical vignettes, either the African American female "Shanita" vignette (Appendix J), a composite of the various cultural archetypes or the White American female comparison "Beth" vignette (Appendix K).

I used priming via exposure to cultural archetypes of Black women to test whether implicit bias/stereotyping was activated among the participants. The clinical case vignettes were structured to list presenting concerns with a brief client history including socio-cultural variables, family history and background. As with the Gushue (2004) study, the African American female

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vignette was embedded with stereotypes in the client description. These vignettes were stereotypic archetypes unique to Black women. As stated earlier, the case vignettes were presented clinical symptoms ambiguous enough to warrant either a less or more severe diagnosis. A comparison vignette was also composed—one in which the race of the client in the original case vignette had been changed so that it was a White female client, however still presenting the identical ambiguous clinical presentation. The comparison vignette was included in an attempt to discern whether her whiteness contributed to less pathological diagnoses. Once participants were done with the demographic section of the survey, they were given a prompt in the following form: "Please read the case vignette below. Answer the following questions. There is no correct or incorrect diagnosis to the vignette." Then they were asked to diagnose the client. The second question the participants were given was "Please rate your own feelings of confidence in this diagnosis by answering whether you think your diagnosis is Somewhat Likely or Very Likely." Third, the participants were asked, "Please explain your reasoning for this diagnosis." Part three of the survey was a multiple-choice format. It utilized the CCCI-R scale (Appendices L and N; LaFromboise et al., 1991), a scale designed to have counselors rate themselves to assess their own competencies of multicultural awareness, knowledge, and skill. Constantine and Ladany (2000) showed that the CCCI-R correlates with other measures of multicultural competency (MCC; r = .63 to .73), thereby demonstrating the validity of the CCCI-R. It has also shown internal consistency (alpha .88 to .95).

In order to ascertain the presence of implicit bias in reaction to the priming represented by the stereotypic cultural archetypes, this survey gathered response latency data as the participants answered the questions in the diagnostic section of the survey. Quicker response times, under the condition of priming, indicated implicit bias. It was thought that as participants

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were subjected to priming conditions they were more likely to rely upon cognitive heuristics or cognitive shortcuts in the form of stereotypes to render judgments and evaluations for the minority clinical case vignette. In this instance the question was whether the priming of the participants with stereotypic cultural archetypes of Black women would lead these same clinicians to rely upon these particular cognitive shortcuts to render more severe clinical diagnoses for the Black woman in the clinical vignette in comparison to the White woman in the second clinical vignette, even as the vignette for the White woman was as ambiguously created and identical to that of the Black woman's vignette. The exception was race.

Data Analysis

Some participants chose not to answer all questions. But if they answered the diagnostic questions in addition to a majority of the questions, their responses were included in the analysis. As stated earlier, all data was cleaned before the start of the analysis and any identifying information was deleted from the open-ended response questions.

Analysis of the mixed-method study consisted of the following: descriptive statistics for demographic data, inferential statistics that evaluated the differences between clinical vignettes and the type of diagnosis, differences between the clinical vignettes and response times, and qualitative analysis of open-ended response questions. Qualtrics provided an SPSS file. Descriptive statistics were used to describe the sample population demographically and to provide a summary of data. Frequencies were run for the following demographics: gender, age, current income and socioeconomic status. Frequencies were also run for years of practice, practice setting, multicultural counseling training, feelings of time pressure in setting, feelings of time pressure to diagnose, the diagnoses, confidence in diagnoses and awareness of stereotyping in the clinical vignettes. Inferential statistics were used to compare the subgroups with each

other: between clinicians who diagnose the Black female clinical vignette and clinicians who diagnose the White female clinical vignette. T-tests were used to examine the differences in these relationships. Finally, inductive coding and thematic analysis were used on the open-ended response questions. I read through these responses noting possible themes and categories.

Survey data were analyzed by the Smith College School for Social Work data analyst Marjorie Postal who uploaded data as an SPSS file with response frequencies from Qualtrics. She then sent the resulting frequencies to me for my use in preparing the quantitative portion of Chapter Four. Finally, my thesis advisor also assisted in the qualitative analysis to ensure the validity of the thematic analysis.

CHAPTER IV

Findings

This chapter presents the demographic characteristics of the sample, the quantitative results of both descriptive and inferential statistics, the results of the qualitative (open-ended) questions via an inductive approach to thematic analysis with in vivo coding, and a summary of the most significant findings.

A total of 85 potential participants logged onto the online survey. Many of these participants either did not meet the screening criteria or did not complete at least 50% of the survey. A total of 64 participants partially completed the survey and the demographic questions, and an additional 16 participants dropped out or did not answer certain questions, which left a total of 48 participants that completed the survey, which compiled the sample size. Because of this small sample size and despite the overall randomization of the sampling method, the findings of this study are not generalizable to the larger population of clinicians who diagnose according to DSM diagnostic criteria. Nonetheless, the implications derived from this study offer insight for future scientific investigation.

Demographic Data

The demographic characteristics are reported in Tables 1-4. Thirty-seven participants (77.1%) identified as female and 11 (22.9%) identified as male while 2 chose not to answer the question (See Table 1). Most of the participants were in their 40s and above (81.3%) with 18 participants (37.5%) being 60 and over; 21 participants (43.8%) reported being in their 40s and

50s, and 9 participants (18.8%) reported being in their 30s and below (See Table 2). The mean

age was 53 and the median was 54. With respect to current income, 4 respondents (8.7%) made

$40,000 or less; 9 respondents (19.6%) made $41,000 to $64,000; 7 respondents (15.2%) made

$65,000 to $86,000; and 26 (56.5%) made $87,000 or more with 2 not reporting (See Table 3).

Among the 48 participants, a majority, 27 participants (57.4%) were practicing for more than 20

years; whereas, 6 participants (12.8%) were practicing for 5 years or less; 8 (17%) were

practicing for 6 to 10 years; and 6 participants (12.8%) were practicing for 15 to 20 years, with 1

not responding (See Table 4).

Table 1

Gender of Participants

n=48	Frequency	Valid Percent
Female	37	77.1
Male	11	22.9

Table 2

Age of Participants

n=48	Frequency	Valid Percent
Age		
60 and over	18	37.5
40s and 50s	21	43.8
30s and below	9	18.8

Table 3

Current Household Income of Participants

n=48		
Current household income	Frequency	Valid Percent
40,000 or less	4	8.7
41,000-64,000	9	19.6
65,000 to 86,000	7	15.2
87,000 or more	26	56.5
Missing	2	

Table 4

Years Practicing Clinical Social Work of Participants

n=48		
Years Practicing Social Work	Frequency	Valid Percent
Five years or less	6	12.8
6 to 10 years	8	17.0
15 to 20 years	6	12.8
More than 20 years	27	57.4
Missing	1	

Participants also provided information on their theoretical orientations, practice settings and types of multicultural competency training in an open response format. Among the 48 participants who identified their theoretical orientation and therapeutic approaches, 28 (58.3%) identified as using an eclectic approach (i.e., various combinations of cognitive behavior therapy (CBT), psychodynamic theory, dialectical behavior therapy (DBT), eye movement desensitization randomization (EMDR), etc.); 7 (14.61%) identified as only practicing CBT; 7 (14.6%) identified practicing solely psychodynamic therapy and 4 (8.3%) identified as other (i.e., Bowen family system, Eriksonian, and integrated trauma). Among the 48 participants who reported their clinical settings, some identified as practicing in multiple settings with 12 (25%) who identified as working in community health; 21 (43.8%) in private practice; 7 (14.6%) identified as outpatient mental healthcare centers; 6 (12.5%) identified as inpatient residential and 6 (12.5%) identified with others (health maintenance organization, human services, and college health). Finally, all participants reported having multicultural competency training from workshops, to graduate courses, to continued education unit trainings.

Quantitative Data

The quantitative data reports on the 2 research questions and the concomitant hypotheses. The first research question was "(1) Do clinicians issue more severe and stereotype-consistent diagnoses to Black female clients than they do to White female clients?" The accompanying hypothesis was "Despite identical symptomatology, the Black female clinical vignette will be assigned more severe psychotic diagnoses than the White female clinical vignette." Initially, the DSM-V categorizations for psychotic diagnoses (including schizophrenia and schizoaffective disorder), mood disorder, anxiety disorders, and personality disorders were used to classify the diagnoses issued to the Black and White female clinical vignettes by the clinicians in this study.

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Table 5 shows that 23.1% (n = 6) of the clinicians assigned a psychotic disorder to the Black

female vignette compared to 35% (n = 7) of the clinicians who issued a psychotic disorder for

the White female vignette. These relative frequencies in clinician responses do not approach

significance due to effect size, or small variation in numbers. Thus, they could not be analyzed

via Chi Square because there is an assumption that there are no more than 20% of the cells with

an expected value of <5. In this case, 67% had an expected value of <5. In sum, the data from

this study's clinician population did not initially yield significant evidence to show that more

diagnoses of psychotic disorders, schizophrenia or schizoaffective disorders, are assigned to the

Black female vignette than to the White female vignette. Thus, Hypothesis 1 is rejected.

Table 5

DSM-V Diagnoses by Vignette

DSM-V Disorders	Black Female	Valid %	White Female	Valid %
Psychotic Disorders	6	23.1%	7	35.0%
Mood Disorders	16	61.5%	12	60.0%
Anxiety Disorders	2	7.7%	0	0%
Personality Disorders	1	3.8%	1	5.0%
Other	1	3.8%	0	0%
TOTAL	26	100%	20	100%
No Diagnosis	2		1	

*One person gave two diagnoses, hence the total of 49 instead of 48 participants.

Clinicians were also asked about their feelings of confidence in their diagnosis. (See

Table 6) There were 47 responses. Of those 47 responses, less than a majority, 36.2% (n=17)

reported that they were very confident while 63.8% (n=30) reported that they were somewhat

confident, and one participant did not respond.

Table 6

Feelings of Confidence in Diagnosis

N=48	Frequency	Valid Percent
Feelings of confidence in diagnosis		
Somewhat likely	30	63.8
Very likely	17	36.2
Missing	1	

The second research question was "Is there a difference in reaction time in clinician

diagnosis of severe psychotic disorders between a clinically-identical Black female vignette and

a White female vignette?" The hypothesis was "Clinicians diagnosing the Black female clinical

vignette with a severe psychotic diagnosis will demonstrate quicker reaction times than clinicians

diagnosing the White female clinical vignette with a severe psychotic diagnosis, which shows an

implicit bias." The time was measured in seconds by Qualtrics' time stamp data, which were

converted to minutes. Data on four participants were deleted due to missing data.

Out of curiosity, initially an analysis was run to determine if differences existed in the

response times for each vignette in general regardless of diagnosis; a t-test was utilized (See

Table 7). (Equal variances were not assumed. The significance level for the F value of 1.698

was not less than .05; it was 0.199 significance level.) A significant difference was not found in

the amount of response time that clinicians took to diagnose the African American female

vignette compared with the White American female regardless of the specific diagnosis. The

reaction time in minutes for the African American female vignette was a mean of 5.5965 minutes

(N=27) compared to a mean of 6.4972 minutes (N=21) for the White female vignette (t (37.764)

= .482, two-tailed) p = .633).

Table 7

T Test for Reaction Times Regardless of Specific Diagnoses

Reaction time in minutes	Vignette	N	Mean	Std. Deviation	Std. Error Mean
	Afr. Amer. female	27	5.5965	5.61300	1.08022
	Euro Amer. female	21	6.4972	6.99473	1.52638
Levine's Test for Equality of Variances		F		Significance	
		1.698		.199	

Next, a t-test was run to test the second hypothesis, to determine if the reaction time spent

in minutes for the African American female vignette when given a psychotic diagnosis was less

than the reaction time for the White American female vignette when issued with a psychotic

diagnosis (See Table 8). (Equal variances were not assumed. The significance level for the F

value of 3.573 was greater than .05; it was 0.085 significance level). A significant difference was

not found in the reaction time spent diagnosing the Black and White female vignettes with a

psychotic disorder. The difference in means for response times appeared large with 6.8995

minutes for White American female vignette group and 2.9767 minutes for African American

female vignette group (t (6.409) = 1.261, two-tailed p =.251). The lack of significance in these

data findings leads to a rejection of the second hypothesis. However, the mean in Table 8 was

somewhat skewed by one person who spent 24 minutes diagnosing the White American female

vignette.

Table 8

T Test for Reaction Times for Severe Psychotic Diagnoses by Vignette

Reaction time in minutes	Vignette	N	Mean	Std. Deviation	Std. Error Mean
	Afr. Amer. female	6	2.9767	1.38574	.56573
	Euro Amer. female	7	6.8995	8.09083	3.05805
Levine's Test for Equality of Variances		F		Significance	
		3.573		.085	

The outlier was removed and the means were compared again (See Table 9). (Equal variances were not assumed. The significance level for the F value of 4.892 was .051, which is almost equivalent to .05.) The clinicians who diagnosed the White American female vignette still spent longer with 4.0589 minutes (N=6) than the African American vignette group with 2.9767 minutes (N=6) (t (6.727) = -.744, two-tailed p =.482). But again this is based on a very small number of subjects and was not different from a statistical point of view. Therefore, no significant difference was found regarding all clinicians who provided a psychotic diagnosis by vignette when the outlier was removed.

Table 9

T Test for Reaction Times When Outlier Was Removed

Reaction time in minutes	Vignette	N	Mean	Std. Deviation	Std. Error Mean
	Afr. Amer. female	6	2.9767	1.38574	.56573
	Euro Amer. female	6	4.0589	3.28245	1.34005

Levine's Test for Equality of Variances	F	Significance
	4.892	.051

Data was also analyzed regarding the reaction time for clinicians diagnosing psychotic and non-psychotic diagnoses overall, regardless of vignette and a t-test was utilized (See Table 10). (Equal variances were not assumed. The significant level for the F value of 2.188 was .147, greater than .05.) A significant difference was not found in the reaction time that clinicians spent diagnosing psychotic and non-psychotic diagnoses. The difference in means of response times for psychotic and non-psychotic diagnoses were 3.5178 and 5.6007, respectively, (t (39.415) = 1.789, two-tailed p=.081. Regardless of which case clinical vignette was under consideration, less time was spent diagnosing both vignettes with psychotic diagnoses.

Table 10

T Test for Reaction Times for Psychotic vs. Non-Psychotic Diagnoses Regardless of Vignette

Reaction time in minutes	Diagnosis	N	Mean	Std. Deviation	Std. Error Mean
	Psychotic	12	3.5178	2.46774	.71238
	Non-psychotic	32	5.6007	5.72088	.92063

Levine's Test for Equality of Variances	F	Significance
	2.188	.147

Finally, data regarding multicultural competency scores were gathered via the CCCI-R survey, a 20 item 6-point scale (See Table 11). The Cronbach's Alpha was .904 signaling high reliability for this scale, which is consistent with the literature (LaFromboise, et al., 1991). There were three subscales into which multicultural counseling was divided: cross cultural counseling skills, sociopolitical awareness, and cultural sensitivity. The cross-cultural counseling skills subscale consisted of 10 questions wherein the minimum possible score was 10 and the maximum was 60. Among the 48 participants, the mean and median for this subscale was 52.4167 and 53.000, respectively, with a standard deviation of 5.71237. The sociopolitical awareness scale consisted of 6 questions with a possible minimum score of 6 and a maximum possible score of 36. Among the 48 participants, the mean and median scores were 30.0833 and 30.0000, respectively with a standard deviation of 3.7932. The cultural sensitivity subscale consisted of 4 questions with a minimum possible score of 4 and a maximum possible score of 24. Among the 48 participants, the mean and medium scores were 18.292 and 18.5000, respectively with a standard deviation of 2.88237. The minimum total possible score was 20 and

the maximum total possible score was 120. Among the 48 participants, the total minimum score received was 52 and the total maximum score received was 118. For this sample, the overall mean score for participants was 100.7292 and the median was 101.5000 with a standard deviation of 11.2258 so the level of explicit bias among participants was quite high.

Table 11

CCCI-R Survey Results

CCCI-R Subscale	Mean	Median	Standard deviation
Cross cultural counseling skills	52.4167	53.0000	5.71237
Sociopolitical awareness	30.0833	30.0000	3.7932
Cultural sensitivity	18.2292	18.5000	2.88237
Total mean = 100.7292 Total median = 101.5000 Total standard deviation = 11.22258			

In addition to the specific findings derived from data addressing the explicit hypotheses detailed in this study, there were other findings. Observations and detailing during the research process sometimes leads to serendipitous discovery, which can add to the richness of one's findings. In this study, serendipity played an important role. Other relevant discoveries from this research warrant mentioning.

Qualitative

A question on the online survey asked participants if they had noticed any stereotypes embedded in their particular vignette and if so, they were then asked to report their observations in an open response section. Their open responses were analyzed through inductive thematic analysis. Through an initial reading of the text data, I identified quotes that fit into 13 different thematic categories utilizing in vivo coding for the White American female clinical vignette and 14 different thematic categories for the African American female vignette. The 13 and 14 categories were later reduced to 6 and 8 thematic categories for the White American female vignette and the African American female vignette, respectively. During this process smaller categories were merged with similar allied categories. For instance, poverty, minimal education and welfare categories were reduced to a theme labeled 'low socioeconomic status, with dependence on welfare,' and the categories of multiple children, multiple fathers and sexuality were reduced to a theme of 'promiscuity'. Many of the themes that emerged were common to both the African American female and White American female vignettes.

Themes Common to Both Vignettes

Forty-two (89.4%) of the clinicians recorded stereotypes embedded within their particular clinical vignette, and 5 (10.6%) did not observe a stereotype (See Table 12). Of those clinicians who had the African American female vignette, it was rare for a respondent not to notice any stereotype; 24 stated that they recognized stereotyping and 3 stated that they did not recognize any stereotyping within the African American female clinical vignette, which is 89% and 11.1%, respectively (See Table 13). Of those clinicians who had the White American female vignette, it also was rare for a respondent not to recognize stereotyping; 18 stated that they recognized

stereotyping and 2 stated that they were not aware of any stereotyping, which was 90% and 10%, respectively (See Table 13).

Table 12

Awareness of Stereotypes in the Clinical Vignettes by Response

n=48	Frequency	Valid Percent
Yes	42	89.4
No	5	10.6
Missing	1	

Table 13

Awareness of Stereotypes in the Clinical Vignettes by Race

n=48	Frequency	Valid Percent
African American female vignette	Yes=24	88.9
	No=3	11.1
White American female vignette	Yes=18	90.0
	No=2	10.0
Missing	1	

The 42 responses from the question of awareness of stereotyping fell into nine (9) themes: (1) young, single motherhood, (2) promiscuity, (3) relationship problems with father, (4) negative attitudes towards men, (5) poor speech, appearance, and demeanor, (6) low socioeconomic status with dependence on welfare, and (7) drug use, which were common

themes that emerged in both vignettes with the addition of (8) race/ethnicity and (9) multigenerational transmission of poverty that arose only in the African American female vignette. Table 14 refers to the percentage of themes mentioned in total for both vignettes. Tables 15 and 16 present themes and percentages by participants for the African American female vignette and the White American female vignette, respectively.

Commonality was central to the African American female and the White American female vignettes; however, seven themes stood out in particular (See Table 14). They ranked in the following order from the highest number of mentions to the least: promiscuity (80.9%), low SES with dependence on welfare (57.1%), young, single motherhood (35.7%), poor speech, appearance, and demeanor (28.6%), relationship problems with the father (23.8%), drug use (11.9%), and negative attitudes towards men (9.5%).

The percentages of themes that emerged for each of the vignettes were grouped. It was interesting to note that although all clinicians observed the same or similar patterns of behaviors in the clinical vignettes, they appeared to be weighted differently in terms of percentages (See Tables 15 and 16). For both the African American female and the White American female the leading theme was promiscuity at comparable rates with 83.3% for the African American female vignette and 77.7% for the White American female vignette. The second largest theme to emerge, low SES with dependence on welfare, was also the same for the African American female vignette and the White American female vignette with 66.7% and 44.4%, respectively with a difference of 22.3% in favor of the African American female vignette. After these two themes, the ranking diverged. The theme of young, single motherhood was 33.3% for the Black female vignette and 38.8% for the White female vignette. The percentages for poor speech, appearance, and demeanor were 25% for the African American female vignette and 33.3% for

the White American vignette. The theme of relationship problems with fathers arose as a theme at a percentage rate of 20.8% for the African American female clinical vignette and 27.7% for the White female clinical vignette. As for the theme of negative attitudes towards men, the African American female vignette was four times that for the White American female vignette with a percentage of 4.1% for the former and 16.6% for the latter. The final theme that emerged as a common theme for both was that of drug use and there was a substantial difference between the rates at which it was noted for each vignette at 8.3% for the African American female vignette and 33.3% for the White American female vignette.

Samples of the direct quotes and the overarching themes held in common are as follows:

Promiscuity

African American Female Vignette

White American Female Vignette

"Sexually active as a teen"

"Using her sexuality to manipulate situations with

"Sexually promiscuous"

men"

"Hypersexualized Black female"

"the woman's sexual history"

"Basing symptoms on lifestyle"

"Number of children and fathers"

"multiple children (out of marriage?)"

"Single mother with most kids by different fathers"

"African American woman with

"Single mother, with several partners"

multiple children by different fathers"

"Stress leading to … promiscuity"

"Young black single mother,

"single parent with multiple children from

who has many children of

multiple fathers"

different fathers"

"the woman's sexual history"

Low SES and dependent on government assistance

African American Female Vignette	White American Female Vignette
"underemployed"	"underemployed"
"low income"	"works at a fast food chain"
"minimum wage job"	"did not finish high school, blue collar worker"
"welfare recipient"	"Classic welfare family"
"relying on public aid"	"had children to stay on welfare"
"needing federal assistance"	
"use of word welfare to refer to public assistance"	
"minimizing socioeconomic and psychiatric issues"	
"limited money"	
"She fit the profile of many African American women living in inner city"	
"entry level job"	
"poverty"	
"poor"	
"unskilled capacity"	
"urban area resident"	
"uneducated and works in menial job"	
"use of government assistance and poverty"	

Young, single motherhood

African American Female Vignette	White American Female Vignette
"Teenage mom"	"number of children"
"Pregnant at 15"	

Relationship problems with the fathers

African American Female Vignette	White American Female Vignette
"Lack of support"	"dead beat dads"
"Poor relationship with fathers"	"Different fathers with little support economy
"Minimal support"	of ally or emotional."
"many kids with different fathers,	
most of whom don't pay child support"	

Negative attitudes towards men

African American Female Vignette	White American Female Vignette
"Her characterization of men"	"men are worth nothing"
	"perceptions/attitude toward men, not as
	commonly expressed like that by 'European
	American women"

Poor speech, appearance, and demeanor

African American Female Vignette	White American Female Vignette
"Portrayed as angry"	"dress, appearance, cleanliness"
"Loud"	"dyed hair … not being fit … somewhat
"Her weight, hair, dress, way of speaking	overweight"
Mentioning 'house shoes' and	"The way she spoke. I forgot the exact wording
unkempt hair'"	but the syntax was stereotypical of urban, low
"Wearing certain types of clothing in	income people, usually African American"
session, use of profanity and poor	"use of slang"
grammar, dyed hair"	"way of patient's speaking/dialect implied
	education level of the patient"
	"overweight with a pony tail wearing house
	slippers"

Drug use

African American Female Vignette	White American Female Vignette
"She had smoked marijuana in the past"	"Smoking"
"possible drug use"	"Stress leading to substance abuse"

Two themes emerged for the African American female vignette that were unique to this vignette—race/ethnicity and multigenerational transmission of poverty. Again, samples of direct quotes along with the overarching themes are as follows:

Race/ethnicity

<u>African American Female Vignette</u>

"Black female with a unique sounding name"

"African derived name"

"Choice of client's name

"her ethnicity"

"hypersexualized black female"

"She fit the stereotype of the African American women living in the inner city"

"mention of dark skin"

Multigenerational transmission of poverty

<u>African American Female Vignette</u>

"Multigenerational family systems"

"Limited institutional supports"

"Multigenerational involvement of family"

Table 14

Themes Common to the African American Female and White American Female Vignettes

Themes n=42	Number of Participants	% of Participants
Young, single motherhood	15	35.7%
Promiscuity	34	80.9%
Relationship problems with father	10	23.8%
Negative attitudes towards men	4	9.5%
Poor speech, appearance, demeanor	12	28.6%
Low SES with dependence on welfare	24	57.1%
Drug use	5	11.9%

Table 15

Themes for the African American Female Vignette

Themes n = 24	Number of Participants	% of Participants
Young, single motherhood	8	33.3%
Promiscuity	20	83.3%
Relationship problems with father	5	20.8%
Negative attitudes towards men	1	4.1%
Poor speech, appearance, demeanor	6	25.0%
Low SES with dependence on welfare	16	66.7%
Drug use	2	8.3%
Race/ethnicity	10	41.7%
Multigenerational transmission	3	12.5%

Table 16

Themes for the White American Female Vignette

Theme n=18	Number of Participants	% of Participants
Young, single motherhood	7	38.8%
Promiscuity	14	77.7%
Relationship problems with father	5	27.7%
Negative attitudes towards men	3	16.6%
Poor speech, appearance, demeanor	6	33.3%
Low SES with dependence on welfare	8	44.4%
Drug use	3	33.3%

Summary

This was a mixed methods study that used both random and non-random purposive snowball convenience sampling in an effort to recruit a wide range of participants. The purpose of the study was to investigate whether clinicians issue more severe psychotic DSM diagnoses to Black female clients than to White female clients when primed with clinically identical stereotype-consistent vignettes. Two hypotheses were examined for this study: (1) Despite identical symptomatology, the Black female clinical vignette will be assigned more severe psychotic diagnoses than the White female clinical vignette; and (2) Clinicians diagnosing the Black female clinical vignette with a severe psychotic diagnosis will demonstrate quicker reaction times than clinicians diagnosing the White female clinical vignette. The study's most

significant findings were: (1) Data did not yield significant evidence to show that more diagnoses of psychotic disorders were assigned to the Black female vignette than to the White female vignette; and (2) Although clinicians were found to spend more time diagnosing the White female clinical vignette than the Black female vignette, the difference was not significant. The study consisted of 48 participants.

Chapter 5 discusses the major findings of this study in relation to existing literature, the strengths and limitations of the study, and the implications of the study for practice and policy.

CHAPTER V

Discussion

The purpose of this study was to investigate whether stereotypic cultural archetypes lead clinicians to issue Black female clients more severe and stereotype-consistent diagnoses than White female clients. Hypothesis 1, which stated that the Black female clinical vignette would be assigned more severe psychotic diagnoses than the White female clinical vignette, despite identical symptomatology, was rejected. Hypothesis 2 was rejected, for, although it was it was observed that clinicians in this study generally did spend more time diagnosing the White female clinical vignette overall, and with a psychotic condition specifically, the differences were statistically insignificant. When reviewing thematic responses from clinicians regarding the clinical vignettes in this study, serendipitous findings were noted. These serendipitous findings bear mentioning because they give nuance to the overall study by illustrating the intersectional lens through which both vignettes were viewed by the clinicians. First, clinicians reported awareness of the hybrid of cultural archetypes primed in the African American female vignette but did not put a name to the cultural archetypes, which suggests the potency of these stereotypes on an unconscious level. Second, clinicians reported common themes present in both vignettes. A surprising find in this study was that clinicians deemed the White female clinical vignette just as stereotyped as the African American female vignette. In the sections to follow, I discuss these findings in relation to the literature review, present the strengths and limitations of this study,

make recommendations for future research, and finally, conclude with the implications of this study for practice and theory.

Literature Review and Results

In many ways, the results of this study were inconsistent with the literature. With respect to the study's first major finding, client race did not appear to be a key factor in clinicians' diagnoses of severe psychotic disorders of the female vignettes in this study. Despite this, a preponderance of research has demonstrated that Blacks are more likely diagnosed with psychotic disorders such as schizophrenia, whereas Whites are more likely diagnosed with mood disorders (Garb, 1997; Neighbors, Trierweiler, Ford, & Muroff, 2003; Neighbors, Trierweiler, Munday, Thompson, Jackson, Binion, & Gomez, 1999; Neighbors & Williams, 2001; Pavkov, Lewis, & Lyons, 1989; Iwamasa et al., 2000; Mukherjee et al., 1983). Solomon (1992) found that the same symptoms labeled "schizophrenic" among Blacks were labeled "emotional" and "affective" disorders among Whites.

However, there may be another way to view or interpret data that does not reveal bias in diagnoses for Black clients. Gushue (2004) examined the impact of reported client race (Black or White) on perceptions of clients' symptom severity. Gushue (2004) used intake reports as part of a packet of questionnaires distributed to a sample of 158 students during classes for graduate level degrees in counseling and clinical psychology. He used Monica Biernat's "shifting standards" model of social judgment (Biernat, 2003; Biernat, 1995; Biernat & Kobrynowicz, 1997; Biernat & Manis, 1994; Biernat, Manis, & Nelson, 1991). The shifting standards model posits that participants may shift the referents they use, that is, use unacknowledged cognitive schemas as reference points when making subjective judgments about members of social groups who are subjected to stereotypes. Gushue (2004) found that the

participants reported perceiving the Black client as significantly less symptomatic compared to the White client, which supports the shifting standards model. According to Biernat and her colleagues (Biernat & Kobrynowicz, 1997; Biernat & Manis, 1994; Biernat et al., 1991), individuals from negatively stereotyped, low-status groups encounter a different set of judgment evaluations than individuals from positively stereotyped, high status-groups. Gushue's (2004) finding of consistency with the shifting standards model suggests "that apparently more favorable evaluation for the client of color is the result of a judgment based on lower standards that reflect racist societal stereotypes. Thus, the meaning of the evaluation is really "healthy *for a Black person*" (Gushue, 2004, 403).

The current study used DSM diagnostic criteria to diagnose the clinical vignettes with severe psychotic disorders. Other studies have examined the relationship between patient race, schizophrenia, schizoaffective disorder, depression and bipolar disorder. For example, Neighbors, et al., (2003) explored the relationship between patient race to schizophrenia, schizoaffective disorder, major depression, and bipolar disorder and the extent to which a patient's race is related to the way in which clinicians link individual symptoms to diagnoses. They analyzed 665 African American and White psychiatric inpatients using a semi-structured instrument and found racial differences in DSM diagnoses (2003). Even with the use of semi-structured instruments in tandem with DSM criteria, there were still significant race differences in diagnoses. African Americans were found more likely to receive diagnoses of schizophrenia while Whites were more likely to receive diagnoses of bipolar disorder. No race differences were observed with respect to major depression. Neighbors, et al. (2003) also found that some patterns of symptom attribution differed by race as well.

The use of standardized diagnostic criteria does not eliminate the racial disparity in certain mental illness diagnoses. A more research-based semi-structured diagnostic instrument can presumably cause clinicians to pay more attention to DSM criteria, which is actually more accurate than other diagnostic procedures that are often used in clinical settings/agency-based diagnoses (Neighbors et al., 2003). Therefore, depending upon the diagnostic instrument used, it may explain the diagnostic equivalence found in this study, that is, whether they used a version of the DSM other than DSM-V or used a different diagnostic instrument. Another potential explanation may be that the clinical vignettes were read rather than interactive, which precluded interactive dialogue between clinician and client.

An underlying assumption of my first hypothesis was that there is equal equivalence among the various races and ethnicities for mental disorders. Perhaps the assumption should not be made that certain mental illnesses are ***not*** more or less prevalent among certain minority or ethnic populations ***for whatever reason***. The overdiagnosis of schizophrenia, on the one hand, and the underdiagnosis of mood disorders, on the other hand, of Blacks in comparison to Whites reflects an assumption that all disorders are of equal equivalence across race and ethnicities. That may not be the case. Also, diagnostic divergence—agreement and disagreement across assessment procedures and patient race—does not automatically lead to the conclusion of clinician bias because much of psychiatric diagnosis depends upon client self-report, leaving clinicians to operate under a certain degree of clinical uncertainty (Neighbors et al. 2003).

Hypothesis 2, that clinicians would respond quicker to diagnosing the African American female vignette with a severe psychotic diagnosis, was not only unfounded, but was inconsistent with much of the literature as well. All participants, clinical social workers, reported having multicultural competence training and took the CCCI-R survey, which measures explicit bias.

First, the high MCC scores in this study demonstrated low explicit bias and were in tandem with the response latency data that evinced low implicit bias, which contradicts literature that finds a differentiation between explicit and implicit measures of bias (Boysen and Vogel, 2008; Boysen 2009). Boysen and Vogel's (2008) study found that counselor trainees' implicit bias diverged from their low levels of self-reported, explicit bias. Boysen's (2009) literature review of counseling literature also revealed divergence between self-reports of explicit bias and implicit bias among counselors. However, this finding supports the Castillo et al. (2007) study, which utilized response latency data and the racial IAT and found that counselor trainees' course in MCC both statistically increased their cultural awareness and decreased their implicit racial bias. Second, my finding was contrary to literature that states that stereotype-consistent primes should have sped up the processing and responses to this target (Givens & Monahan, 2005; Monahan, Shtrulis, & Brown-Givens, 2005; Monahan, Brown-Givens, & Shtrulis, 2003).

Considering the literature and findings from the current study, I drew several inferences. Although I am reluctant to do so based on the small numbers of participants, it may be that African American women are diagnosed more akin to White American women in that gender differences trump racial differences. Therefore, mood disorders may more likely be diagnosed among both White and African American women than men (Arnold, 2003; Baldassano, Marangell, Gyulai, Ghaemi, Joffe, Kim, et al., 2005; Nivoli, Pacchiarotti, Rosa, Popovic, Murru, Valenti, et al., 2011) assuming equal equivalence. A second inference that may be drawn is that reading a clinical vignette wherein the African American and White female vignettes are diagnostically identical is not the same as a clinician having a live client before them where they will be exposed to visual and auditory cues in a way that cannot be replicated by written vignette. For instance, studies have shown that when participants have been exposed to a visual mediated

stereotype of one African American woman that they then go on to stereotype another African American female in a different social situation in a stereotypical manner as well (Givens & Monahan, 2005; Monahan, Shtrulis, & Brown-Givens, 2005; Monahan, Brown-Givens, & Shtrulis, 2003). That is, the stereotypic images of one Black female did activate stereotype-consistent perceptions of another Black female in a different social situation. Possibly, the visual and auditory effect of a visually mediated format may be more salient for participants than a written vignette, which perhaps led to more stereotype-consistent perceptions and diagnoses according to the studies mentioned here. Third, the difference in findings with the Boysen and Vogel (2008) study and the Boysen (2009) literature review may be because of the difference in disciplines. It may be that the multicultural competency training of these social work clinicians as opposed to counselors, which was varied, was more effective in training them to be cognizant of stereotyping of minority clients (perhaps from an intersectional perspective) and therefore more vigilant in diagnosing them with more severe diagnoses. These clinicians' reluctance to over-pathologize minorities due to their cultural competency training may have led to diagnostic equivalence as was the finding in this study.

Serendipitous Findings

Serendipity played a role in analyzing my research findings—findings that emerged during data collection but that were not the focus of this study and that were drawn from thematic analysis of open response data. First, when clinicians were explicitly asked whether they were aware of stereotypes in the African American female vignette, very few clinicians reported that they were not aware of stereotypes. As seen from the quotes in Chapter 4 on the findings, the African American female vignette was viewed as stereotyped in the following way: uneducated, poor, dark-skinned, loud, angry, overweight, promiscuous, hypersexualized ethnic

female with multiple children and multiple fathers, which befits the stereotype of an African American female living in an inner city who has a negative characterization of men, relying on government assistance. Many of these quotes were consistent with the characteristics used by White university students in the Weitz and Gordon (1993) study that described African American women as loud, aggressive, profane, quick-tempered, bitchy, disorderly and too many children. The clinicians in this study identified a hybrid stereotype. The African American female clinical vignette was seen as reminiscent of the loud, hostile, aggressive, shrewish, emasculating Sapphire (Thomas, Witherspoon, & Speight, 2004; West, 2008). The emphasis on the African American female vignette as promiscuous and having multiple children with multiple fathers proved to be a major theme, indeed the leading theme. She was seen as having been stereotyped as a sexually irresponsible breeder who had multiple children out-of-wedlock as reminiscent of the Welfare Queen. And the emphasis on the multigenerational effects of poverty and the multigenerational involvement of the family was suggestive of the Matriarch who Collins (2000) identified as being stereotyped as a failed Mammy. The Black American female vignette was stereotyped by her overweight and dark-skinned physical presentation (Shaw, 2005) as consistent with evocations of the stereotype of the Mammy. But unlike the Mammy, the Black woman presented in this study's vignette was not seen as hypofeminine. Instead, her hypersexuality and promiscuity were more befitting the stereotype of the Jezebel (Collins, 2000; West, 2008). The identification of her as a teenage mom, and the emphasis on her appearance of wearing tight clothes and dyed hair, who is involved in problematic relationships with multiple fathers who do not contribute financial or psychological support harkened to the Baby Mama stereotype. The fact that the clinicians who diagnosed the Black female clinical vignette

in this study saw so many archetypes in her presentation is further proof of the potency of these stereotypes.

A surprising finding was that regardless of random assignment, clinicians viewed the White American female and the Black American female clinical vignette as being stereotyped in much the same manner. Most of the themes that emerged in the thematic analysis were common to both clinical vignettes. The White American female was identified as being stereotyped for her appearance, her demeanor, her promiscuity, her negative attitudes towards men, her class, her reliance on government welfare (one participant even said that she had children to stay on welfare), etc.

This was indeed surprising, considering findings from Givens and Monahan (2005), which suggested that the presence of schema/stereotyping effects, when participants were primed with negative stereotypical word associations when evaluating both the Black American and White American interviewees, only occurred within the African American interviewee experimental condition. This implied that activation of an African American stereotype is an activated schema that only manifests salience, influence and significance for a Black target and not for a White target (Zarate and Smith 1990). However, this was not the case in the present study. Two inferences can be drawn. First, the presentation of the White American female in this study was "colored" in the clinical vignette, which was nearly identical to that of the African American female vignette. A couple of comments from participants suggest that this was the case.

"perceptions/attitude toward men, not as commonly expressed like that by 'European American women"

"The way she spoke. I forgot the exact wording but the syntax was stereotypical of

urban, low income people, usually African American"

So it seems that for at least among some participants in this study, the White American female

was deemed as being as stereotyped in the same manner as a Black American female.

Another possible interpretation is that I may have unknowingly evoked a particular

negative stereotype(s) familiar to clinicians of the White woman as "White trash" or "trailer

trash" or "redneck." One participant identified her "family interaction-uncle teaching her to

shoot" as indicative of how the White female in the vignette was being stereotyped. No one

mentioned guns in the African American female vignette. Another participant saw the White

female as "ethnic." Particularly, this participant thought that she seemed Russian. The

participant said, "I thought she might be Russian because I've dealt with Russian clients who

have exhibited paranoia and have a negative view of men." If all variables are the same when it

comes to client demographics (i.e., race, gender, SES, caste, education, language, religion,

membership, etc.), if indeed this is the case, then the bias for these stereotypes as defined in the

literature would become non-existent and client diagnosis may become more equalitarian. But

most importantly and also sanctioned by the literature is the importance of clinician cultural

competency. An important lesson from the current study is the potential harm by clinicians to

Black women in therapeutic spaces when they are beseeched by the power of stereotypic cultural

archetypes

Strengths of the Current Study

The addition of the qualitative component to this study was invaluable. The open

response format, along with the thematic analysis, and the quantitative findings strengthened this

study immensely. By not specifying the type of stereotyping (whether it be race, ethnicity,

gender or class) that may have been present in the clinical vignettes left the door open in a way that allowed the researcher to see how intersectionality was at play for the White female vignette as well as for the Black female vignette. I had not duly considered that White women's unique marginality would be salient in the minds of the clinicians in potentially jeopardizing *her* clinical diagnosis. This was only exposed with the addition of the awareness check and the thematic analysis. In one sense the study had high validity in that the multiple choice format as well as the open response format allowed capture of a range of possible responses that closed responses alone would not have allowed. The awareness check also revealed that the clinical vignettes reliably primed cultural archetypes for the Black female clinical vignette. Finally, the CCCI-R instrument as a measure of multicultural counseling has high reliability and validity ratings.

Limitations of the Current Study

There were a number of limitations in the current study. First, the sample size is not sufficient enough to be generalizable to the larger clinical population group. Equally important, data from this study does not reflect the race and ethnicity of study participants; thus these results cannot be generalized to the entire population of clinicians and therefore signify a threat to external validity. Since the CCCI-R is a cross-cultural scale, it was not used to the effect that it was intended due to the lack of collection of data on race and ethnicity.

Second, while the research questions did examine the content that I was expecting, the choice of methodology curtailed the extent to which I could do so. *After* reading the African American female clinical vignette, *after* diagnosing it, and *after* completing the multicultural competency segment of the survey, the presentation of the archetypes being primed remained salient in the minds for the clinicians who diagnosed the African American female vignette. Given that an overwhelming majority of clinicians were aware of the stereotypes being primed,

the question arises as to whether the priming was sufficiently disguised enough to elicit their gut reactions, their unconscious and implicit bias.   Or, were the clinicians cued to be aware of the stereotypes by the awareness check, that is, the awareness question itself?

For Stepanikova (2012) the awareness check was used to determine if the presentation of the stimulus was truly subliminal, which is the intent of priming, such that the demographic information of race, gender, class do not enter conscious awareness. As Stepanikova (2012) stated, "This bolsters confidence that the observed differences in medical decisions were caused by automatic cognitions and that conscious strategies, including those that involve self-presentation, did not play a role" (334). The virtue of priming is that it is used to activate implicit bias by presenting demographic information in a way that doesn't resonate consciously; thereby, priming makes it more difficult for participants to alter their responses in order to appear less biased.   It appears that my awareness check revealed that the priming of cultural archetypes resonated with the clinicians and that it resonated consciously rather than unconsciously. That and the fact that there was no time pressure may have made it less likely to elicit an IAT effect.

Third, had the response latency data been paired with the imposition of time pressure, I think that it would have been more likely to elicit an implicit reaction. For, closely associated with the IAT effect is time pressure as a constraint to obtain the IAT effect. To uncover an IAT effect, reactions are measured using response latency data, i.e., the response time of actions in milliseconds, when time pressure is imposed on participants to create a situation in which participants are more likely to rely on their implicit bias and judgments. That was not the case in the current study.

Fourth, the lack of uniform testing conditions not only may have skewed the response latency data results but also the diagnoses themselves, which are in and of themselves complex

concepts. Although a criterion for this study was that the clinicians have experience using the DSM to diagnose, it was not a requirement that they do so to diagnose their specific clinical vignette. Clinicians may have used other and/or different diagnostic instruments. The decision to use one diagnostic instrument over another in diagnosing the clinical vignettes may have affected the diagnoses to the extent that differential diagnoses or diagnostic divergence were not found. Hence, a limitation of the study was the lack of uniform, sterile conditions under which the survey was performed, which threatened respondent reliability. Were it the case that the participants did use the same DSM-V instrument, it would call into question the instrument validity of the DSM-V itself. The DSM-V is a book of diagnoses, diagnoses of complex, complicated concepts; this, too calls into question construct validity regarding the way *individual* diagnoses have been constructed. Even the usage of the same diagnostic instrument, the DSM-V, may have elicited (and seems to have elicited in this study) many varied diagnoses ranging from personality disorders to depression, from bipolar disorder to PTSD attributed to both clinical vignettes so much so that I had to simplify the diagnoses into psychotic versus non-psychotic when the clinical vignettes were constructed to elicit diagnoses of either bipolar disorder I or schizoaffective disorder.

Finally, it would have been useful to determine exactly what the participants' multicultural competency courses, workshops, trainings, seminars, etc. entailed; that is, whether they entailed an intersectional theoretical component. That may explain my finding of equal equivalence in diagnosis rather than differential diagnosis as was the case in a preponderance of previous studies.

Recommendations for Future Research

My recommendations for future research stem in large measure from the limitations evidenced in the current study. In hindsight, I would have collected racial/ethnic data, imposed a time limitation for participants to react to the vignettes and diagnose in order to truly evoke unconscious, gut reactions from the response latency data. I would have been more specific in requesting that participants only use the DSM-V as their diagnostic instrument. Finally, I would have gathered data on the content of their MCC training to discern whether or not it is being taught from an intersectional perspective.

Implications of the Current Study for Practice and Theory

Despite limitations cited for this study, my findings and the preponderance of research studies named in this investigation continue to evince diagnostic divergence along racial lines, and emphasize the need to advance future studies in this area. Additionally, cultural competency training taught from the perspective of intersectional theory is pivotal to eliminating this race bias. Cultural competency has been adopted in the field of clinical social work and education programs because of the increase of racial and ethnic diversity and cultural heterogeneity, recognition of the disparities in the quality of services delivered to marginalized populations, and the possibility of replication of oppression in the therapist-client dyad. Now, it is nearly taken for granted in the field of social work that to achieve a successful counseling relationship with members of marginalized populations in particular, clinical social workers must achieve or strive towards cultural competency. However, more is necessary given that unconscious implicit stereotyping and bias can contribute to misdiagnoses and differential diagnoses for marginalized groups even among culturally sensitive clinical social workers. There are diagnostic implications when cultural archetypes, whether supporting positive or negative stereotypes, are

endorsed by the dominant culture. In addition, it is important to avoid the stereotyping and overgeneralization that can occur when applying cultural knowledge pertaining to marginalized groups to marginalized individuals. In the words of Kumagai and Lypson (2009) when speaking to cultural competency in the medical field, "Cultural competency is not an abdominal exam" (783). I posit that it is more likely to be treated as such when cultural competency goes without critique through the lens of intersectionality and when it goes without respectful and serious consideration of the psychological power that cultural archetypes hold on our psyches. Both are necessary to locate and situate cultural competency in a social, political, economic and historical perspective that accurately reflects the reality of many individuals belonging to marginalized populations, like Black women. Training in the psychology of implicit bias, most often stoked by appealing to stereotypic cultural archetypes, can enhance cultural competence when cultural competence is informed by intersectionality.

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SMITH COLLEGE

December 15, 2015

Kim Dubose

Dear Kim,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Narviar Barker, Research Advisor

SMITH COLLEGE
IRB RESEARCH PROPOSAL FORM

2015-2016
RESEARCH PROJECT PROTOCOL CHANGE FORM
Smith College School for Social Work

You are presently the researcher on the following *approved* research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:

«Project_Name»
Student's Name
Research Advisor's/Doctoral Committee Chair Name

....
Please complete the following:

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

[DESCRIBE ALL PROTOCOL CHANGES BEING PROPOSED IN NUMERIC SEQUENCE; BE BRIEF AND SPECIFIC]

1. I need to change the email address as contact information to kmdbs777@gmail.com on the informed consent form, the classified ad and the recruitment material.

2. Also, I would like to collect response latency (timing) data for **all** of the survey. This requires no change in the format of the survey. It is only a change in the data that Qualtrics can automatically collect.

....

__X__ I understand that these proposed changes in protocol will be reviewed by the Committee.
__X__ I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.
__X__ I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

Signature of Researcher: _Kim T. DuBose_

Name of Researcher (PLEASE PRINT): _Kim T DuBose_   **Date:** _1/24/2015_

PLEASE RETURN THIS SIGNED & COMPLETED FORM TO Laura Wyman at LWyman@smith.edu or to Lilly Hall Room 115.

***Include your Research Advisor/Doctoral Committee Chair in the 'cc'. Once the Advisor/Chair writes acknowledging and approving this change, the Committee review will be initiated.*
....

APPENDIX C: PROTOCOL CHANGE FORM #2

SMITH COLLEGE
IRB RESEARCH PROPOSAL FORM

2015-2016
RESEARCH PROJECT PROTOCOL CHANGE FORM
Smith College School for Social Work

You are presently the researcher on the following *approved* research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:

Presenting Image/Presenting Symptoms: Clinicians' Diagnoses of Black Females
Kim Teresa DuBose
Dr. Narviar C Barker

Please complete the following:

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

1. I wish to add additional recruitment venues to my originally approved HSR Application. These recruitment sites will include various professional associations such as the American Group Psychotherapy Association, Clinical Social Workers Association, etc.).
2. I also wish to add Facebook as a recruitment site.

Approval of this request is necessary in order to increase the likelihood of my obtaining a sufficient sample size in order to conduct my research project.

_X__ I understand that these proposed changes in protocol will be reviewed by the Committee.
_X_ I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.
_X_ I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

Signature of Researcher: _Kim T. DuBose_

Name of Researcher (PLEASE PRINT): _Kim T. DuBose_   Date: 3/3/2016

PLEASE RETURN THIS SIGNED & COMPLETED FORM TO Laura Wyman at LWyman@smith.edu or to Lilly Hall Room 115.

***Include your Research Advisor/Doctoral Committee Chair in the 'cc'. Once the Advisor/Chair writes acknowledging and approving this change, the Committee review will be initiated.*

APPENDIX D: NASW NEWSLETTER—CLASSIFIED AD

SEEKING LCSW/LICSW for Participation in Research Study!!!

My name is Kim DuBose. I am a Master's of Social Work student at Smith College School for Social Work. I am completing a mixed methods study for completion of my Master's Thesis to be presented in the summer of 2016. The purpose of this study is to explore the consistency or lack thereof of DSM diagnoses among a diverse array of licensed clinical social workers who are experienced in diagnosing mental illness according to the DSM. This is a brief survey that should take no more than 30 minutes. This study protocol has been reviewed and approved by the Smith College for Social Work Human Subjects Review Committee (HSRC).

Your feedback is greatly appreciated and important to the field of clinical social work! If you decide to participate in this study, the following link https://smithcollege.qualtrics.com/SE/?SID=SV_5AdUyIqmf0RljYF will take you to an informed consent document before you begin the survey. Your responses are anonymous and confidential. If you have questions or concerns, please contact me at xxxxxxxxxxxxxxxxxxx.

Share your valuable knowledge, perspective and experience! Thank you in advance for your time and potential participation.

SEEKING LCSW/LICSW for Participation in Research Study!!!

Dear NABSW/NASW Member,

My name is Kim DuBose and I am currently enrolled in the Smith College School for Social Work Master of Social Work Program. I am contacting you to solicit your participation my research study that is designed to explore the consistency, or lack thereof, of DSM diagnoses among a diverse array of licensed clinical social workers who are experienced in diagnosing mental illness according to DSM criteria. This research is in partial fulfillment of the completion of my thesis.

Based upon eligibility, you are being asked to complete an anonymous online survey that consists of several components: brief demographic data, a clinical vignette with several open-response questions, a multiple-choice component and a final closed-ended and open-ended question at the end of the survey. This survey should take no longer than 30 minutes to complete. This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).
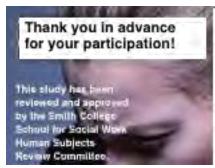
I would greatly appreciate your assistance in recruitment for my study. Attached you will find a flyer with the following link [https://smithcollege.qualtrics.com/SE/?SID=SV_5AdUyIqmf0RljYF] to the survey. Can you publicize, disseminate or post this recruitment flyer (See attachment) to your membership? If not, can you offer advice in how I might do so? In addition, would you please forward this email to anyone you know who might be interested in completing my survey or could offer help in another way? If you have additional ideas for recruitment efforts, I am grateful for that as well.

Do not hesitate to contact me at xxxxxxxx@xxxxxxxxxx with any questions or concerns.

Thank you for your time and help!
MSW Student
Smith College School of Social Work

APPENDIX F: RECRUITMENT FLYER

Thank you in advance for your participation!

This study has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee.

Seeking licensed clinical social workers who are experienced in diagnosing mental illness according to DSM criteria! Your participation is welcomed in a brief survey of the consistency of DSM diagnoses. You can find the survey at the link below:

https://smithcollege.qualtrics.com/SE/?SID=SV_5AdUyIqmf0RIjYF

SMITH COLLEGE

2015-2016
Consent to Participate in a Research Study
Smith College School for Social Work ● Northampton, MA

……………………………………………………………………………..

Title of Study: Presenting Image/Presenting Symptoms: Clinicians' Diagnoses of Black Females
Investigator(s): Kim Teresa DuBose
                Smith College School for Social Work
                xxxx-xxx-xxxx

……………………………………………………………………………..

Introduction
- You are being asked to participate in a survey of the consistency, or lack thereof, of DSM diagnoses among a diverse array of licensed clinical social workers.
- You were selected as a possible participant because you fulfill the criteria of membership as a professional clinician who has experience in diagnosing mental illness according to the Diagnostic Manual Statistical (DSM) criteria. If this does not apply to you, then you are excluded from participating in the survey.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study
- The purpose of this study is to explore the consistency, or lack thereof, of DSM diagnoses among a diverse array of licensed clinical social workers who are experienced in diagnosing mental illness according to the DSM.
- This study is being conducted as a research requirement for my Master's in Social Work.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures
- If you agree to be in this study, you will be asked to do the following things: You will be asked to take a demographics questionnaire. Once completed, you will read a case vignette and then answer a few questions based on the vignette. Finally, you will

complete a multiple choice component and a final open-response and closed-ended question. This survey will take approximately 30 minutes to complete. There will be no follow-up to this research study except for those who volunteer to participate in the online focus group.

Risks/Discomforts of Being in this Study
- There are some risks in all research. However, the probability and magnitude of harm, distress or discomfort anticipated in the proposed research are not greater than those risks ordinarily encountered in daily life or when individuals undergo routine self-examination, assessments and evaluations.
- There are no reasonable, foreseeable risks.
- Study participants will be encouraged to call the 2-1-1 helpline, which is a free 24/7 confidential information, referral and crisis counseling helpline for those in need of consultation, support or counseling services.

Benefits of Being in the Study
- The potential benefits of participation are that you will gain greater awareness of the possibility of diagnostic inconsistency among clinicians when using the DSM to diagnose clients and patients and the knowledge that you will be contributing to and improving practitioner knowledge regarding diagnostic inconsistency for yourself and for your profession. In addition, you will have access to the results of the study once it is completed and therefore can gain insight from the study's findings should you choose to by contacting me via email.
- The benefits to the field of social work are that clinical social workers and others engaged in the mental health profession who treat those diagnosed with mental illness will gain a better understanding and insight into the possibility of inconsistency of diagnoses among clients.

Confidentiality [*choose one of the following*]
- The questionnaire will be administered online via the software survey, which does not collect any identifiable information including names, email addresses or IP addresses. Therefore, the researcher will not be able to collect any information on the participants and your anonymity and confidentiality are protected. Your responses will only be available to the researcher via the use of password protection. Please refrain from disclosing any identifying information in the open-response questions to further protect your anonymity. The researcher will review all open-responses and remove any identifying information of participants before allowing anyone else to view the data. Once the coding is done by the software survey and any identifying information is removed from the open-response section by the researcher, the research advisor and research consultant will have access to the data. In any publications or presentations, the data will be presented in brief illustrative quotes or vignettes, with no data to identify participants' identities. All research materials including recordings, transcriptions, analyses and consent/assent documents will be electronically stored in a secure password protected and encrypted location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. We will not include any information in any report we

may publish that would make it possible to identify you. Your participation in this online study is entirely voluntary. If you choose to participate, you may skip questions or you may withdraw from the survey at any point. If you do so, then the survey may be discarded. But once you have submitted your data, it will be impossible to withdraw from the study as your data is anonymous and I will be unable to identify your survey responses from the others that have participated in the study.

Payments/gift
- There will be no compensation offered or given for participation in this research study.

Right to Refuse or Withdraw
- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* while you are taking the survey without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point until you press "Done." If you choose to withdraw, I will not use any of your information collected for this study. Once you agree to take the survey you may stop at anytime. But once the survey is completed and you press "Done" I will not be able to go back and see or find your results.

Right to Ask Questions and Report Concerns
- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Kim T. DuBose at xxxxxxxx@xxxxxxxxxxx. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent
- Your consent below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above.

If you agree to continue, press the button, "Agree." If not, simply close the browser window.
………………………………………………………………………………..

Form updated 9/25/13

APPENDIX H: DEMOGRAPHIC QUESTIONS

Please answer all of the questions to the best of your ability. You may at your discretion skip any questions that you wish. But, I would appreciate your completing all of the questions because your contribution will add to the richness of the data.

Part I: Demographic Questions

It is important that I gather some demographic data so that I may accurately characterize my sample's diversity and generalizability. Please answer the questions to the best of your ability.

1. What is the gender to which you identify? _____

2. In what year were you born? (Enter 4-digit birth year, for example, 1973)
    _____

3. What do you identify as your race/ethnicity?
    _____

4. What is your current household income?
    A. 40,000 or less
    B. 41,000 to 64,000
    C. 65,000 to 86,000
    D. 87,000 or more
5. How do you describe your socioeconomic status growing up?
    A. Poor
    B. Working poor
    C. Middle class
    D. Upper middle class
    E. Wealthy
6. How many years have you been practicing clinical work?
    A. Five years or less
    B. 6 to 10 years
    C. 11-14 years
    D. 15-20 years
    E. More than 20 years
7. What theoretical orientation(s) do you identify with (i.e., psychodynamic, cognitive behavioral therapy, relational, attachment, etc.)?
    _____

8. What is the setting in which you practice (i.e., community health, residential inpatient, etc.)?
    _____

9.   What kind of multicultural competency training have you had (i.e., course, workshop, few classes, none)?
    _____

10. Are you in a stressful setting that imposes time pressure on you as a clinical social worker to diagnose quickly?
    A. Yes
    B. No
11. Do you feel that time pressure to diagnose is a common stressor for you as a social worker?
    A. Yes
    B. No

Part II.

Please read the case vignette below.   Answer the following questions. There is no correct or incorrect diagnosis to the vignette.

1. Based on the presenting symptoms and your clinical knowledge and experience, what DSM diagnosis would you give this client?

2. Please rate your own feelings of confidence in this diagnosis by answering whether you think your diagnosis is
    A. Somewhat Likely
    B. Very Likely

3. Please explain your reasoning for this diagnosis.

APPENDIX J: **THE CASE OF SHANITA**

Shanita is a 29-year-old African American woman. She grew up and lives in an urban area in the northeastern part of the United States. She is a single mom with 5 children. She had her first child when she was 15 years old. All but two of the children, twins, have different fathers. Shanita, herself, also grew up without a father in the home.

Shanita did not graduate from high school and works at a fast food restaurant. She receives child support from one of the four fathers. But she is still unable to make ends meet without government assistance. Even with welfare assistance she is constantly strapped for money to cover rent and utilities. Shanita is reportedly not on good terms with any of the fathers. During more lucid moments, Shanita has told me that she has used her sexuality to her advantage in getting what she wants from men, "not that it's done much good," she once said. And then she raised her voice and said, "These men … shit fuck excuses for men! They ain't nothin'."

For the last month, Shanita's mother reports that she has been acting differently. She reports her as being more quick-tempered and "fiery." Her mother says that she's always been argumentative and sometimes intimidating but never intimidating to her. She and other family members say that while at times she seems despondent and lethargic, at other times she seems energetic and "on the go." Lately Shanita has been expressing the belief that someone is following her and is "out to get her." She also believes that someone is trying to poison the food and water in their apartment. She drags the furniture behind the apartment door whenever she returns home, gets rid of any food that has been prepared and left in the refrigerator overnight and any water or Kool-Aid in pitchers for fear that it has been poisoned. She also carries a knife in her purse and takes it out as she checks every room and closet in her small apartment to check for intruders. Last week Shanita asked her maternal uncle to teach her to use a gun so that she can protect herself and her children against the people who are out to get her. As far as her family knows she doesn't currently possess a gun.

Shanita is large but not obese. Her hair is unkempt. She wears it in a short ponytail and it is dyed burgundy. She wears house shoes in the sessions. She usually wears a mini skirt and blouse, which are a little too tight. Her mother reported to me that her appearance is not much different than normal. Shanita presents as euphoric and energetic. Her speech is rapid and pressured. Shanita herself says she doesn't have racing thoughts. She also seems confused as to what I mean by racing thoughts no matter how many times or different ways I try to explain what I mean. During my multiple attempts at explanation she interrupted me by speaking of not liking the painting hanging up on my wall and complaining about her toe nail polish. At one point, Shanita told me that the voices inside her head were warning her that someone was trying to hurt her but they won't tell her why, but she thinks it's because of her dark complexion. According to Shanita's records, she has been healthy except for an operation to remove ovarian cysts two years ago. She has told me in the past that she has smoked pot regularly with her boyfriends but "not lately," but isn't specific about what she means by not lately. Currently, she is not on any medication except for occasionally taking over-the-counter medicine for headaches, which she says "aren't all that effective." Shanita does smoke cigarettes and has since she was 14 years old. She says she smokes to reduce stress. Heart disease and diabetes run in her family on her maternal side and one aunt on her paternal side had cancer.
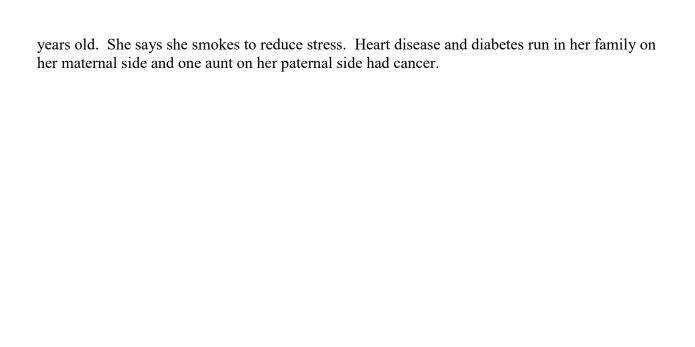
Beth is a 29-year-old White American woman. She grew up and lives in an urban area in the northeastern part of the United States. She is a single mom with 5 children. She had her first child when she was 15 years old. All but two of the children, twins, have different fathers. Beth, herself, also grew up without a father in the home.

Beth did not graduate from high school and works at a fast food restaurant. She receives child support from one of the four fathers. But she is still unable to make ends meet without welfare assistance. Even with government assistance she is constantly strapped for money to cover rent and utilities. Beth is reportedly not on good terms with any of the fathers. During more lucid moments, Beth has told me that she has used her sexuality to her advantage in getting what she wants from men, "not that it's done much good," she once said. And then she raised her voice and said, "These men … shit fuck excuses for men! They ain't nothin'"

For the last month, Beth's mother reports that she has been acting differently. She reports her as being more quick-tempered and "fiery." Her mother says that she's always been argumentative and sometimes intimidating but never intimidating to her. She and other family members say that while at times she seems despondent and lethargic, at other times she seems energetic and "on the go." Lately Beth has been expressing the belief that someone is following her and is "out to get her." She also believes that someone is trying to poison the food and water in their apartment. She places the furniture behind the doors whenever she returns home, gets rid of any food that has been prepared and left in the refrigerator overnight and any water or Kool-Aid in pitchers for fear that it has been poisoned. She also carries a knife in her purse and takes it out as she checks every room and closet in the small apartment to check for intruders. Last week Beth asked her maternal uncle to teach her to use a gun so that she can protect herself and her children against the people who are out to get her. As far as her family knows she doesn't currently possess a gun.

Beth is large but not obese. Her hair is unkempt. She wears it in a short ponytail and it is dyed burgundy. She wears house shoes in the sessions. She usually wears a mini skirt and blouse, which are a little too tight. Her mother reported to me that her appearance is not much different than normal. Beth presents as euphoric and energetic. Her speech is rapid and pressured. Beth herself says she doesn't have racing thoughts. She also seems confused as to what I mean by racing thoughts no matter how many times or different ways I try to explain what I mean. During my multiple attempts at explanation she interrupted me by speaking of not liking the painting hanging up on my wall and complaining about her toe nail polish. At one point, Beth told me that the voices inside her head were warning her that someone was trying to hurt her but they won't tell her why.

According to Beth's records, she has been healthy except for an operation to remove ovarian cysts two years ago. She has told me in the past that she has smoked pot regularly with her boyfriends but "not lately," but isn't specific about what she means by not lately. Currently, she is not on any medication except for occasionally taking over-the-counter medicine for headaches, which she says "ain't all that effective." Beth does smoke cigarettes and has since she was 14

years old. She says she smokes to reduce stress. Heart disease and diabetes run in her family on her maternal side and one aunt on her paternal side had cancer.

APPENDIX L: CCCI-R SURVEY

1. You are aware of your own cultural heritage.
   A. Strongly disagree
   B. Disagree
   C. Somewhat disagree
   D. Somewhat agree
   E. Agree
   F. Strongly Agree

2. You value and respect cultural differences.
   A. Strongly disagree
   B. Disagree
   C. Somewhat disagree
   D. Somewhat agree
   E. Agree
   F. Strongly Agree

3. You are aware of how your own values might affect your clients.
   A. Strongly disagree
   B. Disagree
   C. Somewhat disagree
   D. Somewhat agree
   E. Agree
   F. Strongly Agree

4. You are comfortable with differences.
   A. Strongly disagree
   B. Disagree
   C. Somewhat disagree
   D. Somewhat agree
   E. Agree
   F. Strongly Agree

5. You are willing to suggest referral for extensive cultural differences.
   A. Strongly disagree
   B. Disagree
   C. Somewhat disagree
   D. Somewhat agree
   E. Agree
   F. Strongly Agree

6. You understand the current sociopolitical system and its impact on your clients.
   A. Strongly disagree
   B. Disagree
   C. Somewhat disagree
   D. Somewhat agree
   E. Agree
   F. Strongly Agree

7. You demonstrate knowledge about your clients' cultures.
   A. Strongly disagree
   B. Disagree
   C. Somewhat disagree
   D. Somewhat agree
   E. Agree
   F. Strongly Agree

8. You understand the counseling process.
   A. Strongly disagree
   B. Disagree
   C. Somewhat disagree
   D. Somewhat agree
   E. Agree
   F. Strongly Agree

9. You are aware of institutional barriers that affect your clients.
   A. Strongly disagree
   B. Disagree
   C. Somewhat disagree
   D. Somewhat agree
   E. Agree
   F. Strongly Agree

10. You elicit a variety of verbal and nonverbal responses from your clients?
    A. Strongly disagree
    B. Disagree
    C. Somewhat disagree
    D. Somewhat agree
    E. Agree
    F. Strongly Agree

11. You communicate a variety of verbal and nonverbal messages to your clients.
    A. Strongly disagree
    B. Disagree
    C. Somewhat disagree
    D. Somewhat agree
    E. Agree
    F. Strongly Agree

12. You suggest institutional intervention skills to your clients.
    A. Strongly disagree
    B. Disagree
    C. Somewhat disagree
    D. Somewhat agree
    E. Agree
    F. Strongly Agree

13. Your communication is appropriate for your clients.
    A. Strongly disagree
    B. Disagree
    C. Somewhat disagree
    D. Somewhat agree
    E. Agree
    F. Strongly Agree

14. You perceive a problem within the client's cultural context.
    A. Strongly disagree
    B. Disagree
    C. Somewhat disagree
    D. Somewhat agree
    E. Agree
    F. Strongly Agree

15. You present your own values to your clients.
    A. Strongly disagree
    B. Disagree
    C. Somewhat disagree
    D. Somewhat agree
    E. Agree
    F. Strongly Agree

16. You are at ease talking with your clients.
    A. Strongly disagree
    B. Disagree
    C. Somewhat disagree
    D. Somewhat agree
    E. Agree
    F. Strongly Agree

17. You recognize limits placed by cultural differences on the counseling relationship.
    A. Strongly disagree
    B. Disagree
    C. Somewhat disagree
    D. Somewhat agree
    E. Agree
    F. Strongly Agree

18. You appreciate the social status of your clients who belong to an ethnic minority.
    A. Strongly disagree
    B. Disagree
    C. Somewhat disagree
    D. Somewhat agree
    E. Agree
    F. Strongly Agree

19. You are aware of your professional responsibilities.
    A. Strongly disagree
    B. Disagree
    C. Somewhat disagree
    D. Somewhat agree
    E. Agree
    F. Strongly Agree

20. You acknowledge and are comfortable with cultural differences.
    A. Strongly disagree
    B. Disagree
    C. Somewhat disagree
    D. Somewhat agree
    E. Agree
    F. Strongly Agree

APPENDIX M: AWARENESS CHECK

For some participants we attempted to activate bias by embedding stereotypes in the clinical vignettes.

1. Were you aware of any stereotypes in your clinical vignette?
   A. Yes
   B. No
2. If so, could you write what you noticed.

_____
_____
_____
_____
_____
_____
_____

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Cross-Cultural Counseling Inventory—Revised

PsycTESTS Citation: LaFromboise, T. D., Coleman, H. L. K., & Hernandez, A. G. (1991).
Cross-Cultural Counseling Inventory—Revised [Database record]. Retrieved from PsycTESTS.
doi: 10.1037/t02925-000

Test Shown: Full

Test Format: 20 items; 6-point Likert scale ranging from 1 (strongly disagree) to 6 (strongly
agree).

Source: LaFromboise, Teresa D., Coleman, Hardin L., & Hernandez, Alexis (1991).
Development and factor structure of the Cross-Cultural Counseling Inventory—Revised.
Professional Psychology: Research and Practice, Vol. 22(5), 380-388. doi: 10.1037/0735-
7028.22.5.380

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Cross-Cultural Counseling Inventory--Revised CCCI-R

Items

Cross-Cultural Counseling Skill
4. Comfortable with differences
16. At ease talking with client
1. Aware of own cultural heritage
8. Understands counseling process
19. Aware of professional responsibilities
2. Values and respects cultural differences
13. Communication is appropriate for client
12. Suggests institutional intervention skills
20. Acknowledges and comfortable with cultural differences
11. Communicates variety of verbal and nonverbal messages

Socio-Political Awareness
5. Willing to suggest referral for extensive cultural differences
10. Elicits variety of verbal and nonverbal responses
18. Appreciates social status of client as an ethnic minority
3. Aware of how own values might affect client
14. Perceives problem within the client's cultural context
6. Understands the current sociopolitical system and its impact on the client

Cultural Sensitivity

15. Presents own values to client
7. Demonstrates knowledge about client's culture
17. Recognizes limits placed by cultural differences on the counseling relationship
9. Aware of institutional barriers that affect the client