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# Predisposition to seek mental health care among Black males transitioning from foster care

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## Abstract

This study examined the predisposition to seek mental health care in the future for personal and mental health problems among Black males transitioning from the foster care system (*n*=74). Results of simultaneous multiple regression analysis showed that custody status, diagnosis of a DSM-IV psychiatric disorder, and emotional control contributed significantly to the prediction of Black male's predisposition to seek mental health care. Specifically, Black males who were still in foster care were more predisposed to seek mental health care, whereas those diagnosed with a DSM-IV psychiatric disorder and who adhered more to the norm of emotional control were less predisposed to seek mental health care. Implications for mental health service delivery are discussed.

### Keywords

Black males; Foster care; Help-seeking; Mental health services; Masculine norms

## 1. Introduction

Children and youth in foster care have been described as the most vulnerable group in American society (Bergman, 2000). Generally speaking, most foster children and youth have been the victims of abuse and/or neglect resulting in temporary-to-permanent removal from the homes of their birth parent(s). As a consequence, rates of emotional and behavioral problems among foster care youth are significantly greater than youth in other high-risk populations (Kortenkamp & Ehrle, 2002; Pilowsky, 1995). For older youth who are transitioning from the foster care system, poor psychosocial outcomes are all too common. In comparison to a nationally-representative sample of 19-year olds in the Continental United States, Courtney et al. (2005) found that 19-year old, former foster care youths were less likely to have a high school diploma or GED, less likely to be currently employed, more likely to have at least one child, more likely to be the victims and perpetrators of violent acts, and more likely to report poor overall health. When comparing the adult functioning between 19-year olds still in foster care and 19-year olds who were formerly in foster care, Courtney et al. (2005) found that those no longer in foster care had higher rates of recent alcohol abuse, substance dependence, and substance abuse based on DSM-IV diagnostic criteria, with these rates being significantly greater among males than females.

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Arguably, the transition to adulthood is even more difficult for ethnic minority males. Studies show poorer outcomes with regard to employment status, housing stability, educational attainment, and criminal justice involvement among ethnic minority males upon their exit from the foster care system (Kerman, Wildfire, & Barth, 2002). Gibbs (1988) asserted that poor educational and vocational preparedness specifically among young Black males (i.e., 15–24 years old) increases the probability of unemployment, which increases the risks of criminal involvement, which, in turn, increases vulnerability to drug abuse and other psychological difficulties. The combined statuses of being young, Black, male, and in foster care suggest a probable high need of mental health care. In this study, we sought to examine factors that are related to the predisposition to seek mental health care in the future for personal and mental health problems among Black males transitioning from the foster care system. Research of this nature is particularly important given the Surgeon General's call for culturally relevant research that informs the elimination of racial and ethnic disparities in mental health treatment among vulnerable populations (U.S. Department of Health and Human Services [USDHHS], 2001).

### 1.1. Help-seeking predispositions among youth

A predisposition to seek mental health care for personal, emotional, and psychological difficulties may have tremendous consequences for the short- and long-term well-being of Black males transitioning from foster care. Cauce et al. (2002) delineated a number of cultural and contextual factors that may be related to ethnic minority youths' decision to seek help. Youth's perception of need is a critical factor in their decision to seek help, albeit research suggests that youth are not likely to seek help from formal or informal sources even when they subjectively experience emotional and psychological difficulties (Cauce et al., 2002). Even when there is evidence of epidemiologically defined need based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association, 1994), the research is clear that the majority of youth do not receive mental health services (USDHHS, 1999). Furthermore, Black and other ethnic minority youth from high-risks groups have lower rates of mental health service use than their non-Hispanic White counterparts (Garland et al., 2005). Aside from potential structural factors such as biased referral practices (Garland et al., 2005), demographic, individual, and socio-cultural factors that may deter ethnic minority youth from seeking or receiving needed mental health care include male gender, low income, the use of certain avoidance coping strategies (e.g., refusing to think about it), adherence to certain culturally- or community-proscribed norms (e.g., exuding strength in spite of adversity), negative attitudes or low receptivity to care, anticipated negative consequences from others, stigma concerns, adherence to certain norms that are arguably proscribed based on gender (e.g., self-reliance), and the need for privacy (Cauce et al., 2002). The literature also suggests that fear of treatment, mistrust, and cultural/ethnic differences between clients and providers also contribute to a low proclivity among ethnic minorities to seek mental health services particularly from specialty settings and providers (Cauce et al., 2002; USDHHS, 2001).

### 1.2. The present study

Studies examining the attitudes and predispositions toward seeking mental health services among Black males, in general, are not abundant. Yet, the available evidence suggests that adult Black males are not likely to seek professional help for personal or mental health problems (Neighbors & Howard, 1987). In this study, we examined the relative contribution of the following factors to Black male's predisposition to seek mental health care for personal and mental health problems in the future: foster care custody status, counseling status and history, diagnosis of a DSM-IV psychiatric disorder, cultural mistrust of mental health professionals (i.e., extent to which White mental health professionals are mistrusted), stigma beliefs (devaluation–discrimination and secrecy), and adherence to certain masculine norms (self-reliance and emotional control). No hypotheses were made concerning the contribution of custody status, counseling status and history, DSM-IV psychiatric disorders, cultural mistrust

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of mental health professionals or stigma beliefs given the limited empirical evidence concerning these factors among youth and young adults. Previous research among predominantly adult White male samples, however, has shown that the masculine norms of self-reliance and emotional control are related to more negative attitudes toward seeking professional psychological help (e.g., Berger, Levant, McMillan, Kelleher, & Sellers, 2005; Good, Dell, & Mintz, 1989; Mahalik, Locke, Ludlow, Diemer, Scott & Gottfried, 2003). Hence, we hypothesized that the more Black males adhered to the norms of self-reliance and emotional control, the less predisposed they would be to seeking mental health care in the future.

## 2. Method

### 2.1. Participants

From an on-going longitudinal study of older foster care youths in the care and custody of the Missouri Children's Division (MCD), Black males were recruited to participate in a separate study that focused on their readiness to seek help for personal, behavioral, or emotional problems upon transitioning from the foster care system. The longitudinal study at baseline consisted of 406 older foster care youth (mean age=16.99, SD=.09), 97 (23.9%) of whom were Black males. Seventy-four (76.3%) of the 97 were successfully contacted and agreed to participate in this study. Participants were 18 (*N*=68, 91.9%) and 19 (*N*=6, 8.1%) years of age. The Foster Care Independence Act (FCIA) of 1999 expanded the eligibility for care, support, and services to older youth in foster care up to age 21 (Collins, 2004). Hence, the majority of participants were still in the care and custody of the Missouri Children's Division (*N*=44, 59.5%). Based on self-report, 27% (*N*=20), were currently receiving counseling services from a mental health professional, 36.5% (*N*=27) had previously received counseling services from a mental health professional, and 36.5% (*N*=27) had never received counseling services. As assessed by the Diagnostic Interview Schedule (DIS) at baseline in the larger longitudinal study, close to half of Black male participants (*N*=34, 45.9%) met criteria for lifetime or past-year psychiatric disorders based on DSM-IV diagnostic criteria (American Psychiatric Association, 1994). The most prevalent disorders were oppositional disorder (*N*=21, 28.4%) and conduct disorder (*N*=15, 20.3%), followed by major depression (*N*=10, 13.5%) and attention deficit/hyperactivity disorder (*N*=10, 13.5%). Nearly all (*N*=63, 85.1%) had a history of placement in congregate care settings (group homes or residential treatment centers). Results of attrition analysis showed that the 74 Black male participants did not significantly differ on major study variables (e.g., age at entry into foster care, psychiatric history, etc.) from the 23 Black males in the larger longitudinal study who could not be located.

### 2.2. Measures

**2.2.1. Cultural mistrust of mental health professionals—**Cultural mistrust of mental health professionals was measured by a modified version of the Cultural Mistrust Inventory (CMI; Terrell & Terrell, 1981). The CMI is a 48-item scale that measures the tendency of Blacks to mistrust Whites in four areas of life: educational and training settings, the political and legal system, work and business interactions, and interpersonal and social contexts. Research shows that the CMI continues to be a reliable and valid measure of cultural mistrust among Blacks (Whaley, 2001). In this study, the 13-item Interpersonal Relations subscale of the CMI was modified to assess participant's beliefs and opinions about the trustworthiness of White mental health professionals. For example, the original item, “It is best for Blacks to be on their guard when among Whites” was modified to read, “It is best for Blacks to be on their guard when dealing with White mental health professionals,” and the original item, “Blacks should be cautious about what they say in the presence of Whites since Whites will try to use it against them” was modified to read, “Blacks should avoid sharing their personal thoughts and feelings with White mental health professionals because they will use it against you.” Participants responded to items on a 5-point, Likert-type scale ranging from *strongly*

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*disagree* (1) to *strongly agree* (5), with higher mean scores indicating greater cultural mistrust of mental health professionals. The internal reliability estimate (α) for the modified version of the CMI subscale was .78.

**2.2.2. Stigma beliefs—**Stigma beliefs were measured by modified versions of the *devaluation–discrimination* and *secrecy* scales designed by Link, Cullen, Struening, Shrout, & Dohrenwend (1989). The devaluation–discrimination scale is a 12-item scale that measures the extent to which respondents believe that a person who has received mental health treatment will be devalued and discriminated against by most people. The secrecy scale is a 5-item scale that measures coping orientations that persons with mental illness might use to deal with stigmatization. Link et al. (1989) reported internal reliability estimates (α) of .76 for the devaluation–discrimination scale and .71 for the secrecy scale. In the present study, the devaluation–discrimination and secrecy scales were modified in order to (a) update terms that might be less familiar to participants and (b) contextualize mental health problems and services in a more recognizable manner. Example modifications for the devaluation–discrimination scale included revising the original item, "Most people feel that entering a mental hospital is a sign of personal failure" to read, "Most people feel that getting help for serious mental health problems is a sign of weakness," and the original item, "Most people in my community would treat a former mental patient just as they would treat anyone" to read, "Most people in my community would treat someone who used to have serious mental health problems just as they would treat anyone." Example modifications for the secrecy scale included revising the original item, "If you have been treated for a serious mental illness, the best thing to do is keep it a secret" to read, "If you have been treated for a serious mental health problem, the best thing to do is keep it a secret." Participants responded to items on a 5-point, Likert-type scale ranging from *strongly disagree* (1) to *strongly agree* (5), with higher mean scores indicating greater stigma beliefs. In the present study, a number of items from the devaluation–discrimination (4 items; e.g., "Most women would be reluctant to date a man who has been treated for serious mental health problems") and secrecy (2 items; i.e., "A person who used to have a serious mental health problem will have to hide the fact that he or she has been hospitalized in the past") scales were omitted to increase reliability estimates. The internal reliability estimate (α) for the modified version of the devaluation–discrimination scale (8 items) was .70. The internal reliability estimate (α) for the modified version of the secrecy scale (3 items) was .73.

**2.2.3. Masculinity norms—**Adherence to masculine norms was measured by the Conformity to Masculinity Norms Inventory (CMNI; Mahalik et al., 2003). The CMNI is a 94-item scale that assesses 11 masculine norms: winning, emotional control, risk taking, violence, power over women, dominance, playboy, self-reliance, primacy of work, disdain for homosexuality, and pursuit of status. In the present study, only the emotional control (11 items) and self-reliance (6 items) subscales were administered given their relevance and consistent, significantly positive relationship with help-seeking attitudes among White males. The emotional control subscale assessed the degree to which participants restricted their expression of emotions (e.g., "It is best to keep your emotions hidden" and "I hate it when people ask me to talk about my feelings"). The self-reliance subscale assessed the degree to which participants were disinclined to ask for help (e.g., "It bothers me when I have to ask for help" and "Asking for help is a sign of failure"). Participants responded to items on a 4-point, Likert-type scale ranging from *strongly disagree* (0) to *strongly agree* (3). Several items were recoded so that higher mean scores indicated greater adherence to masculine norms. Mahalik et al. (2003) reported internal reliability estimates (α) of .91 for the emotional control subscale and .85 for the self-reliance subscale. The concurrent validity of scores on the total CMNI and its subscales was demonstrated through their significant associations with three masculinity-related measures. Test–retest (2–3 week time period) coefficients were .95 (total scale), .90 (emotional

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control), and .80 (self-reliance). In this study, the internal reliability estimates (α) were .86 for the emotional control subscale and .80 for the self-reliance subscale.

**2.2.4. Predisposition to seek mental health care—**Predisposition to seek mental health care was measured by four modified items from the National Survey of Black Americans (Jackson & Gurin, 1997). Items included: "In the future, would you seek help from a mental health professional or mental health clinic if you felt down and depressed, so low that you felt like you could not get going?" and "In the future, would you seek help from a mental health professional or mental health clinic if you had a personal problem you could not handle by yourself?" Participants responded to items using a 4-point, Likert-type scale: *definitely not* (0), *probably not* (1), *probably* (2), or *definitely yes* (3), with higher mean scores indicating a greater predisposition on the part of participants to seek mental health care in the future. The scale had an internal reliability estimate (α) of .85. Furthermore, the measure of predisposition to seek mental health care showed evidence of concurrent validity given its significant correlation with the *Confidence In Mental Health Practitioner* subscale ($r$=.51, $p$<.001) from the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970).

### 2.3. Procedure

Details of the procedures used in the longitudinal study from which participants in the present study were recruited are reported elsewhere (McMillen et al., 2004). For this study, the names and contact information of Black males in the longitudinal study were provided to the first author who was an investigator on the longitudinal study. The first author had clearance to review the files of participants in the longitudinal study and also took an active role in interviewing Black male participants. Black males who were successfully contacted for the present study were still active participants in the longitudinal study from which they were recruited. The first author contacted prospective participants directly to solicit their participation. None of those contacted refused to participate. Upon providing informed consent, participants were interviewed in person by the first author, a Black male, at their place of residence ($N$=66, 89.2%) or by telephone ($N$=8, 10.8%). Interviews were conducted from July 2003 to November 2004. The measures were read aloud to control for reading difficulties. Participants interviewed by phone resided in locales that were a significant distance from the project site (>100 miles). All participants were paid $20. The Washington University Institutional Review Board approved the procedures for this study.

### 2.4. Analysis

Data analysis occurred in a number of steps. First, descriptive statistics were computed to provide a profile of the sample on the primary study variables. Second, *t*-tests were conducted to examine the relations of background characteristics – custody status (still in foster care vs. no longer in foster care), previous/current receipt of counseling (yes vs. no), history of psychiatric disorders based on DSM-IV diagnostic criteria (yes vs. no) – to predisposition to seek mental health care. Third, correlational analysis was conducted to examine the relationship of cultural mistrust of mental health professionals, stigma beliefs, and masculine norms to predisposition to seek mental health care. Simultaneous multiple regression analysis was then conducted with only those variables showing a moderate-to-significant bivariate relationship ($p$<.10) to examine their relative contribution to the prediction of Black male's predisposition to seek mental health care. Missing data was handled through listwise deletion.

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## 3. Results

### 3.1. Descriptive and correlation analyses

Table 1 shows the means, standard deviations, skewness, and ranges of the study variables. Results of independent-samples *t*-tests showed that custody status was significantly related to Black male's predisposition to seek mental health care, $t(72)=-2.05$, $p=.04$, with those still in foster care ($M=2.05$, SD=.64) reporting a greater predisposition than those no longer in foster care ($M=1.71$, SD=.75). Diagnoses of a DSM-IV psychiatric disorder was marginally related to predisposition to seek mental health care, $t(72)=1.77$, $p=.08$, with those with a DSM-IV psychiatric disorder ($M=1.76$, SD=.81) reporting a lower predisposition to seek mental health care than those without a DSM-IV psychiatric disorder ($M=2.04$, SD=.57). Previous/current receipt of counseling was unrelated to predisposition to seek mental health care, $t(72)=-.44$, $p=.66$. Table 2 shows the intercorrelations among primary study variables. Results showed that cultural mistrust of mental health professionals, devaluation–discrimination, and emotional control were significantly and inversely correlated with predisposition to seek mental health care. Secrecy was a moderate, inverse correlate of predisposition to seek mental health care.

### 3.2. Multiple regression analysis predicting predisposition to seek mental health care

To examine what factors significantly contributed to Black male's predisposition to seek mental health care, a simultaneous multiple regression analysis with custody status, diagnosis of a DSM-IV psychiatric disorder, cultural mistrust of mental health professionals, devaluation–discrimination, secrecy, and emotional control entered as independent variables was conducted. A summary of beta coefficients, standard errors, and semi-partial correlation coefficients ($Sr^2$)is shown in Table 3. Results are based on the 64 participants who completed the assessment of their predisposition to seek mental health care. The total model explained 35% of the variance in predisposition to seek mental health care, adjusted $R^2$ =27, $F(6, 57)$ =4.86, $p\leq.001$. Results showed that custody status ($Sr^2$ =.11), psychiatric history ($Sr^2$ =.07), and emotional control ($Sr^2$ =.11) contributed significantly to the prediction of predisposition to seek mental health care. These factors accounted for 29% of the explained variance with custody status and emotional control emerging as the largest unique contributors. Specifically, Black males who were still in foster care were more predisposed to seek mental health care, whereas those diagnosed with a DSM-IV psychiatric disorder and who adhered more to the norm of emotional control were less predisposed to seek mental health care for personal and mental health problems in the future.

## 4. Discussion

This study examined the predisposition to seek mental health care for personal and mental health problems in the future among Black males transitioning from the foster care system. Results of bivariate analyses showed that Black males who were still in foster care tended to express greater predispositions to seek mental health care, whereas those who were more culturally mistrustful of mental health professionals, reported greater beliefs that a person receiving mental health treatment will be devalued and discriminated against, and adhered more to the norm of emotional control tended to express lower predispositions to seek mental health care in the future.

To determine which factors contributed significantly to the prediction of Black male's predisposition to seek mental health care, simultaneous multiple regression analysis was conducted. Results showed that custody status, psychiatric history, and emotional control contributed significantly to the prediction of Black male's predisposition to seek needed mental health care, with custody status and emotional control evolving as the largest unique contributors. As hypothesized, Black males who adhered more to the norm of emotional control

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were less predisposed to seek mental health care in the future for personal and mental health problems. One suggestion given for why males are generally disinclined to seek mental health care is the belief that they will be asked or required to express their emotions or delve into emotionally laden content (Mahalik, Good, & Englar-Carlson, 2003). Such concerns are arguably more pronounced for Black males. Many young Black males have been socialized from childhood to repress their feelings. This socialization is often reinforced by "macho messages" delivered by peers that the expression of feelings and emotions is unmanly (Boyd-Franklin, Franklin, & Toussaint, 2000,p.229). The fear of being labeled "crazy" or being called "soft" is likely to constrain the expression of a range of emotions by Black males in family, school, and community contexts (Lindsey et al., 2006). It cannot be diminished, however, that the repression of certain feelings and emotions that might signal vulnerability serves a legitimate function in the community and neighborhood contexts that many Black males reside and must daily navigate. As pointed out by Anderson (1990), one function of the public display of an invincible or strong demeanor is to ward off potential victimization in communities where violence and crime are common place, hence catching many young Black males in a "cultural catch-22" (p. 177). Such a demeanor is not likely to be relinquished easily even in the face of trauma, emotional pain, and psychological distress. This contributes to a general disinclination to voluntary seek mental health care or to engage meaningfully in the therapeutic process even when coerced into treatment by authoritative agents (Hobbs, 1985). Regrettably, the failure of Black males to seek the care they need limits their opportunities for emotional healing and tends to exacerbate presenting or dormant problems (Head, 2004).

Concerning custody status, results showed that Black males who were still in foster care were more predisposed to seek mental health care in the future for personal and mental health problems. Understandably, being in foster care may be related to more positive dispositions about a range of potential services. It is not likely that Black males upon turning 18 years of age would remain in the care and custody of state authorities if they didn't desire to do so, that is, against their will. Those who remain in custody have greater access to financial and tangible resources afforded by the child welfare system that are generally less accessible to those who are no longer in the care and custody of state authorities. It is also likely that these young men are strongly encouraged, and perhaps mandated to continue receiving a range of mental health services (e.g., counseling, psychotropic medications) as part of their treatment plans. As such, Black males still in foster care may view mental health care for prospective problems as more pertinent for their continued growth and advancement in life. Those no longer in foster care are more likely confronting a multitude of stressors and challenges where merely surviving and living from day-to-day takes precedence over seeking care that may ameliorate their problems or help them to cope effectively with problems. Due to the many stressors associated with transitioning to adulthood, Black males no longer in foster care may be at increased risk for psychosocial adjustment problems that necessitate mental health care. Clearly, research that elucidates why these young men are not willing to seek needed mental health care is critical.

Diagnosis of a psychiatric disorder based on DSM-IV diagnostic criteria was the third and final significant contributor to Black male's predisposition to seek mental health care. Specifically, those with DSM-IV psychiatric disorders were less predisposed to seek mental health care in the future. The predominant diagnoses for Black males in this study were oppositional disorder and conduct disorder. It would be easy to simply conclude that the symptoms or characteristics of these disorders (e.g., negativistic behavior toward adults) are in keeping with an unwillingness to seek or receive services from specialty providers or settings. However, these young men are more likely to have received a myriad of specialized services. In the larger study from which participants in the present study were recruited, McMillen et al. (2004) found that youth of color (predominantly Black) with lifetime and past 12 month psychiatric disorders were less likely to have received outpatient therapy, but more likely to have received residential or group home treatment, which are arguably among the most stigmatizing and invasive types

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of mental health services. Hence, the lower predisposition to seek mental health care among Black males with psychiatric disorders might be equally attributable to the nature of and perceived quality of the mental health care received while in foster care. However, that Black males with histories of serious emotional and behavioral problems are less inclined to seek mental health care than those without such histories is a cause for concern.

Despite significant bivariate relationships, cultural mistrust of mental health professionals and fear of devaluation–discrimination did not evolve as significant contributors to Black male's predisposition to seek mental health care. This might be attributable to a number of issues including their shared variance with factors that evolved as significant predictors. It is also important to note that cultural mistrust of mental health professionals and stigma beliefs may be indirectly related to Black male's help-seeking predisposition. For example, the fear of being devalued is asserted to be a primary contributor to the masking of vulnerability and emotional pain among Black males, which in turn significantly reduces their likelihood of voluntary seeking professional help (Head, 2004). Future research with larger clinical, community and nationally-representative samples of Black males is important for elucidating how myriad individual factors such as stigma, cultural mistrust, and masculine norms may be complexly related to their help-seeking attitudes and behaviors.

### 4.1. Limitations of the study

This study possesses a number of limitations that must be noted. First, the findings are based on a small, non-representative sample of Black males transitioning from the State of Missouri foster care system. Hence, no generalizations can be made about Black males, in general, or Black males in the Missouri foster care system, in particular. Second, the cross-sectional nature of this study does not allow for causal inferences to be made. Third, the findings are based on self-report and are subject to problems of recall and social desirability. Socially desirable responding may have been evident particularly in participant's responses to the items assessing cultural mistrust of mental health professionals where the issue of race was infused. Future research should include measures of social desirability to control for this possible effect. Fourth, the study did not assess whether Black males who exited foster care did so voluntarily or involuntarily to determine its possible relationship to primary study variables. For example, results might have shown that many Black males who had exited foster care did so voluntarily due to dissatisfaction with the social and mental health services received, hence serving to negatively color their view of potential professional sources of help for personal and mental health problems.

### 4.2. Implications for mental health service delivery

Despite the limitations of this study, the findings have important implications for mental health service delivery to Black males who are transitioning from the foster care system. Stevenson, Davis, Herrero-Taylor, and Morris (2003) assert that one of the most problematic ways in which public agencies and institutions respond to young Black males is by approaching their problems from an either/or perspective. Black males are more often viewed as exhibiting symptoms that are characteristic of externalizing disorders (e.g., conduct disorder) rather than internalizing disorders (e.g., depression). The diagnoses that males and Blacks receive based on various psychiatric diagnostic tools (e.g., Minsky et al., 2006) tend to substantiate this approach; the present study included. As such, they are more likely to be directed toward the more evasive and restrictive forms of treatment (Hoberman, 1992). The assertion that anger, violence, and other “acting out” behaviors may be signals that young Black males are depressed (Boyd-Franklin et al., 2000; Stevenson et al., 2003) is important to consider. Approaching the behaviors exhibited by Black males from a dualistic or multidimensional standpoint is likely to increase the range of treatment options considered by mental health professionals and the agencies charged with their care.

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The work of Alford et al. (Alford, 2003; Gavazzi, Alford, & McKenry, 1996), Lee (1990), Liddle, Jackson-Gilfort, and Marvel (2006), Rasheed and Rasheed (1999), Utsey, Howard, and Williams (2003), and Watts, Abdul-Adil, and Pratt (2002) are instructive for treatment and programming designed to prepare Black males for life after foster care. Black male developmental issues, in and of themselves, necessitate the provision of treatment and programs that integrate culture-specific content. When coupled with severely disrupted developmental histories arising from neglect and/or abuse and subsequent placement in foster care, the need for specialized treatment and programs is clear. Despite the enhancement of independent living services to youth leaving foster care in terms of financial assistance, housing, and life skills (Collins, 2004), failure to attend to the unique social and cultural dimensions of the lives of Black males may contribute to reduced impact of independent living services (Alford, 2003; Gavazzi et al., 1996). The development and provision of group-based, manhood training and psycho-educational programs are viable options for agencies and programs that administer services to older foster youths. For example, the manhood training modules developed by Lee (1990) incorporate mediums (e.g., rap music, black-oriented films) that are likely to be particularly engaging to Black males. These mediums are used as a means to facilitate critical thinking and consciousness as it relates to the challenges of being young, Black, and male in their local communities and society at-large (Lee, 1990; Watts et al., 2002). For Black males transitioning from foster care, culture-specific treatment and programs can be used to facilitate their processing and critique of the content of their lives and then to the reconstruction of new realities and possibilities that may enable some and perhaps many to relinquish anger and other negative emotions that contribute to poorer transitional outcomes (Lee, 1990; Rasheed & Rasheed, 1999; Watts et al., 2002). The efficacy and effectiveness of such specialized treatment and programming are largely undetermined. Yet, the work of Jackson-Gilfort, Liddle, Tejeda, and Dakof (2001) suggest that addressing feelings about what it means to be a Black male contributes to subsequent engagement in the therapeutic process. It is probable that Black males who are disengaged from the services provided to aid in their successful transition to adulthood will not fully and sufficiently avail themselves of vital independent living and skill building programmatic efforts. In the final analysis, evidence of poorer transitional outcomes among ethnic minority males after leaving foster care suggests that a myriad of treatment and life skill training approaches should be considered.

Concerning stigma and erroneous notions of manhood, the question of how to combat these barriers to Black males' openness to seeking needed mental health care is a difficult one to answer. Nothing short of systematic educational efforts tailored for the Black community, in general, and Black males, in particular, will likely begin to “penetrate the wall of silence and shame” that Black males have constructed around mental health issues (Poussaint & Alexander, 2000). Such efforts should include Black mental health professionals and ministers speaking out about the normalcy of experiencing personal and psychiatric difficulties given the daily stressors that many Black males confront (Poussaint & Alexander, 2000). However, the most prudent course of action by mental health service agencies and professionals is to allow the voices of Black males to direct their efforts. For example, a group of Black males recommended the following to one organization: media education and awareness campaigns that address their mental health needs; more opportunities to express themselves openly without feeling that they are perceived as weak; more men support groups to help them in the healing process; and more sensitive and sincere mental health professionals who are not judgmental (Community Voices, 2003). Efforts targeted at young Black males should consider the use of popular cable television (e.g., BET — Black Entertainment Television, MTV-Jams), internet (MTV.com, BET.com) and print (e.g., Hip-hop magazines — XXL, Vibe, The Source) mediums. For example, recent articles in popular print magazines, which target Black and young audiences, have addressed mental illness among young Black males and Hip-Hop artists (Kelly, 2005; Linden, 2006). Mediums such as these might aid in the normalization of mental health problems among young Black males, thereby enabling some, and perhaps many, to view counseling and other mental

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health services as relevant and appropriate for emotional, personal, behavioral, or mental health problems.

## 5. Conclusion

In conclusion, the findings from this study contribute to the burgeoning body of literature that focuses on the help-seeking attitudes and predispositions of ethnic minority youth and young adults. Further research is needed to determine whether the present findings generalize to other clinical and community samples of young Black males. Importantly, in their seminal work, Gurin, Veroff, and Feld (1960) suggested that individuals are prone to provide intellectual responses to questions about their likelihood or predisposition to use various sources of specialty care for mental health concerns, while not having any intentions of ever seeking mental health services or believing they could ever experience problems serious enough to warrant seeking or utilizing mental health services. In addition, Duncan (2003) suggests that a positive attitude or predisposition toward professional psychological help may not motivate Black males to actually seek it. For this reason, it is pertinent for future studies to assess the relationship of custody status, psychiatric history, cultural mistrust of mental health professionals, stigma beliefs, and adherence to masculine norms to actual service use. Such efforts are critical for informing community-based and system-based (i.e., child welfare, mental health) interventions for ameliorating barriers to mental health care among Black male populations who are most vulnerable.

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**Table 1**

Means, standard deviations, skewness, and ranges for study variables

| Variable | *M* | SD | Skewness | Obtained range | Possible range |
|---|---|---|---|---|---|
| Cultural mistrust of MH professionals | 2.63 | .64 | .23 | 1.23–4.08 | 1.00–5.00 |
| Stigma beliefs | | | | | |
| Devaluation–discrimination | 2.75 | .77 | .39 | 1.25–4.50 | 1.00–5.00 |
| Secrecy | 2.30 | 1.02 | .85 | 1.00–5.00 | 1.00–5.00 |
| Masculine norms | | | | | |
| Self-reliance | 1.15 | .56 | −.04 | .00–2.67 | .00–3.00 |
| Emotional control | 1.28 | .51 | .12 | .00–2.91 | .00–.300 |
| Predisposition to seek mental health care | 1.91 | .75 | −.38 | .00–3.00 | .00–3.00 |

*Note*. MH = mental health.

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**Table 2**

Intercorrelations among primary study variables

| | A | B | C | D | E | F |
|---|---|---|---|---|---|---|
| A. Cultural mistrust of MH professionals | — | | | | | |
| B. Devaluation–discrimination | .20 | — | | | | |
| C. Secrecy | .19 | .08 | — | | | |
| D. Self-reliance | .21 | .11 | .29* | — | | |
| E. Emotional control | .19 | .33** | .22 | .45*** | — | |
| F. Predisposition to seek mental health care | −.28* | −.28* | −.21+ | −.19 | −.37** | — |

*Note*. MH = mental health.

+ $p \leq .10$.

* $p \leq .05$.

** $p \leq .01$.

*** $p \leq .001$.

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**Table 3**

Simultaneous regression results predicting predisposition to seek mental health care

| | *B* | SE | *β* | *t* | Sr[2] |
|---|---|---|---|---|---|
| Custody status (in state custody= 1) | .45 | .17 | .29 | 2.64* | .11 |
| DSM-IV psychiatric diagnoses (yes = 1) | −.34 | .16 | −.23 | −2.08* | .07 |
| Cultural mistrust of MH professionals | −.13 | .15 | −.11 | −.91 | .01 |
| Devaluation–discrimination | −.12 | .12 | −.13 | −1.05 | .02 |
| Secrecy | −.11 | .08 | −.14 | −1.29 | .03 |
| Emotional control | −.47 | .18 | −.32 | −2.63** | .11 |

* $p \leq .05$.

** $p \leq .01$.