Effects of Gender-Matching and Racial Self-Labeling on Paranoia in African-American Men with Severe Mental Illness

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Objective: The present study examined the effects of gender-matching and racial self-labeling on the paranoid symptoms of African-American men with severe mental illness. It was hypothesized that gender matching would: 1) reduce self-reports of both interpersonal and cultural paranoia in these male participants with severe mental illness, and 2) the gender effect would be strongest among those patients who racially self-label as African-American.

Method: One-hundred-twenty-four African-American male psychiatric patients were interviewed by a male or female black psychologist. A multivariate analysis of variance (MANOVA) was conducted with the Fenigstein Paranoia Scale (FPS) and Cultural Mistrust Inventory (CMI) as dependent variables, and the male gender-matched group (0=no, 1=yes) and racial self-labeling as the independent variables controlling for age; education; never married (0=no, 1=yes); diagnosis of schizophrenia (0=no, 1=yes); need for approval; self-esteem; and the scales of Distrust, Perceived Hostility of Others, and False Beliefs and Perceptions from the Psychiatric Epidemiology Research Interview.

Results: There was a significant main effect for male gender-matching on the FPS. Participants in the male gender-matched group scored lower than the other group on the FPS. For the CMI, there was a significant interaction of male gender match by racial self-labeling effect. Participants who were male gender-matched and self-labeled as African-American reported the highest scores on the CMI.

Conclusion: The findings provide partial support for the hypotheses. Both gender-matching and racial identity together may be important considerations for black males needing mental health services.

Key words: African Americans ■ men's health ■ gender ■ racial identity ■ paranoia ■ mental illness

African-American men tend not to utilize mental health services voluntarily. A recent epidemiological study of the hospitalization of men for mental health problems revealed that black men with high levels of distrust were hospitalized less often than their white counterparts.[1] Thus, one factor that may contribute to African-American men's underutilization is their lack of trust in the mental health system. Franklin[2] asserted that African-American men may avoid mental health services because they do not believe that providers will understand their unique challenges in American society. The issue of trust seems to be particularly problematic in interracial therapeutic encounters.[3-5] Jones[5] found, in a survey of psychiatrists, that 99% of black psychiatrists and 48% of white psychiatrists had treated black patients. Indeed, a number of empirical studies have also found that African Americans disclose less to whites than to other blacks in psychotherapy.[3] Ridley[3] pointed out that this lack of self-disclosure by black clients has been misinterpreted as an indication of underlying pathological paranoia, but that it is really a reflection of cultural mistrust due to a history of racism and oppression. Moreover, a recent study of African-American men receiving inpatient psychiatric treatment found that the lack of interracial trust is not significantly correlated with pathological paranoia.[6]

A biased perspective among therapists and counselors may have contributed to the confounding of mental health and self-disclosure.[7] It may also be the reason for the failure to differentiate between lack of trust at the interpersonal level and cultural mistrust in African Americans. The distinction between interpersonal distrust and cultural mistrust has received empirical support.[4,8,9] Empirical research also suggests that both interpersonal distrust and cultural paranoia, or cultural mistrust, fall on the mild end of

the paranoia continuum.[9-12] Whaley[1] noted that understanding paranoid symptoms is important because of their prominent role in the diagnosis and treatment of severe mental illness. The present study focused on the expression of paranoid symptoms in African-American male psychiatric patients.

The unique experiences of racial discrimination faced by African-American men require mental health professionals who can appreciate the impact of both race and gender on their sense of identity.[2,13,14] Research suggests that negative stereotypes about blacks in public attitudes tend to focus on men.[15] In addition, Gary[13] found that black men's perceptions of discrimination were associated with high levels of racial consciousness and endorsement of a highly masculine gender role identity. Because of gender differences in the cultural experiences of blacks, it may be that African-American men require both racial and gender matches to feel comfortable in a mental health setting. Consistent with this perspective, African-American mental health professionals observe that black men tend to seek help from their informal network of close male friends and significant male relatives because the bond of commonality fosters a sense of trust.[14] Furthermore, it may be that inadequate representation of African-American men in the mental health system is part of the reason for underutilization.

However, reviews of the literature indicate that ethnic/racial matching of black clients or patients to mental health clinicians has not improved treatment participation or adherence.[16-19] Based on reviews of the literature, several researchers have also argued that ethnic/racial match is simply a proxy measure of cultural match and that the latter is most important for mental health interventions.[3,4,16,17,19] Moreover, individuals have multiple identities that may come into play during social interactions. For example, a mental health coordinator may be sensitive to racial matching (e.g., black male therapist and black female client), when the presenting problems are such that gender-matching (e.g., Latino female therapist and black female client) may be the more culturally sensitive approach. A number of factors determine which social identity a person expresses in a given social context. One consideration is the importance of the particular identity to the individual. Divided loyalties felt by individuals when faced with membership in two different categories may prevent them from completely favoring a single category, unless the two categories are of unequal importance.[20] Pittinsky, Shih and Ambady empirically demonstrated that individuals favor the identity which is most adaptive to a given situation.[21]

Research on race-related variables, including interracial attitudes, racial identity and racial self-labeling in the mental health context, have shown that such factors moderate the outcomes of ethnic/racial matching.[22-24] Many researchers examine the reasons behind particular ethnic/racial label preferences, the relation of these preferences to other indices of ethnic/racial identity and their effects on perceptions of the dominant culture. Individuals who prefer the label *African-American* over *black* explain their choice in terms the former connecting them with their heritage.[25-29] Jackson and Kirschner[30] found that individuals who self-identified as black or Afro-American preferred a counselor of the same ethnic/racial background significantly more than those who labeled themselves as Negro. Another study found no significant effect of racial self-designation on counselor preference.[31]

The weight of the evidence in other domains is consistent with the findings of a significant racial

Table 1. Means and standard deviations for continuous dependent and independent measures by male gender match

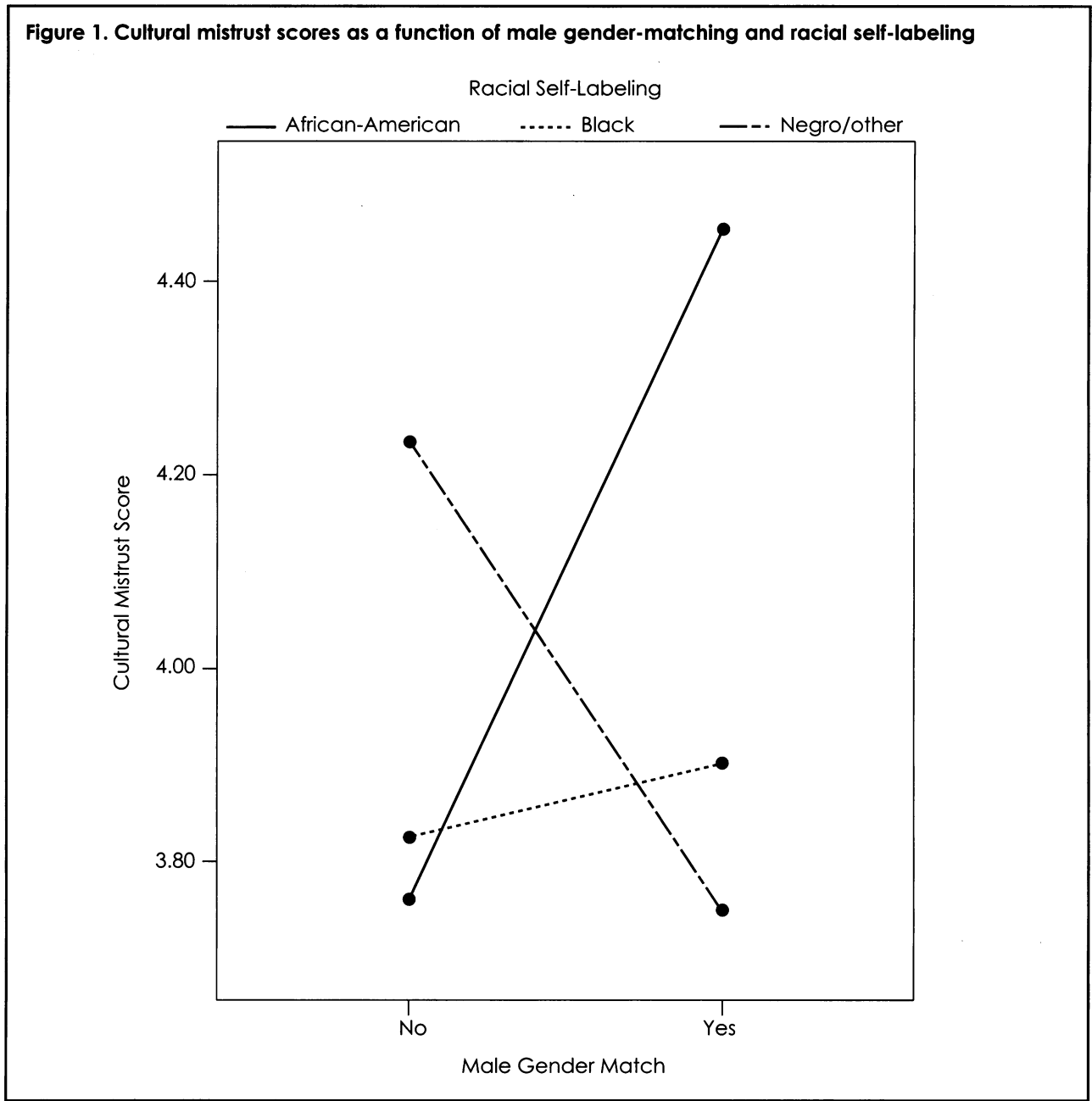| Measure	Male Gender Match			
	No		Yes	
	Mean	SD	Mean	SD
Fenigstein Paranoia Scale	2.79	0.74	2.48	0.65
Cultural Mistrust Inventory	3.95	0.75	3.99	0.77
Age	38.09	10.03	38.54	9.33
Education	9.94	1.69	11.16	1.46
Never married*	0.65	0.48	0.73	0.45
Diagnosis of schizophrenia*	0.48	0.50	0.61	0.49
Self-esteem	3.52	0.63	3.61	0.61
Need for approval	1.17	0.27	1.23	0.34
Distrust	1.87	0.80	1.92	0.82
Perceived hostility of others	1.65	1.09	1.56	1.02
False beliefs and perceptions	1.54	1.07	1.33	0.86

* Mean proportions for categorical variables

labeling effect. Research suggests that those who self-label as African-American score higher on other measures of ethnic/racial identity, perceptions of discrimination and mistrust of interracial encounters.[25,29,32,33] The effects of ethnic/racial matching may depend on racial self-labeling in the assessment or treatment context. These situational factors must be taken into account in investigations of ethnic/racial and/or gender-matching effects on self-disclosure, feelings of trust or paranoia in mental health settings.

Approaches to the effects of matching the social group traits of clinicians to their clients or patients, especially the impact on the expression of paranoia in individuals, must address the following concerns: 1) the relative importance of the different social identities of the individual, particularly ethnicity/race, 2) the confounded measurement of pathology and normal suspiciousness or distrust, and 3) the distinction between interpersonal and cultural dimensions of paranoia. Shin et al.[18] recommended that studies of ethnic/racial matching take into account the potential moderating effects of gender. This recommendation is consistent with the finding of gender differences in the cultural experiences of African Americans.

Thus, the purpose of the present study is to examine the effects of gender-matching and racial self-labeling on black male patients' self-reports of paranoid symptoms during a screening interview. The first factor is taken into account by the between-gender,

Figure 1. Cultural mistrust scores as a function of male gender-matching and racial self-labeling

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within-race design. In other words, ethnicity/race is held constant by focusing on African-American clinicians and patients, matching them on gender. Racial self-labeling is an assessment of within-race variability of the importance of ethnic/racial identity. Ghee[26] noted that, on a continuum of racial consciousness, the self-label of African-American reflects the highest level of ethnic/racial identity.

The second factor is addressed by controlling for a continuum of measures of interpersonal paranoia in multivariate analyses. Paranoia is conceptualized as falling along a continuum of severity with mild forms reflecting distrust, suspiciousness and self-consciousness to severe forms, including delusions, hallucinations and ideas of reference.[8,32,33] Measures of social desirability and self-esteem are also included as covariates in the multivariate analyses. The control for self-esteem and social desirability of patients' responses is to ensure that their reports of paranoia are not confounded with response biases, because both of these variables have been shown to be significantly correlated with self-reported paranoia in past studies.[3,8,10,32,34,35] The third and final consideration is addressed by the use of measures reflecting both the interpersonal and cultural dimensions of mild paranoia. The Cultural Mistrust Inventory is the measure of cultural paranoia.[36] The Fenigstein Paranoia Scale is the measure of interpersonal paranoia.[32] Watkins and Terrell[24] and Whaley[4] both suggested that directly addressing issues of trust with African Americans may be the more culturally appropriate technique. Atkinson[16] concluded, based on his review of the literature on ethnic/racial matching in counseling, that ethnic/racial similarity is more relevant to issues of self-disclosure and personal/social problems.

The current study is a quasiexperiment of an intake interview or first session assessing a wide range of paranoid symptoms. Because the current study involved the administration of a research interview protocol, it is a highly structured interaction. This highly structured and focused interview is probably less threatening than a traditional clinical assessment, because standard unstructured interviews contain a broader array of personal or intimate questions. This quasiexperimental clinical interview may provide a baseline assessment of African-American male patients' expression of symptoms of interpersonal and cultural paranoia under different interview conditions of matched versus unmatched male gender dyads. It was hypothesized that gender matching would: 1) reduce self-reports of interpersonal distrust or mild paranoia in these male participants with severe mental illness, and 2) the gender effect would be strongest among those patients who racial self-label as African-American. It was also hypothesized that the reports of cultural paranoia would occur less frequently in male gender-matched dyads among self-labeled African Americans.

METHOD

Participants

The participants were a sample of African-American psychiatric patients who were interviewed for the Culturally Sensitive Diagnostic Research Interview Project (CSDRIP).[8] The final sample of patients from the initial screening interview consisted of 176 out of 177 (99.4%) patients, with complete data on all measures relevant to the current study. The study sample was 70% male (N=124). Of the male subsample, 69% never married, and 56% were

Table 2. Summary of univariate ANOVA results for measures of paranoia

Variable	Fenigstein Paranoia Scale (FPS)				Cultural Mistrust Inventory (CMI)			
	Sum of Squares	df	Mean Square	F	Sum of Squares	df	Mean Square	F
Age	0.01	1	0.01	0.02	0.58	1	0.585	1.13
Education	0.05	1	0.05	0.22	1.16	1	1.16	2.27
Never married	0.05	1	0.05	0.21	0.07	1	0.07	0.13
Diagnosis of schizophrenia	0.00	1	0.00	0.00	0.66	1	0.66	1.29
Need for approval	0.39	1	0.39	1.61	1.01	1	1.01	1.98
Self-esteem	0.21	1	0.21	0.86	0.01	1	0.01	0.02
Distrust (DST)	2.64	1	2.64	10.89†	5.92	1	5.92	11.58†
Perceived hostility of others (PHO)	6.13	1	6.13	25.30†	0.03	1	0.03	0.05
False beliefs and perceptions (FBP)	1.09	1	1.09	4.48*	0.77	1	0.77	1.51
Male gender match (MGM)	1.29	1	1.29	5.33*	0.19	1	0.19	0.37
Racial self-labeling (RSL)	0.19	2	0.09	0.39	1.13	2	0.57	1.11
MGM X RSL	0.40	2	0.20	0.83	4.99	2	2.49	4.87§
Error	26.16	108	0.24		55.27	108	0.51	
Total	901.99	123			2010.59	123		

* p<0.05; § p<0.01; † p<0.001

schizophrenic. Participants ranged in age from 18–59 (Mn=38.35, SD=9.60) and in years of education from 4–16 (Mn=10.63, SD=1.67).

Interviewers

Two licensed African-American clinical psychologists—one male and one female—conducted the screening interviews. These two interviewers were similar in age, training and background. Both interviewers were blind to the intent of the current study by virtue of the fact that it was not part of the original study design.

Measures

Fenigstein Paranoia Scale (FPS). This is a 20-item scale derived from the MMPI paranoia scale for use with nonclinical populations. Each item has a five-point range from 1 ("not at all") to 5 ("extremely"). Total scores (1–5) are derived by summing the item scores and dividing by the number of items. High scores are indicative of more paranoia. This measure has been used reliably with both college students and a psychiatric population.[34,38]

Cultural Mistrust Inventory (CMI).[36] This is a 48-item measure which taps African Americans' level of mistrust of white society in the domains of education and training, business and work, interpersonal relations, and politics and law. Total scores (1–7) are obtained by summing ratings across the 48 items and dividing by the number of items. High scores indicate high levels of cultural mistrust. The CMI has been shown to have good reliability with college students and psychiatric patients.[9,37]

Racial Self-Labeling. While obtaining demographic information during the screening interview, interviewers asked patients the following question: How would you describe yourself in terms of ethnic or racial identity? There response options were "African-American," "black," "Negro" or "other." Participants' choice was indicated on the screening interview form by the interviewer. If participants selected the "other" category, they were asked to elaborate. The Negro and "other "categories were collapsed for analyses, because between-group comparisons did not yield significant differences between these two labels.[33]

Continuum of Paranoia. The scales of Distrust (DST), Perceived Hostility of Others (PHO), and False Beliefs and Perceptions (FBP) of the Psychiatric Epidemiology Research Interview (PERI) are self-report measures of mild, moderate and severe types of paranoia, respectively.[38] All of the PERI scales have five-point response formats. Total scores (1–5) are derived from summing individual items and dividing by the number of items for DST (five items), PHO (five items), and FBP (13 items). High scores reflect more paranoia. These three scales have adequate internal consistency reliability in the current sample.[9,10] Moreover, the continuum relationship among the PERI paranoia scales has been demonstrated in previous research.[9] Dohrenwend et al.[39] found the scales to be equally reliable in patient and nonpatient populations.

Rosenberg Self-Esteem Scale. The Rosenberg scale contains 10 items which are scored on a five-point scale. It is a measure of global self-esteem with both negative and positive self-statements. Negative statements are reverse scored so that high total scores reflect high self-esteem. This is a widely used measure of global self-esteem with very good internal consistency reliability.[40] Total scores range from 1–5 and are computed by summing item scores and dividing by 10.

Need for Approval Scale. This is a measure of social desirability adapted from the Social Desirability Scale by Crowne and Marlowe.[41] It is included in the PERI as a 15-item scale, which can be responded to as "true" (2), "false" (0) or "don't know" (1).[38] Half of the statements describe desirable traits and the other half undesirable traits. "True" for desirable traits and "false" for undesirable traits are scored in the same direction. The total score is based on the sum of the items divided by the total number of items with a range from 0–2.

Procedure

The two interviewers selected patients in the order that they appeared on the list of new admissions. After verbally consenting to be interviewed, participants received a mental status exam to assess their capacity to give written informed consent. Those participants who passed and gave written informed consent underwent the screening interview. The screening interviews were conducted by one of the two African-American clinical psychologists—a male or female—each with more than five years of clinical experience. The screening interview consisted of self-reported demographic background, psychiatric history and inventory measures. All items were interviewer-administered to ensure uniformity in reading comprehension and to minimize missing data. Participants were debriefed at the end of the screening interview. They were paid $5 for their participation or, in the case of incomplete interviews, at a rate of $5 per hour paid for the time spent.

RESULTS

Analysis of Matching Process

Of the total sample of 176 participants, 13% of the interview dyads were female interviewer/female patient (FI/FP), 31% were female interviewer/male

patient (FI/MP), 16% were male interviewer/female patient (MI/FP) and 40% were male interviewer/male patient (MI/MP), χ^2(3, N=176)=32.77, p=000. The maldistribution in final numbers of gender-matched black male patients cannot be attributed to bias, because participants' assignment to interviewer dyads was independent on the gender of the interviewer, χ^2(1, N=176)=0.01, p=ns. The interview dyads were reclassified into 70 yes (56%) and 54 no (44%) on male gender-matching for African-American male patients by comparing MI/MP to FI/MP.

The distribution of racial self-labels were 42 (34%) African-American, 58 (47%) black, 24 (19%) Negro/other. The self-label of African-American represents the more socially desirable response because of its psychological importance.[24] There was a differential distribution of racial self-labels by whether or not the participant was in the male gender-matched group, χ^2(2, N=124)=6.94, p=0.031. However, participants in the "no" group self-identified as African-American more frequently than those in the "yes" or male gender-matched group (43% vs. 27%), suggesting no experimenter bias.

Multivariate Analyses

Means and standard deviations for dependent and independent measures of those who were (yes) and were not (no) male gender-matched are presented in Table 1. Between-group comparisons indicated that gender-matched male patients had lower scores on the Fenigstein scale, t (122)=2.44, p=0.016, and more years of education, t (122)=-4.31, p=0.000, than their mismatched counterparts. A multivariate analysis of variance (MANOVA) was conducted with the FPS and CMI as dependent variables and the male gender-matched group (0=no, 1=yes) and racial self-labeling as the independent variables controlling for age; education; never married (0=no, 1=yes); diagnosis of schizophrenia (0=no, 1=yes); need for approval; self-esteem; and the scales of DST, PHO and FBP from the PERI. There was a significant multivariate effect for male gender match, Wilk's Lamda=0.940, F(2, 107)=3.42, p=0.036, and a significant male gender-matched by racial self-labeling interaction, Wilk's Lamda=0.902, F(4, 214)=2.82, p=0.027. Significant multivariate effects were also observed for the scales of DST, Wilk's Lamda=0.859, F(2, 107)=8.82, p=0.000; PHO, Wilk's Lamda=0.803, F(2, 107)=13.16, p=0.000; and a marginal effect for FBP, Wilk's Lamda=0.956, F(2, 107)=2.46, p=0.090.

Table 2 presents the summary of the results from univariate tests of the regression models for the two measures of paranoia to determine their contributions to the significant multivariate effect. Multiple comparisons with a Bonferroni correction were conducted

to indicate between-group differences on male gender-matching and racial self-labeling underlying significant univariate tests. Univariate tests revealed a significant main effect for male gender match on the FPS scores, F(1, 108)=5.33, p=0.023. Participants in male gender-matched dyads scored lower on the FPS than their counterparts (p=0.023). As can be seen in Table 2, univariate tests also showed FPS scores to be significantly correlated with the scales of DST, PHO and FBP. High scores on the FPS were positively associated with high scores on all three PERI paranoia scales. The significant univariate effect for the male gender match by racial self-labeling interaction was on CMI scores, F(2, 108)=4.87, p=0.009. Figure 1 depicts the interaction effect on CMI scores. Male participants in gender-matched dyads who self-labeled as African-American scored significantly higher on the CMI than those labeling themselves black (p=0.039). Pairwise comparisons also revealed that participants in the yes or male gender-matched group (M=4.40) had significantly higher CMI scores than those in the no group or male gender-mismatched dyads (M=3.74) among self-labeled African Americans (p=0.007).

DISCUSSION

The results of the present study provided support for the first hypothesis. African-American men with severe mental illness in a gender-matched dyad reported significantly less paranoid symptoms, as measured by the FPS, than their counterparts in other dyad during an assessment interview. This finding may reflect gender-matching effect increasing the openness and comfort on the part of male patients. A more unstructured approach may have yielded more information about the reasons underlying the matching effect. Although the FPS is considered a measure of mild, nonclinical paranoia, it is unique in that studies have shown the FPS to operate differently in normal and severe mentally ill populations.[34,38]

Contrary to the hypothesis, participants in the male gender-matched dyads reported more cultural mistrust than other dyads. Black male psychiatric patients' higher levels of self-reported cultural mistrust only occurred among those who self-labeled as African-American in the male gender-matched group. These findings are consistent with those of Gary,[13] who found both gender role identity and racial consciousness to be predictors of increased reports of discrimination in a community sample of black men. They are also consistent with the theoretical and empirical arguments advanced by Jones and his colleagues that the issue of racial discrimination must be addressed by psychotherapeutic approaches to the problems of black men.[5,14] Consistency of such a finding across clinical and nonclinical populations

lends further support to the notion that African-American men's experiences of discrimination are unique in some ways.

These findings also suggest that matching African-American men on gender and race may be more important for those who express a strong racial identity. Moreover, black mental health professionals high in racial consciousness may also be required for African-American men with a strong racial identity.[23] Future studies should examine the effects of the interaction between gender-matching and ethnic/racial identity on help-seeking behaviors, attitudes toward mental health professionals and the reporting of other symptoms of distress.

The discrepant findings for the FPS and CMI suggest that these instruments are tapping different dimensions of paranoia. The FPS is a measure of interpersonal paranoia, and the CMI examines cultural aspects of paranoia. Measures tapping the interpersonal versus cultural dimension of paranoia are examining fundamentally different experiences in African-American psychiatric patients.[8] Another manifestation of this phenomenon is the finding that the interpersonal relations subscale of the CMI showing the poorest reliability relative to subscales assessing social or institutional contexts (i.e., business/work, education/training, and politics/law).[8] However, another important difference between the two measures is their relationship to the continuum of severity. Consistent with past research, the CMI was found to be correlated solely with the mild end of the severity continuum.[8] In contrast, the current study revealed that the FPS was a significant correlate of mild, moderate and severe measures of paranoia, i.e., the entire continuum of severity.

Fenigstein and Vanable developed the FPS ostensibly as a nonclinical measure, and it presumably reflects mild levels of paranoia.[34] Other studies have shown the FPS to operate differently in individuals with severe mental illness, such as schizophrenia.[38] Research suggests that the mild of end of the paranoia continuum is most susceptible to cultural influences.[9] Given the male gender match by racial self-labeling interaction effect on CMI scores, it seems plausible that paranoid symptom severity is the main distinguishing feature of the scores on the FPS vis-à-vis the CMI in black men with severe mental illness.

The significant gender-matching effect in the present study is also discrepant with the empirical literature on matching. Several studies have found no significant racial or gender-matching effects.[42-44] Some of these studies suggest that matching clinicians or counselors to clients or patients on gender and race does not necessarily facilitate assessment, diagnosis or treatment in mental health settings.[43,44] Major differences in the research designs of the cur-

rent study are the within-race, between-gender-matching and a direct assessment of paranoid symptoms that are directly relevant to interactions during the interview. Other studies have examined ethnicity/race and gender, but they treated both variables as between-group variables. As recommended by Shin et al.[18] the current design examines the effects of gender-matching on racially similar dyads.

The current findings also imply that increasing the number of black males in mental health professions may help to address the problem of underutilization of services by African-American men. Indeed, Jones et al. found in their survey of psychiatrists that most black male patients were seen by clinicians matched on gender and race.[5] Past studies have shown that lack of trust in the mental health system was a major barrier to mental health service utilization by black men.[1] It is clear from the current findings that matching black male patients to African-American male providers may reduce the level of distrust of the mental health system. Among participants in the male gender-matched group, the lower scores on the FPS and higher scores on CMI among those with a strong racial identity suggest a significant connection between patient and provider when they share the same race and gender. The gender- and race-matched therapeutic encounters may be reminiscent of the male bonds that black men experience in their communities.[14] This issue should be explored further in future research because of the policy implications for workforce development in the mental health professions.

There are a number of other methodological shortcomings that should be addressed in future studies. First, self-report assessments should be supplemented by observational or clinician-rated measures of psychological functioning. Second, multiple interviewers of different genders and races would provide a more comprehensive study of the matching process. This would also minimize the possibility of the results being due to personality and behavioral characteristics of the interviewer.[43] Third, this study is a quasiexperimental analogue so it needs to be conducted in a real-world mental context. Finally, the external validity of this study will be established, if it is replicated with other ethnic/racial patient populations and nonpatient samples of African Americans.

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