Cultural Mistrust: An Important Psychological Construct for Diagnosis and Treatment of African Americans

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Although clinicians are encouraged to be more sensitive to cultural factors in the diagnosis and treatment of mental disorders, as evidenced by the significant changes in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; American Psychiatric Association, 1994), little information is provided to help them determine which aspects of culture are important to the mental health of African Americans. This article discusses the importance of cultural mistrust as a psychological construct in the lives of African Americans. The origins of the construct, the research it has generated over the past 2 decades, and implications for improving interventions with Black clients seeking mental health care are discussed.

The need for greater cultural sensitivity in psychological interventions with African Americans often places mental health clinicians in a double bind. On the one hand, they are told to acknowledge and respect cultural differences. On the other hand, they are warned about relying on stereotypes and generalizations in working with people of African descent who are in need of psychological services. One way to avoid this apparent contradiction is to review the literature and identify cultural themes or issues that have been shown to have direct relevance to the mental health treatment of African Americans. Psychologists interested in cultural variables often fail to identify the specific aspects of culture that are thought to influence behavior (Betancourt & Lopez, 1993).

Prevalence studies indicate that paranoid schizophrenia is the most frequent diagnosis given to African Americans (Collins, Rickman, & Mathura, 1980; Mukherjee, Shukla, Woodle, Rosen, & Olarte, 1983; Toch, Adams, & Greene, 1987). This finding has been explained by some in terms of clinicians' insensitivity to different cultural norms for paranoid ideations in the Black population (Adebimpe, 1981; Grier & Cobbs, 1968; Jones & Gray, 1986; Ridley, 1984). However, this explanation remains an un-

tested assumption, because the empirical research on the topic has given only descriptive accounts of the phenomenon. This gap in the literature can be bridged by using the construct of cultural mistrust to explain the psychiatric misdiagnosis of Blacks (Whaley, 1997, 1998b). The central hypothesis is that clinicians' misinterpretation of cultural mistrust as clinical paranoia contributes to the misdiagnosis of African Americans as schizophrenic (Ridley, 1984). The purpose of this article is to review the evidence supporting the notion that cultural mistrust is an important psychological construct in the lives of African Americans. First, the plausibility of the assumption that cultural mistrust is a valid cultural phenomenon with implications for African American mental health is assessed. Next, evidence of overlap between self-processes and cultural mistrust in the general population as well as in patient samples of African Americans is presented. Finally, some implications of research on cultural mistrust for interventions with African Americans seeking mental health services are addressed.

Cultural Mistrust and African American Mental Health

Conceptualizations of Cultural Paranoia

The notion that African Americans have developed paranoid-like behaviors due to historical and contemporary experiences with racism and oppression was first espoused by Grier and Cobbs (1968). Since they introduced the notion of "healthy cultural paranoia" in their now classic book *Black Rage* (Grier & Cobbs, 1968), a number of clinicians and researchers have argued that the Black experience in America has resulted in a type of cultural paranoia (Maultsby, 1982; Newhill, 1990; Ridley, 1984; Terrell & Terrell, 1981; Whaley, 1998b). Other researchers have argued that use of the term *cultural paranoia* to describe this adaptive behavior on the part of African Americans is inappropriate (Ashby, 1986; Bronstein, 1986). This controversy may be seen as a recapitulation of the categorical-dimensional debate about the nature of psychopathology in general.

Proponents of the exclusive use of the term to describe genuine clinical symptoms may subscribe to a categorical model of paranoia. Those who advocate a more flexible use of the term encompassing cultural behaviors and nonclinical situations are more in

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accordance with a dimensional perspective. In an earlier study (Whaley, 1997), I tested the feasibility of defining a continuum of paranoia using the scales of Distrust (DST), Perceived Hostility of Others (PHO), and False Beliefs and Perceptions (FBP) taken from the Psychiatric Epidemiology Research Interview (PERI; Dohrenwend, Levav, & Shrout, 1986; Dohrenwend, Shrout, Egri, & Mendelsohn, 1980) and also explored the hypothesis that sociocultural differences in paranoid symptom expression exist when biases due to clinicians' lack of adherence to diagnostic criteria are taken into account. The results suggested decreasing ethnic–racial or sociocultural differences and increasing psychopathology along with movement from mild (DST) to moderate (PHO) to severe (FBP) paranoid symptoms.

In another study (Whaley, 1999), I also attempted to replicate previous research by demonstrating that paranoia forms a distinct dimension of psychopathology apart from other symptoms (Minas et al., 1992; Mirowsky & Ross, 1983a). Although the PERI paranoia scales did not form a unique dimension, the scales of DST and PHO clustered with symptoms representing global psychological distress, and the scale of FBP clustered with symptoms reflecting severe psychopathology at the most basic level (i.e., two clusters) of organization. These studies demonstrated that cultural influences on African American mental health are best studied with a dimensional approach to paranoid symptom expression (Whaley, 1997, 1999). Therefore, the notion of cultural paranoia can be reconceptualized as cultural mistrust, falling at the mild end of the paranoia continuum. Indeed, high levels of cultural mistrust have been found to correlate positively with DST scores—but not with PHO or FBP scores—in Black psychiatric patients (Whaley, in press-b).

Moreover, there is a consensus that the concept of cultural mistrust provides an adequate description of this paranoid-like response style in African Americans (Ashby, 1986; Terrell & Terrell, 1981). A measure of Blacks' lack of trust at the cultural level, the Cultural Mistrust Inventory (CMI), was developed by Terrell and Terrell (1981). The CMI is based on the assumption that cultural paranoia in the form of mistrust of Whites exists among Blacks due to past and contemporary experiences with racism and oppression (Terrell & Terrell, 1981). Although the research on the cultural mistrust construct has been sparse, it has yielded some important results.

Studies on Cultural Mistrust

The majority of the published studies have addressed the association between cultural mistrust and attitudes toward counseling among Blacks, especially in an interracial context. These studies suggest that African Americans who are high in cultural mistrust tend to have more negative views and expectations of White counselors (Grant-Thompson & Atkinson, 1997; Nickerson, Helms, & Terrell, 1994; Poston, Craine, & Atkinson, 1991; Terrell & Terrell, 1984; Thompson, Worthington, & Atkinson, 1994; Watkins & Terrell, 1988; Watkins, Terrell, Miller, & Terrell, 1989). Most of these were studies of counseling or psychotherapy analogues conducted with college students. One exception, the study by Terrell and Terrell (1984), revealed a positive association between cultural mistrust and premature termination rates among Black clients at a community mental health center.

In a recent study (Whaley, 2001c), I examined negative attitudes toward White mental health clinicians in Black psychiatric inpatients as a function of self-reported (subjective) and clinician-rated (objective) cultural mistrust. Both objective (clinicians' ratings) and subjective (CMI scores) indicators of cultural mistrust indicated that high cultural mistrust scores among African Americans recently admitted to a psychiatric hospital were associated with more negative attitudes toward White clinicians (Whaley, 2001c). Such findings are consistent with the argument that therapeutic context, reflecting the power relationships and cultural values of the larger society, may elicit cultural mistrust in African Americans (Maultsby, 1982; Ridley, 1984). Thus, it is quite plausible that Black clients or patients exhibit paranoid-like behaviors during interracial therapeutic encounters. Ridley (1984) pointed out that low self-disclosure, which has been interpreted traditionally as a manifestation of psychopathology, may be due to cultural mistrust or adaptive paranoia. Thus, a healthy response to a racist society may be misinterpreted as pathology by mental health professionals.

Ahluwalia (1990/1991) compared African Americans, Native Americans, Hispanics, and Asian Americans in terms of their cultural mistrust level in relation to their attitudes toward mental health services for their children. A strong positive association between cultural mistrust and dissatisfaction with and unwillingness to seek mental health services was evident for Black and Native American parents but not for their Hispanic and Asian American counterparts (Ahluwalia, 1990/1991). African Americans and Native Americans can be classified as involuntary or castelike minorities, whereas Hispanics and Asian Americans are voluntary or immigrant minorities (Ogbu, 1988). The cultures of castelike minorities have been shaped, in part, by their ongoing relationships with the dominant White culture, but immigrant minorities have an independent cultural identity before the crosscultural encounter. Ahluwalia's finding of differences between castelike and immigrant minorities can be construed as evidence of the construct validity of the CMI as a measure of individuals' cultural experiences with racism and oppression.

The associations of cultural mistrust with a number of negative psychosocial outcomes have also been studied. High levels of cultural mistrust in Black students have been found to be associated with poorer IQ test performance with a White examiner versus a Black examiner (Terrell & Terrell, 1983; Terrell, Terrell, & Taylor, 1981). African American youth who obtain high cultural mistrust scores also have lower occupational expectations (Terrell, Terrell, & Miller, 1993) and are more prone to engage in antisocial behavior (Biafora et al., 1993). Klonoff and Landrine (1997) found that distrust of Whites was negatively correlated with knowledge of AIDS transmission in an African American community sample. These adverse outcomes are inconsistent with the belief that cultural mistrust always represents an adaptive or beneficial strategy in the context of a racially oppressive society.

However, the factors underlying the association of cultural mistrust with these negative outcomes must be better understood before any firm conclusions can be reached. For example, Black youth's occupational aspirations may reflect a realistic appraisal of the job market and the opportunities available to them (Bowman, 1984; Whaley, 1993). In a similar vein, low IQ test performance may be appropriate for African Americans in an interracial context if superior performance leads to their being the target of retribution

for daring to "not stay in their place" and challenge racial stereotypes based on the status quo (Lovaglia, Lucas, Houser, Thye, & Markovsky, 1998; Whaley, 1998c). Lovaglia et al. concluded

> from the . . . evidence that African Americans not only expect to be penalized for a high score on standardized tests but actually do bear a cost for success. . . . Thus, underperformance on an ability test represents an adaptive response by African Americans. (p. 207)

As an example, Lovaglia et al. cited the case of a Black man who was fired from his job, on the spot, for demonstrating that he could operate a complex machine that his White supervisor believed him to be unable to master.

Additional evidence comes from Fine's (1983) research on high school dropouts in New York City. Fine (1983) found that her sample of Black and Latino high school dropouts, compared with their in-school peers, had higher IQ scores, better self-esteem, and less depression. Another critical difference between those Black and Latino youth who dropped out versus those who stayed in school was the fact that the former group tended to challenge social injustices in the school system (Fine, 1983). These examples can be construed as support for the proposition that underperformance by African Americans may reflect, at times, a decision to acquiesce to injustice and avoid social retribution. Moreover, Whaley and Smyer (1998) reported that high levels of cultural mistrust among African American high school dropouts were positively correlated with global self-worth, indicating that leaving school may not reflect personal inadequacies. In some instances, the apparent negative outcomes associated with high levels of cultural mistrust may result from rational decisions instead of irrational fears. None of the studies showing the negative effects of cultural mistrust explored the question of motivation underlying the association, so it remains a matter of speculation. It must be emphasized that an adverse outcome is undesirable regardless of the underlying motivation for a behavior resulting from cultural mistrust. However, the clinical strategy to promote positive behavior change or to prevent negative outcomes associated with cultural mistrust may differ depending on whether or not the motivation is rational.

Methodological studies of cultural mistrust are important for clinicians in terms of understanding what it is and how to measure it. The CMI is the most popular measure of cultural mistrust. I conducted a meta-analysis of the 22 empirical studies of research on cultural mistrust in African Americans to test some substantive and methodological hypotheses about the CMI (Whaley, 2001b). Effects of cultural mistrust on African Americans' attitudes and behaviors were not significantly different in mental health–related studies compared with studies of other psychosocial domains. The findings supported the substantive hypothesis that African Americans manifest cultural mistrust similarly in mental health contexts as they do in other situations. In other words, Black individuals high in cultural mistrust are likely to view the White clinician as representative of the larger White society. This meta-analytic review, along with other methodological studies, also indicated that the CMI is a reliable and externally valid instrument for assessing a psychological construct that is pervasive in the lives of African Americans (Whaley, 2001b, 2001d, in press-b).

Self-Processes, Cultural Mistrust, and African American Mental Health

Scientific advances in theory and research on paranoia are consistent with the hypothesis that cultural variations in delusional symptoms contribute to psychiatric misdiagnosis of African Americans. The notion that paranoid symptoms fall along a continuum of severity has received both theoretical and empirical support. Several recent models of paranoia explicate a process of progression from normal experiences and beliefs to the psychotic symptoms of clinical paranoia (Mirowsky & Ross, 1983b; Ridley, 1984; Vinogradov, King, & Huberman, 1992). The typology presented in Ridley's (1984) model of paranoia is categorical, but it can be arranged along an implicit continuum based on the specificity and intensity of treatment he recommends for each of the four different types. These models suggest that paranoia at the mild end of the continuum reflects interactions between individuals and their threatening social environment, whereas severe paranoia represents delusional beliefs that are functionally autonomous and independent of social reality.

Conceptualization of paranoia as falling along a continuum of severity has paved the way for the study of nonclinical aspects of paranoia. Symptom-based studies of paranoia examine its normal counterparts (i.e., self-consciousness, suspiciousness, mistrust, etc.) in nonclinical populations (Bodner & Mikulincer, 1998; Fenigstein, 1997; Fenigstein & Vanable, 1992; Kramer, 1994) or patients with paranoia are compared with other psychiatric patients (i.e., those with depression or schizophrenia) and individuals from the general population in terms of their cognitive styles (Bentall & Kaney, 1996; Garety & Hemsley, 1994; John & Dodgson, 1994; Kinderman & Bentall, 1996, 1997; Young & Bentall, 1997). Research on both clinical and nonclinical populations indicates that paranoid thinking is a mechanism by which individuals protect the self against negative affective states such as anxiety, guilt, low self-esteem, or depression associated with personal failures by attributing blame to others (Bentall et al., 1994; Kramer, 1998; Kramer & Messick, 1998; Ridley, 1984; Trower & Chadwick, 1995; Vinogradov et al., 1992; Zigler & Glick, 1988). Situations leading to increased self-consciousness, involving interactions between individuals of unequal social status and where there is a risk of harm to the disadvantaged person psychologically, physically, or socially, may engender paranoid responses.

African Americans' social status as a visible minority may cause them to have a heightened sense of public self-consciousness (Kramer, 1998). Public self-consciousness reflects the individual's perception of self as a social object (Fenigstein, Scheier, & Buss, 1975). Indeed, research suggests a positive correlation between public self-consciousness and paranoia (Bodner & Mikulincer, 1998; Fenigstein & Vanable, 1992; Kramer, 1994). Bodner and Mikulincer found that greater self-focused attention after personal failure resulted in depressive-like responses, whereas greater other-focused attention under the same circumstances produced paranoid-like responses. These findings are consistent with research on patients with clinical paranoia who are similar to patients with depression in terms of negative self-relevant information but differ in that they make external attributions or blame others for their personal failings (Bentall et al., 1994). This relationship between self-consciousness and paranoia may explain the paradoxical finding of high self-esteem and low personal efficacy in

African Americans (Hughes & Demo, 1989). African Americans may attribute their lack of personal efficacy to sociostructural barriers instead of to dispositional factors.

Because of the greater social disadvantage and oppression experienced by out-groups, paranoia at the mild end of the continuum in terms of lack of trust is likely to be more prevalent among out-groups than their in-group counterparts. In support of this assertion, Terrell and Barrett (1979) found that Black, female, and low-socioeconomic-status college students reported lower levels of interpersonal trust than their White, male, and high-socioeconomic-status counterparts, respectively. Thus, the cultural norms of Black clients and White clinicians relevant to paranoid behaviors are markedly different. Paranoia may serve as a self-protective function against racially based threats to self-esteem for African Americans, but it may be misinterpreted as pathology by clinicians, leading to the misdiagnosis of schizophrenia (Ridley, 1984). Insensitivity to cultural aspects of paranoia may be further complicated by the fact that lack of trust in African Americans is more likely to be, in actuality, associated with depression than with schizophrenia (Whaley, 1997); however, clinicians tend to overlook symptoms of depression in Blacks and overdiagnose schizophrenia (Strakowski et al., 1997). Consistent with Zigler and Glick's (1988) hypothesis, cases of paranoid schizophrenia may really be "camouflaged depression" in African Americans. Overdiagnosis of schizophrenia reflects, in part, a lack of awareness on the part of clinicians of the heightened public self-consciousness associated with mistrust that is culturally based and that is more likely to conceal an underlying depression in African Americans—if there is a mental health problem at all.

Implications of Cultural Mistrust for Interventions With African Americans

Assessment and Diagnosis

The initial assessment of an African American client or patient requires the clinician to separate cultural aspects of paranoia from true pathology. The CMI or related measures, such as Landrine and Klonoff's (1996) Distrust of Whites subscale of the African American Acculturation Scale, should be added to assessment batteries. A copy of the CMI was presented as an appendix in Terrell and Terrell (1981).[1] Some researchers have recommended the use of the Interpersonal Relations and Education/Training subscales or items from those scales (Thompson, Neville, Weathers, Poston, & Atkinson, 1990; Thompson et al., 1994), because those were the only two scales correlated in the original study on scale development (Terrell & Terrell, 1981). My meta-analytic study (Whaley, 2001b) suggests that studies using the total scale tend to yield superior outcomes, compared with those using only subscales. Thus the literature indicates that psychologists and other mental health professionals should use the total scale of the CMI instead of subscales to assess cultural mistrust in Black clients.

Use of the 48-item total scale may be impractical for some counselors or therapists. Clinicians can use Landrine and Klonoff's (1996) Distrust of Whites subscales, which is much shorter and is available as an appendix in their book. With respect to the CMI, a general rule should be that subscales relevant to the social context in which the Black client experiences mistrust or interracial encounters can be reasonable substitutes for the total scale. Even

though the total scale yields the more reliable assessment of cultural mistrust, psychologists working in predominately White college and secondary school environments can use the Interpersonal Relations and Education/Training subscales. The Interpersonal Relations and Education/Training subscales are useful measures of mistrust in such school environments, because Black students' experiences involve ongoing interracial encounters in interpersonal and educational situations.

The Interpersonal Relations and Education/Training subscales may have less utility in the provision of services to African American adults with severe mental illness who have less than a high school education and currently live in segregated urban environments. These individuals may be more reliably assessed with the Business/Work and Politics/Law subscales because their interracial interactions with White people tend to be through institutional contacts (banks, jobs, law enforcement, etc.). It is very unlikely that African Americans with mental illness who live in segregated urban environments would have the types of personal relationships with White individuals tapped by the Interpersonal Relations subscale of the CMI. It is for this reason that the Interpersonal Relations subscale does not reliably assess cultural mistrust in this population (Whaley, 1998b, in press-b). In addition to teasing out cultural from pathological aspects of paranoia in African Americans, clinicians must understand that interpersonal distrust and cultural mistrust are separate constructs that may or may not significantly overlap, depending on the interracial context.

Another potential advantage of using the total scale of the CMI is the possibility of detecting patterns of mistrust that point to particular domains of interracial difficulties. For example, a Black person who scores high on the Business/Work subscale relative to the other subscales may feel that he or she has been passed over for a job promotion because of racial discrimination. The individual may be coping with some strong feelings about the situation but may not verbalize them in the session unless the clinician creates a safe atmosphere for discussing the issue by exploring the pattern of scores on the CMI. The pattern may be very particular, even occurring at the item level. Thus, the CMI may be a useful tool in exploring issues of the psychological impact of racial discrimination with Black clients seeking mental health services.

Ridley (1984) proposed that cultural paranoia and pathological paranoia are orthogonal dimensions that combine to produce four paranoia types in African Americans. A Black person may score high on cultural mistrust but low on clinical paranoia or vice versa, reflecting cultural paranoia and pathological paranoia types, respectively, or the individual may score high on both dimensions, in which case the person has "confluent paranoia" (Ridley, 1984). To identify cases of confluent paranoia, psychologists have to use measures of both cultural and pathological features of paranoia. For example, I performed a median split on scores on the CMI and the FBP to classify a group of patients with high (i.e, above the median) scores on both scales as having confluent paranoia (Whaley, in press-a). Psychologists with small numbers of patients can use scale scores for individuals to determine whether or not they have confluent paranoia. A person scoring above the midpoint

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of 4 on the CMI and 2 on the FBP could be classified as having confluent paranoia.

If an African American client shows this complex mixture of cultural and clinical paranoia, Ridley (1984) recommended treatment by an ethnically similar clinician who would be able to separate the cultural from the pathological features of paranoid symptom expression for interventions. An inexperienced clinician may ignore the pathological features in those cases in the name of being culturally sensitive. In an empirical test of Ridley's typology, master's-level clinicians were found to give higher ratings of cultural mistrust to the cultural paranoia group than to the confluent paranoia group (Whaley, in press-a). These clinicians also diagnosed less paranoid schizophrenia than did African American mental health professionals who were cultural experts (Whaley, 2001a). To focus solely on the cultural dimension in a Black person with confluent paranoia may lead to the underdiagnosis of severe disorder. At a minimum, the clinician should consult with an African American cultural expert about such cases.

It should be noted that cultural mistrust may, in some cases, reflect nothing more than a reaction to an interracial encounter. When this occurs, White therapists should construe it as a challenge to rapport building and deal accordingly with the issue. Ridley (1984) recommended that clinicians take a more flexible approach to working with mistrustful Blacks, such as self-disclosing to establish rapport with the client. Another important caveat is that ethnic–racial match is not the same as cultural match. Reviews of the research literature indicate that ethnic–racial matching of therapist and client has proven to be of limited effectiveness (Atkinson, 1983; Sue, 1988). A few studies have found a main effect for cultural mistrust in relation to attitudes toward Black versus White counselors (Terrell & Terrell, 1984; Watkins & Terrell, 1988). In other words, highly mistrustful Black individuals may also be suspicious of ethnically and racially similar mental health clinicians. One explanation for the main effect is that African Americans' mistrust occurs at a broader level than the interpersonal relationship with the counselor (Terrell & Terrell, 1984; Thompson et al., 1994). Another culturally sensitive approach would be, as Watkins and Terrell recommended, to directly address the mistrust issue. Clinicians should exercise caution and not use therapeutic sessions as opportunities to express their views of race relations. The focus should be exploring the basis for mistrust among Black clients or patients.

Treatment

This review of the literature supports the assertion that cultural mistrust is a significant factor to be addressed in therapeutic interventions with African Americans. Clinicians must first be aware of and acknowledge racism as a legitimate concern with mental health consequences for the Black experience in America (Brantley, 1983; Bronstein, 1986; Whaley, 1998d). Discussions of racism as a clinical issue, even with those patients with severe mental illness, may prove to be a positive experience because of its cultural relevance to African Americans (Whaley, 1998a). Again, this discussion should be oriented toward the client or patient's needs and not the clinicians' desire to espouse their views of racism.

As a staff psychologist, I treated a preadolescent Black male referred to the child psychiatry outpatient department of a hospital serving the

East Harlem community of New York City. The boy's mother was diagnosed as having schizophrenia and was receiving care from the adult outpatient clinic in the same hospital. His feelings about her and her illness were addressed much later in the treatment. The first problem I addressed was his school behavior. One of the presenting problems was that he was a behavior management problem in school. When I asked about the problem, the boy informed me that his teacher, who was a White female, was prejudiced. I asked him to describe how she was prejudiced. He described incidents in the class where he felt the teacher reprimanded him without just cause. During his account, he also admitted that he would blow up when she reprimanded him, which would then lead to more severe punishment. I explained to him that the best way to show that his teacher was prejudiced was for him to do everything that he is supposed to do; then she would have no excuse to punish him. If she still punished him, then a case could be made for her being prejudiced. Many therapists would have taken a different approach. A common reaction from a clinician is to try to convince the child client that he may be mistaken or misunderstands the teacher's motives. This approach not only undermines the client's perspective but also casts doubt on the credibility of the clinician who would defend an unknown person. Most important, it demonstrates that the clinician is unable to entertain the idea of prejudice and racism in the school system, and perhaps the larger society.

Clinicians also need to be aware of their own cultural biases and the possibility of their being manifested during therapeutic encounters with Blacks seeking mental health care. One important bias is the tendency to make interpersonal interpretations of clients' behavior in therapy or counseling sessions. As previously mentioned, the literature on cultural mistrust supports a distinction between lack of interpersonal trust and mistrust at the cultural level (Whaley, 1997, 1998b, in press-b). This issue has been discussed in some detail regarding the psychodynamic concept of transference.

For example, Cohen (1974) asserted that White therapists should not construe Black clients' initial reactions to them as a transference reaction based on a significant other. Rather, the White therapist must realize that he or she represents the larger White society to the Black client, and this is the reason for their actions early in treatment (Cohen, 1974). Along these same lines, clinicians' stereotypes about Blacks may influence their approach to treatment, and mistrustful Blacks may react negatively to what they perceive to be racist attitudes on the part of clinicians. Unaware that their stereotypical attitudes elicited the negative response from the Black client, these clinicians may interpret the behavior as pathological hostility, thereby confirming their stereotype through a self-fulfilling prophecy. This phenomenon has been labeled *pseudotransference* due to cultural stereotyping (Ridley, 1985; Thomas, 1962). In an earlier work (Whaley, 1998d), I theorized that such interpretive biases on the part of clinicians treating Black clients or patients lead to more severe diagnoses and restrictive interventions. Familiarity with the theory and research on cultural mistrust may predispose clinicians to recognize and avoid these biases and the related outcomes.

As consulting psychologist to a foster care agency, I often heard caseworkers describe biological parents as hostile and uncooperative. My first response to their comments tended to be that if someone removed your child from you, and you felt that it was unjust, wouldn't you be hostile and uncooperative too? I tried to reframe the experience for caseworkers to encourage them to take the position that they have

to earn the biological parents' trust to be able to help the family. It is important for helping professionals to be sensitive to normal human reactions in situations where they may be warranted, and not negatively stereotype behaviors out of context.

If extreme levels of cultural mistrust are masking an underlying depression, then it may share features with clinical paranoia (Bentall et al., 1994; Ridley, 1984; Trower & Chadwick, 1995; Zigler & Glick, 1988). Both paranoid conditions and depressive disorders are amenable to cognitive–behavioral interventions. Cultural mistrust at extreme levels may also be responsive to cognitive–behavior therapy. Cognitive therapy focuses on teaching general principles and skills involved in rational belief revision, including emotional regulation during this process, making it particularly applicable for beliefs that may border on the delusional (Lesser & O'Donohue, 1999). For example, clinicians can help clients distinguish between old-fashioned racism that is motivated by racial hatred and aversive racism that stems from feelings of discomfort or a sense of racial superiority, but not hatred, on the part of Whites (Whaley, 1998d). In developing a more differentiated view of White racism, the mistrustful individual can learn to handle interracial conflicts in a more productive way.

Grier and Cobbs (1968) wrote the following:

> We suspect that many of the black racists exhibit a paranoid style of life, because they feel they are facing an enemy of supermen, not simply an enemy which outnumbers them.... The conviction that Charlie is shrewder saps a black man's drive. It is discouraging to compete against a superman even if he is "super" only in one's mind. Humans being what they are, it provides an opportunity to opt out of the struggle altogether and develops an attitude of What's the use? Why fight it? You can't possibly win struggling as ordinary men struggle; ordinary men sleep nights and Charlie never sleeps. (pp. 192–193)

The feelings of helplessness that tend to occur with such overgeneralizations can be minimized by helping the Black client to understand that not all White persons have the power or intention to do him or her harm. Thus, a better understanding of the cultural underpinning of mistrust among African Americans can lead to improvements in diagnoses and treatment, particularly innovative applications of cognitive–behavioral interventions.

> The treatment of my first case of "paranoid schizophrenia" occurred in a maximum security prison in New Jersey as a psychologist-in-training. It was this experience that got me interested in the issue of cultural paranoia and served as the impetus for my research on cultural mistrust. The inmate was in his thirties and convicted of murdering his young daughter, who he believed was possessed by the devil. The case was assigned to me for training purposes, and there was no expectation that the client would improve. Although I did not know at the time, the inmate suffered from confluent paranoia. He would often talk about racial injustice, citing as evidence that there were many inmates who were wrongly convicted or were there simply because their presence generated revenue and jobs for the prison system. He would also quote the Bible and talk about Armageddon. He felt that he had to be released so that he could go on television and warn people about the impending doom. Our sessions consisted of my validating many of his complaints about racism in society and informing him that I could not relate to other comments. The other comments tend to be pathological delusions. I never challenged his delusions of grandeur. I simply said that I was unable to see some of things that he was saying, because I could not see the future. I also informed him

that most people would be like me. When I informed my supervisor, who was a White male, early in the treatment that the inmate agreed with some of my comments, he told me that the inmate never agreed with any of his previous therapists, who I surmised were White and probably did not validate any of his complaints about racism. This differential verbal reinforcement of cultural beliefs and pathological delusions was the essence of the treatment. These exchanges led to a cognitive shift or belief revision on the part of the inmate to acknowledge that some of his ideas may not be acceptable to others. I later learned from my supervisor that the inmate received a favorable evaluation from the parole board after our treatment.

Conclusion

My review of the literature demonstrates that cultural mistrust has a significant impact on the attitudes and behaviors of African Americans, especially mental health services use (Whaley, 2001b). A fundamental requirement for clinicians treating African Americans with high levels of cultural mistrust is that they acknowledge the possibility that such reaction is a legitimate method of coping with racism and discrimination. To be able to do that, they must first accept that racism and discrimination play a significant role in the historical and contemporary experiences of African Americans. A common theme that runs through the case vignettes presented is that Black clients' complaints about racism should be respected, explored, and validated when warranted. Clinicians may increase clients' mistrust if they dismiss such complaints or beliefs out of hand. Experiences with racism and discrimination represent a cultural differences variable, so the principles of cultural sensitivity apply to the treatment of such issues with African Americans seeking mental health care. That is, clinicians must be open to learning from their clients, and they must be nonjudgmental about the clients' cultural perspective, including their level of cultural mistrust.

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