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Chapter 4

ANXIETY AND AFFECT IN RACIALLY UNMATCHED DYADS DURING EVALUATION AND ASSESSMENT

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ABSTRACT

Ethnic matching has shown a positive impact on the establishment of the therapeutic relationships for African Americans. However, limited research exists examining racially different dyads, and the impact of a racial mismatch on anxiety and affect. This study compares anxiety and affect between ethnically mismatched dyads in an evaluative assessment situation. Participants (N = 489) were paired with European American or African American interviewers then administered measures of depression, anxiety, and situational affect. According to multivariate analysis of variance, the interaction between interviewer and participant race was not statistically significant, nor was the effect for interviewer race, but there was a statistically significant effect for participant race. African American participants reported higher severity across all indices of distress compared to European American participants, regardless of interviewer race.

Exploratory analyses also indicated that age, gender, student status, and occupational status may be associated with distress in the African American group. Future research should continue to examine the impact of race and racial match/mismatch within the treatment dyads in assessment situations, and examine methods for ameliorating distress in assessments situations for African Americans.

Keywords: African Americans; affect; anxiety; ethnic differences; implicit attitudes

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INTRODUCTION

The therapeutic relationship is a critical aspect of mental health care based on the compatibility of the client and clinician. The effectiveness of therapy is associated with the clinician’s ability to understand the client’s perspective and cultural background (Flicker, Waldron, Turner, Brody, & Hops, 2008). One of the first opportunities a clinician has to build rapport occurs during the initial assessment portion of therapy. It is common practice for clinicians to gather information about their life experiences and current presenting problem prior to therapeutic interventions.

In order to determine diagnosis and create a treatment plan, clinicians often use self-report measures and clinical interviews as part of the intake process. This evaluative process marks the client’s first experience with the clinician and sets the tone for future therapeutic experiences. Any aversive experience during this process jeopardizes the establishment of a therapeutic relationship and could negatively impact the accuracy and quality of shared information.

Ethnic minority clients may perceive their therapeutic experience to be more effective when culturally relevant issues are included in their care and they are ethnoracially matched (Meyer & Zane, 2013; Lee, Sutton, France, & Uhlemann, 1983). Ibaraki and Nagayama (2014) found that African Americans attended more therapy sessions when ethnically matched; however, ethnoracial matching can be difficult to achieve as the likelihood of receiving a European American clinician is greater due to their majority status and greater educational opportunities (Devereaux, 1991). Researchers have found that African Americans experience more negative experiences when ethnoracially mismatched, explained in part by anxiety over the anticipated imbalance of power in the helping relationship (Cooper et al., 2003) and cultural insensitivity on the part of the clinician (Constantine, 2007; Owen, Tao, Leach, & Rodolfa, 2011). However, only a minority of mental health providers in the US are African American (US Department of Labor, 2013), illustrating the difficulties posed by those seeking an ethnoracial match as a requirement to commencing services.

Historically grounded negative views of mental health services by African Americans may help explain how race/ethnicity may influence rapport-building. Levy, Thompson-Leonardelli, Smith and Coleman (2005) attributed negative views to distrust, fear of maltreatment, discrimination, prejudice, and stigma. African Americans are more likely to experience racism than any other ethnoracial group (Chao, Asnaani, Hofmann, 2012; Cokley, Hall-Clark, & Hicks, 2011), thus many have concerns about receiving inadequate treatment, experiencing discriminatory practices or being misdiagnosed (e.g., Williams, Domanico, et al., 2012). African Americans have a cultural memory of abuses such as the US Public Health Service Syphilis Study at Tuskegee, which continues to affect medical decision-making (Gamble, 1997). It is also likely that many African Americans seeking treatment have suffered from actual experiences of racial inequality during encounters with medical professionals (Whaley, 2001). As such, past negative experiences with healthcare services are likely to increase levels of anxiety and negative affect in African Americans. Fears of experiencing racism may affect the willingness of African Americans to seek treatment, therefore, presenting for treatment and engaging in the evaluative process during an intake may generate negative feelings.
Steele and Aronson (1995) were the first to document stereotype threat when they performed a series of classic experiments illustrative of how Blacks are more likely to underperform on a difficult test if they believe it is a measure of intelligence, especially when race is made salient. When ethnically mismatched in a psychiatric setting, Blacks were likewise concerned about the potential for racial discrimination and reported “scanning” for the possibility of a reoccurrence (Atdjian & Vega, 2005). Because African Americans consider previous experiences during the initial clinical intake (Earle, Mendiesta, Alegria & Linhart, 2011), there is potential for clients to perform poorly based on perceived racial discrimination. Thus, the threat of being perceived as lacking knowledge or being misunderstood could influence performance on tests and measures during the clinically evaluative process.

Conversely for European Americans, treatment effectiveness and retention were not found to be impacted by ethnoracial matching (Bernstein, Wade, & Hoffman, 1987; Flicker et al., 2008; Lee et al., 1983; Wintersteen, Mensinger, & Diamond, 2005). European Americans typically reported no ethnoracial preference for their clinician (Cabral & Smith, 2011; Lee et al., 1983; Shin, Chow, Comacho-Goslaves, Levy, Allen & Leff, 2005). It is often hard to know how European American clients feel about having ethnoracially different clinicians. European Americans struggle to view themselves as “racial beings” (McIntosh, 2003; Scott & Robinson, 2001) and are rarely faced with experiences to challenge the ideal as part of the majority group.

Additionally, European Americans are rarely faced with a mismatch given the limited number of minority professionals in the mental health setting. However, now that minority clinicians are becoming more common (only 6.0% psychologists, but 19.4% of counselors and 23.0% of social workers, US Department of Labor Statistics, 2013), this issue is increasingly important. Nevertheless, it may be difficult to attain a socially unbiased answer from European American clients regarding their feelings about a mismatch, as they may fear judgment or possibly be unaware of their own prejudice. Responses such as non-verbal cues may provide insight into what clients might think but are reluctant to share (e.g., Dovidio, Gaertner, Kawakami, & Hodson, 2002). Therefore, examining affect may be a good window into a client’s potentially negative feelings about the clinician.

The purpose of this study is to examine the relationship between the race of an interviewer, anxiety, and affect in African American and European American participants receiving clinical assessments. Given the historical context and stressful nature of the evaluative process experienced by African Americans, we hypothesize that African Americans will endorse more anxiety and negative affect with a European American interviewer compared to an African American interviewer. Because of the social power differential between majority and minority groups and because European Americans typically do not perceive themselves as racial beings, we predict that European Americans will not experience increased anxiety or negative affect when racially mismatched during their clinical assessments.

This study extends preliminary work conducted by Williams and Turkheimer (2008) examining obsessive-compulsive symptoms and race in a non-clinical sample of African Americans.

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METHOD

Participants

Participants were community residents and undergraduate students from a college town in the Southeast. Of the 489 participants, 26.9% self-identified as “Black or African American” and 73.1% as “White, Caucasian or European American (not Hispanic).” Racial grouping was confirmed by the interviewer. The mean age for African American participants was 26.46 (SD = 13.81), and for European American participants 22.26 (SD = 10.12). Both African American and European Americans had comparable levels of education, with most participants reporting from “some college” (35.04% Black, 28.97% White) or a “4 year degree” (54.70% Black, 54.93% White).

Measures

Participants were administered a measure of depression, situational anxiety and affect. Details of the measures are described below.

Positive and Negative Affectivity Schedule: The PANAS (Watson, Clark, & Tellegen, 1988) is designed to measure affect in different situations. The instrument measures the presence and absence of both positive affect (PA) and negative affect (NA). Negative affect (NA), as measured by the PANAS, is described as a temperament characterized by distress and unpleasurable feelings activated by an environmental factor (Crawford & Henry, 2004). For this study, participants were asked to contrast their feelings “Now,” while being evaluated, to assess “state” (current situational) affect, versus “In General,” to assess “trait” affect. Items were scored from 0 to 4, with higher numbers corresponding to greater agreement. The PANAS has shown adequate internal consistencies for both PA ($\alpha = .89$) and NA ($\alpha = .85$) in a European American sample, and for trait NA in a multiethnic sample ($\alpha = .90$; Brondolo et al., 2008). In the current sample, the internal consistency for the PANAS was excellent ($\alpha_{PA} = .89$).

Spielberger State-Trait Anxiety Inventory: The STAI (Spielberger, Gorsuch & Lushene, 1970) is designed to measure evaluative apprehensive response associated with anxiety. This instrument is used to make a distinction between “state anxiety” as a temporary condition and “trait anxiety” as a more general and longstanding quality. The “state” portion of the STAI was administered to participants to evaluate feelings of apprehension, tension, nervousness and worry. Items were scored from 0 to 3, with higher numbers corresponding to greater agreement. An increase in scores on the state portion illustrates a response to physical danger and psychological stress. The STAI has shown low to moderate internal consistency among African Americans ($\alpha = .68$) and European Americans ($\alpha = .56$; Chapman & Woodruff-Borden, 2009). However, in the current sample, the internal consistency for the STAI was excellent ($\alpha = .93$).

Center for Epidemiologic Studies Depression Scale: Developed by the Center for Epidemiologic Studies (CESD; Radloff, 1977), this is a 20-item; self-report scale designed to measure depression for the general population. Items were scored from 0 to 3, with higher numbers corresponding to greater agreement. The CESD is a widely-used measure, and has demonstrated good internal consistency in samples of older African Americans ($\alpha = .86$; Foley, Reed, Mutran, & DeVellis, 2002). Good internal consistency was also found in a large
study of African American women (α = 0.85; Makambi, Williams, Taylor, Rosenberg, & Adams-Campbell, 2009). Although researchers have questioned the validity of the factor structure of the CESD among African Americans, studies have found support for the validity of the four-factor structure across different samples of African Americans, both low socioeconomic status (Nguyen, Kitner-Triolo, Evans, & Zonderman, 2004), and women (Makambi et al., 2009; Rozario & Menon, 2009). In the current sample, the internal consistency for the CESD was excellent (α = .90).

Procedure
Participants for this study were recruited through direct mail, telephone invitation, flyers, and the university psychology department subject pool as part of a larger study. Written informed consent was obtained from the participants, and the study was conducted in compliance with the university Internal Review Board. Excluded from this analysis were participants whose racial identification did not fit into the “Black/African American” or “White/European American” categories on the demographics questionnaire, and those who reported having lived in the US for less than five years.

African American and European American participants were randomly paired with a trained African American or European American interviewer. As the race of the co-participants can affect performance, to reduce this and other extraneous influences, subjects were brought into the laboratory and assessed individually. The interviewer described the purpose of the study, explained the procedure to participants, provided the measures, and remained nearby in the room for the duration of the assessment. Participants completed paper and pencil versions of the measures described immediately following their interaction with the interviewer. The interviewer had further interactions with the participant by providing some clinician-administered assessments of anxiety. Students received course credit for participation and community subjects were paid $25. Personal information required for financial compensation was collected separately to preserve anonymity. Data were entered by hand by experienced staff at the university’s center for survey research. More information about the study design can be found elsewhere (Williams & Turkheimer, 2008).

RESULTS

Demographic Comparisons

Demographic comparisons were conducted using t-tests and chi square tests for the African American and European American participants. The African American and European American participants significantly differed with respect to age (t[179.77] = 2.99, p < .01), gender (χ²[1] = 13.65, p < .001), marital status (χ²[1] = 7.43, p < .01), and highest education achieved (χ²[3] = 9.66, p < .05).

As such, partial correlations were conducted with trait anxiety, depression scores, and state and trait NA along with participant age, gender, marital status, and highest education achieved while controlling for participant racial group. Participant age, gender, marital status, and highest education achieved were not significantly correlated with measures of anxiety,
depression, and state and trait NA after controlling for racial group; accordingly age, gender, marital status, and highest education achieved were not included in subsequent analyses.

To address study hypotheses, a multivariate analysis of variance was carried out. The model included four dependent variables (i.e., anxiety, depression, and state and trait NA) and two independent variables (i.e., interviewer race and participant race). The multivariate test of the interaction was non-significant, $F(4, 482) = 0.97, p = .42$, $\eta^2_p = .008$, as was the test of the main effect for interviewer race, $F(4, 482) = 1.58, p = .18$, $\eta^2_p = .013$. However, there was a statistically significant and small main effect for participant race, $F(4, 482) = 5.57, p < .001$, $\eta^2_p = .044$.

**Table 1a. by Participant Race Only**

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<tr>
<th></th>
<th>All Pt</th>
<th>EA Pt</th>
<th>AA Pt</th>
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<tr>
<td>State Anx</td>
<td>13.96(10.49)</td>
<td>13.18(9.61)</td>
<td>16.13(12.40)</td>
<td>2.85*</td>
<td>.27</td>
</tr>
<tr>
<td>Depression</td>
<td>14.37(9.76)</td>
<td>13.31(8.89)</td>
<td>17.26(11.35)</td>
<td>3.80*</td>
<td>.39</td>
</tr>
<tr>
<td>Trait NA</td>
<td>22.14(9.55)</td>
<td>21.14(9.94)</td>
<td>24.84(10.65)</td>
<td>3.51*</td>
<td>.38</td>
</tr>
<tr>
<td>State NA</td>
<td>21.26(9.32)</td>
<td>20.23(8.35)</td>
<td>24.08(11.14)</td>
<td>4.00*</td>
<td>.39</td>
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**Table 1b. by Interviewer and Participant Race**

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<tr>
<td></td>
<td>EA Pt</td>
<td>AA Pt</td>
</tr>
<tr>
<td>State Anx</td>
<td>12.14(9.32)</td>
<td>16.01(12.50)</td>
</tr>
<tr>
<td>Depression</td>
<td>13.67(8.62)</td>
<td>16.88(11.32)</td>
</tr>
<tr>
<td>Trait NA</td>
<td>20.90(8.28)</td>
<td>23.27(10.86)</td>
</tr>
<tr>
<td>State NA</td>
<td>19.01(8.07)</td>
<td>22.81(9.99)</td>
</tr>
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Note. Pt = Participant, AA = African American, EA = European American, Anx = anxiety, NA = Negative Affect.

*p < .036 (False Discovery Rate $\alpha_{critical}$).

Table 1 provides descriptive data for each group as well as results for post hoc comparisons for participant race for each dependent variable. Compared to European American participants, African Americans exhibited greater levels of state anxiety, depression, and state and trait negative affect. Error rates were controlled during post hoc testing with a false discovery rate correction ($\alpha_{critical} = .036$) (Benjamini & Hochberg, 1995; Verhoeven, Simonsen, & McIntyre, 2005).

**Means and Standard Deviations for Anxiety, Depression, and Negative Affect across Different Groups within the Sample**

Exploratory analyses were carried out to investigate factors that may be associated with increased distress (i.e., state anxiety, depression, trait and state NA) among African Americans. Participant’s age, gender, education level, occupational status (i.e., full-time employed, part-time employed, seeking work but unemployed, and unemployed and not seeking work), and student status (i.e., full-time student vs. non-student) were included in this exploratory analysis. Age was positively correlated with trait NA ($r = .22, N = 112, p < .05$), maternal education was negatively correlated with state NA ($r = -.27, N = 106, p < .01$).
Gender was associated with depression, $F(1, 113) = 4.41, p < .05$, Cohen’s $d = .45$, male $M(SD) = 13.97(8.87)$, female $M(SD) = 18.58(11.55)$. In addition, non-student status was associated with higher state anxiety, $F(1, 113) = 4.46, p < .05$, Cohen’s $d = .42$, full-time student $M(SD) = 14.40(11.01)$, non-student $M(SD) = 19.79(14.58)$; higher trait NA, $F(1, 113) = 7.09, p < .01$, Cohen’s $d = .57$, full-time student $M(SD) = 23.43(10.20)$, non-student $M(SD) = 29.31(10.92)$; and higher state NA, $F(1, 113) = 4.38, p < .05$, Cohen’s $d = .41$, full-time student $M(SD) = 22.61(9.19)$, non-student $M(SD) = 27.18(12.93)$.

Occupational status was also associated with depression, $F(3, 111) = 3.28, p < .05$, and trait NA, $F(3, 111) = 3.24, p < .05$. Post hoc pairwise comparisons indicated that these two significant omnibus tests of occupational status were driven by three statistically significant group differences: (a) the group employed full-time was less depressed compared to the unemployed group seeking work, $t(36) = 2.05, p < .05$, Cohen’s $d = .69$, full-time $M(SD) = 14.71(11.37)$, unemployed but seeking work $M(SD) = 22.63(11.53)$; (b) the group employed part time reported more trait NA compared to the unemployed group seeking work, $t(36) = 2.64, p < .05$, Cohen’s $d = .68$, part-time $M(SD) = 29.83(12.95)$, unemployed but seeking work $M(SD) = 22.12(9.65)$; and (c) the unemployed group not seeking work reported less depression compared to the unemployed group seeking work, $t(36) = 3.11, p < .1$, Cohen’s $d = .74$, unemployed but not seeking work $M(SD) = 14.81(9.51)$, unemployed but seeking work $M(SD) = 22.63(11.53)$. No other variables were associated with state anxiety, depression, state NA, or trait NA in the AA group.

**DISCUSSION**

**Race of Interviewer Findings**

It was expected that African Americans would experience an increase in distress because of racial mismatching; however, that was not the case. Contrary to expectations, interviewer race had no impact on the report of distress during the evaluative experience. European American evaluators were well-trained in working with ethnically and racially diverse subjects, so this may have prevented negative interpersonal experiences between the European American evaluators and African American participants (e.g., Dovidio, Gaertner, Kawakami, & Hodson, 2002).

**Findings for African Americans**

Compared to European Americans, African Americans reported higher rates of distress overall, which included depression, state anxiety, and state and trait negative affect. Many factors (e.g., culture, stress, discrimination) may account for the differences in distress between the African American and European American groups. Further research would need to tease out the many possibilities. One such possibility is that African Americans may experience the clinical intake process as “invasive” and view the interviewers as cold and “impersonal” resulting in possible distress from being evaluated in a mental health setting and
being perceived negatively, despite the race of the evaluator (Thompson, Bazile & Akbar, 2004).

Post-hoc analyses revealed that African American community participants (non-students) were more distressed than students, as evidenced by greater state anxiety and state and trait negative affect. Students participating in research studies for credit are often familiar with the evaluative process, whereas community participants have little knowledge of the research experience in the university setting and may view the entire process as more stressful (Huang & Coker, 2001). The community sample represented in this study are also older compared to students and may recall more negative experiences linked to evaluative processes. It is possible that previous negative interactions influenced this evaluative process (Earl, Mendieta, Alegria & Linhart, 2011); accounting for the differences observed between community and student participants.

Post-hoc analyses also showed that occupational status in African Americans was related to anxiety and affect. Notably, those who were employed full-time were less depressed than those working part-time or not at all. Depression and anxiety have been linked to unemployment, and as such, full-time employment may have mitigated depressive symptoms in this group (Sidra, Katherine & Wright, 2001).

However, those who were unemployed but not seeking work were less depressed than those who were seeking work. Rejection is a common occurrence when seeking employment, which may explain why African Americans who were unemployed but not seeking work experienced more depressed symptoms. Furthermore, those who are not actively seeking work may have access to other resources (e.g., unemployment income, disability income, government assistance, family support) that eliminates exposure to rejection.

And finally, those working part-time had more trait negative affect than the unemployed who were seeking work. Part-time employment may be associated with poor job satisfaction because it does not provide financial security for many in these economic times. Poor job satisfaction has also been linked to poor psychological health and may help explain the negative affect observed in those reporting part-time employment (Faragher, Cass & Cooper, 2001).

**Implications for Assessment and Treatment**

Despite being ethnically matched with African American evaluators and having culturally competent European American evaluators, this was not enough to mitigate concerns that seem to have been triggered during the evaluative process in African Americans. Thus, participants were mistrustful of the entire evaluative process, even when being interviewed by another African American (Williams, Beckmann-Mendez, & Turkheimer, 2013).

This may suggest that African Americans are concerned about any evaluative experience, even in a clinical setting, which can be explained by stereotype threat giving the likelihood of having prior negative experiences in similar situations (Earl, Mendieta, Alegria & Linhart, 2011). Additionally, African Americans less familiar with the university research setting may view the environment as threatening, which may also account the negative experience. Williams, Chambliss, and Steketee (1998) reported difficulty in recruiting African Americans for a mental health study in Washington DC, an area with a large African American
population, because the authors believed participants were uncomfortable venturing into a White, affluent section of the city.

In a related qualitative study, six participants were selected for in depth interviews with one question focusing on methods to increase the willingness and participation of African Americans to engage in mental health services and research studies (Williams, Beckmann-Mendez, & Turkheimer, 2013). Suggestions for making African Americans more comfortable included ensuring participants felt welcome by including African Americans magazines and artwork in the waiting room, having a peaceful environment that is clean and well-maintained, and having the sessions at a facility in the community rather than at a university, if this is not a part of their regular experience.

With race often being a difficult topic for discussion because of fear of being perceived in a negative manner (i.e., a racist), it may be necessary for clinicians to initiate a discussion on race and ethnicity. Openly discussing the impact of race as a possible barrier to progress may help to build rapport and may ultimately be an opportunity for growth, creating a welcoming environment that respects diverse and race-related client experience. If a client mentions past negative and positive experiences during a session it may be an indicator that race is a variable requiring discussion. Failing to acknowledge an important factor such as race when problem-solving or examining a situation could leave the client feeling misunderstood (Comas-Diaz & Jacobsen, 1995; Leary, 1995; Terwilliger et al., 2013).

**Study Limitations**

Although this study is an important step in understanding affect in an assessment situation, there are several limitations that must be considered. The nature of the relationship between the interviewer and the participant is not a perfect reflection of the client-clinician relationship, and as such, these findings may not transfer directly over to the assessment experience in a counseling setting. Furthermore, we do not know exactly why African Americans experienced more distress than the European American participants, due to the correlational nature of the findings. Distress may be due to a number of reasons, all which need to be investigated further. Also, the data was collected in a specific geographic region, and responses gathered from different parts of the country where demographics and attitudes differ may produce different results (Duque, Williams, Chapman, & Wetternack, 2011).

**Future Directions and Conclusion**

Further research should examine affect in the actual counseling relationship with European American clients and African American clinicians to better elucidate these findings. Additional studies should also be carried out with evaluators/clinicians from other minority groups to determine if similar findings are produced.
ACKNOWLEDGMENTS

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