

## Racial Group Differences in Help-Seeking Behaviors

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**ABSTRACT.** The authors evaluated variations in help-seeking behaviors among Blacks and Whites and the role of cognitive–affective variables as mediators of these variations. Participants were 70 Black and 66 White community college students who completed the SCL-90-R (L. R. Derogatis, 1977, 1994), the Revised Multidimensional Health Locus of Control (T. Bekhuis et al., 1995), the Symptom Interpretation Questionnaire (J. M. Robbins & L. J. Kirmayer, 1991), and a measure of help-seeking behaviors and demographic information. Relative to White college students, Black college students significantly less frequently used psychological or social services and significantly more frequently used religious services. The authors accounted for group differences in religious help-seeking behaviors by beliefs in the power of God and by normalizing symptom attributions. The cognitive–affective variables that were studied did not account for differences in psychological help-seeking behaviors. The authors inferred that to better meet the needs of Black college students, collaboration between mental health services and religious services would likely be beneficial.

Key words: African Americans, locus of control, psychological services, religious services, service use, symptom attribution, Whites

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RACIAL HELP-SEEKING DIFFERENCES have been shown by researchers to clearly exist. Blacks underuse outpatient mental health services (Alvidrez, 1999; Pumariega, Glover, Holzer, & Nguyen, 1998) and overuse inpatient and emergency mental health services (Maynard, Ehreth, Cox, Peterson, & McGann, 1997; Scheffler & Browne Miller, 1991). To date, the majority of researchers have attempted to explain these differences in help-seeking behaviors by focusing on perceived need and on financial and geographical limitations as explanatory variables (Bazargan, Bazargan, & Baker, 1998; Rosenheck & Stolar, 1998). However, Blacks with insurance coverage are still less likely to use outpatient mental

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health services than Whites who have similar coverage (Padgett, Patrick, Burns, & Schlesinger, 1994). Blank, Tetrick, Brinkley, Smith, and Doheny (1994), Flaskerud (1986), and Nickerson, Helms, and Terrell (1994) have identified—in addition to financial and geographical barriers—low availability of services that are culturally sensitive as a potential barrier to help-seeking behaviors among ethnic minorities. Others have argued that the tendency of Blacks to rely on informal support (Van Hook, 1999) and on religious services (Taylor, Ellison, Chatters, Levine, & Lincoln, 2000) impedes their access to mental health services.

While the majority of researchers have tended to study three separate domains of help-seeking behaviors—the medical, psychological, and religious domains—in the present study we assessed all three domains simultaneously, to identify whether the two groups differ in their help-seeking behaviors across the three domains. Furthermore, despite a well-documented gap in formal health help-seeking behaviors between Blacks and Whites, almost no attention has been given to the role of cognitive–affective variables in explaining these differences. These variables represent beliefs and thoughts about one’s experiences in the world. Most researchers have focused primarily on access barriers—such as financial, geographical, or transportation limitations—or on perceived needs, giving little attention to the role that cognitive–affective variables that distinguish between the two groups play in creating and maintaining the help-seeking gap. Understanding the role of cognitive–affective variables is especially important, because they are likely due to cultural and social differences that distinguish the two groups. Furthermore, findings can guide the development of educational, outreach, and clinical interventions that meet the specific needs of Blacks.

Several potential explanations for the high use of medical services in the treatment of mental conditions among Blacks have been offered, including the tendency of Blacks to focus on somatic complaints rather than on psychological complaints, the tendency of Blacks to possess greater trust and respect for medical professionals than for mental health professionals, and the negative stigma of mental health services held by Blacks (Cooper-Patrick, Gallo, Powe, Steinwachs, Eaton, & Ford, 1999). However, the role of symptom attribution and of attitudes toward mental health professionals has not been empirically explored. In addition, research findings have not supported a higher prevalence of stigma of mental illness among Blacks (Alvidrez, 1999; Cooper-Patrick et al.). In contrast to previous researchers who did not pay adequate attention to the role of cognitive–affective variables in group differences in help-seeking behaviors, in the present study we strove to identify several potential cognitive–affective variables to explain the help-seeking gap.

### *Health Locus of Control*

Rotter, Seeman, and Liverant (1962) introduced the term *locus of control* to describe the expectations that people hold regarding their level of control over a

situation. An internal locus of control represents an individual's belief that positive events are due to his or her own behaviors or skills. An external locus of control represents the belief that reinforcements are controlled by forces other than one's self, such as fate, god(s), or powerful others, and thus occur independently of one's actions.

Most research findings support the notion that Blacks have a more external locus of control than Whites. An external locus of control among Blacks was attributed to the fact that Blacks, as members of a disadvantaged ethnic minority group, have more limited access to opportunities (Galanos, Strauss, & Pieper, 1994; Garcia & Levenson, 1975; Hillman, Wood, & Sawilowsky, 1992, 1994; Vecchio, 1981; Wade, 1996; Young & Shorr, 1986). Researchers have shown that relative to Whites, Blacks are more likely to attribute mental illness to spiritual factors (i.e., beliefs in external control; Alvidrez, 1999; Millet, Sullivan, Schwebel, & Myers, 1996). However, to date, no investigator has studied the relationship between mental health locus of control and help-seeking behaviors.

### *Symptom Attribution*

*Symptom attribution* represents one's beliefs about the possible causes of the symptoms. Kirmayer, Young, and Robbins (1994) have argued that when people face physical, cognitive, or emotional symptoms, they try to place the symptoms in well-defined categories and to label them as psychological, physiological, or normalizing (i.e., nonharmful) in nature. Symptom attribution has a significant role in determining the course, the clinical presentation, and the outcome of the illness (Kirmayer et al.). People who attribute their symptoms to a medical condition are likely to focus on their physiological sensations, to seek help from medical professionals, and to actively search for other medical symptoms (Kolk, Hanewald, Schagen, & Gijsbers van Wijk, 2002). In contrast, people who attribute their symptoms to a mental condition are likely to seek the help of mental health professionals and to look for a constellation of psychological symptoms. To date, the roles of psychological, physiological, and normalizing symptom attributions in explaining group differences in help-seeking behaviors have not been explored.

### *The Present Study*

Because investigators have studied help-seeking behaviors primarily in Whites, and because most formal services have been tailored to fit the needs of that group, the present study compares Blacks' help-seeking behaviors to those of Whites. The goals of the present study were (a) to evaluate racial group differences in help-seeking behaviors in a community college sample and (b) to develop an explanatory model of racial group differences in help-seeking behaviors by assessing the roles of health locus-of-control beliefs and symptom

attribution in the group differences that we would identify. On the basis of a review of the literature, we hypothesized that relative to Whites, Blacks less frequently use psychological or social services and psychiatric services and more frequently use medical, emergency, religious, and clergy services for mental health problems. We also hypothesized that relative to Whites, Blacks more strongly hold beliefs in external control (e.g., God, chance, and powerful others) and somatic symptom attributions and less strongly hold beliefs in internal control and psychological symptom attributions. Last, we hypothesized that certain cognitive-affective variables account for differences in help-seeking behaviors between Whites and Blacks. We expected group differences in medical and emergency help-seeking behaviors to be accounted for by beliefs in external control and somatic symptom attributions and group differences in use of psychological and psychiatric services to be accounted for by beliefs in internal control and psychological symptom attribution. Last, we expected differences in religious help-seeking behaviors to be accounted for by beliefs in God's control.

## Method

### *Participants and Procedure*

Participants were 70 Blacks and 66 Whites (mean age = 23.04 years,  $SD = 7.3$  years; 76 [55.9%] women, 57 [41.9%] men; 3 didn't report their gender). All were 18 years or older and self-identified as either Black or White. They formed a convenience sample of community college students in a large Midwestern city. We recruited them at the school cafeteria. After hearing a complete description of the present study, participants gave written informed consent. Participants received \$5 each for completing the questionnaires.

Table 1 summarizes the demographic and clinical characteristics of participants. In all, 147 participants completed the survey. We excluded two participants because of a large number of missing items (both White) and nine participants because they did not identify themselves as either White or Black. The final sample included 70 Black and 66 White students. There were no significant age differences ( $M = 23.5$  years,  $SD = 8.23$  years, vs.  $M = 22.5$  years,  $SD = 6.75$  years, respectively) or sex differences (60.0% female vs. 51.5% female, respectively) between the Black group and the White group.

### *Measures*

*Outcome variable.* We assessed Help-Seeking Behaviors by asking participants to indicate "how frequently have you used each of the following services: Psychologist/ School Counselor/ Social Worker, Psychiatrist, Clergy, Emergency Room, Medical Doctor, Alternative Medicine, Religious Service in

**TABLE 1. Demographic and Clinical Characteristics of the Sample**

Characteristic	Blacks ( <i>n</i> = 70)		Whites ( <i>n</i> = 66)	
Female, % ( <i>n</i> )	60.0	(42)	51.5	(34)
Age, <i>M</i> ( <i>SD</i> )	23.5	(8.23)	22.5	(6.75)
Religious preference*** <sup>a</sup>				
Catholic, % ( <i>n</i> )	22.9	(16)	30.3	(20)
Protestant, % ( <i>n</i> )	37.1	(26)	15.2	(10)
Jewish, % ( <i>n</i> )	0	(0)	1.5	(1)
Muslim, % ( <i>n</i> )	5.7	(4)	0	(0)
Buddhist, % ( <i>n</i> )	0	(0)	3	(4.5)
Jehovah's Witness, % ( <i>n</i> )	4.3	(3)	0	(0)
Spiritual not religious, % ( <i>n</i> )	10	(7)	30.3	(20)
None, % ( <i>n</i> )	20	(14)	12.1	(8)
Sadist/satanist, % ( <i>n</i> )	0	(0)	4.5	(3)
Perceived health problems, <i>M</i> ( <i>SD</i> )	3.21	(.94)	3.24	(.92)
GSI, <i>M</i> ( <i>SD</i> )	0.88	(.66)	1.07	(.71)
% GSI ≥ 1.26, <i>M</i> for psychiatric outpatients	24.3		30.03	
Revised mental health locus of control				
Self, <i>M</i> ( <i>SD</i> )	25.16	(5.89)	24.78	(6.73)
Powerful others, <i>M</i> ( <i>SD</i> )*** <sup>a</sup>	16.62	(5.72)	13.21	(5.16)
Chance of fate, <i>M</i> ( <i>SD</i> )*	19.86	(5.65)	17.48	(5.77)
God, <i>M</i> ( <i>SD</i> )**	38.44	(13.16)	23.42	(13.54)
Symptom Interpretation Questionnaire score				
Somatic Attribution Scale, <i>M</i> ( <i>SD</i> )	23.88	(6.37)	23.10	(6.87)
Psychological Attribution Scale, <i>M</i> ( <i>SD</i> )	26.67	(7.51)	27.66	(7.73)
Normalizing Attribution Scale, <i>M</i> ( <i>SD</i> )*	30.29	(7.15)	32.85	(6.70)

Note. GSI = Global Severity Index.

<sup>a</sup>We conducted *t* test analyses for interval dependent variables and chi-square analyses for discrete dependent variables.

\**p* < .05. \*\**p* < .01.

the past year." These domains were selected for assessment on the basis of a review of the literature. We asked participants to rate the frequency of their visits on a 6-point scale: 1 = *never*, 2 = *once a year*, 3 = *a few times a year*, 4 = *at least once a month*, 5 = *at least once a week*, 6 = *nearly every day*. Use of over-the-counter and prescribed medications was assessed by a dichotomous scale (1 = *Yes*, 2 = *No*).

*Independent variable.* Ethnicity was self-defined. Participants who were born in the United States and who defined themselves as either White or Black were eligible to participate in the present study. We dummy coded the variable (1 = *Whites*; 2 = *Blacks*).

*Control variables.* We evaluated Overall Level of Distress by the SCL-90-R (Derogatis, 1977, 1994). It is a 90-item self-report symptom inventory. We used the Global Severity Index (GSI) of the SCL-90-R as a measure of overall distress level. One computes the GSI by summing all item scores and then dividing by the total number of valid responses. Derogatis (1977, 1994) has considered the GSI to be the best evaluator of the participant's current level or depth of distress. The SCL-90-R has demonstrated high reliability and validity in numerous studies (Derogatis, 1994). To date, the psychometric properties of this measure have not been tested for Blacks. In the present study, the SCL-90-R demonstrated very high reliability for both Whites and Blacks (Cronbach's  $\alpha = .97$  for both groups).

*Perceived health.* We asked participants to rate their perceived health on a 5-point scale from 1 = *poor* to 5 = *excellent*. This single-item measure is commonly used to assess perceived health and has shown high reliability and validity (Singh-Manoux, Adler, & Marmot, 2003).

*Mediators.* We assessed Locus of Control by the Revised Multidimensional Health Locus of Control (Revised MHLC; Bekhuis et al., 1995). This measure includes three modified scales from the Multidimensional Health Locus of Control scale that assess beliefs about the control of self, powerful others, and fate (Wallston, Wallston, & DeVellis, 1978) and a set of nine modified items that assess beliefs about God's control (DeVellis et al., 1985). Bekhuis et al. added the last subscale to differentiate between beliefs in God's control and beliefs in the control of chance or powerful others. An example of a typical item on this additional scale is, "God will keep you safe." The revised measure consists of 27 items. Respondents indicate their level of agreement on a 6-point scale ranging from 1 = *disagree a lot* to 6 = *agree a lot* (Bekhuis et al.). Previous researchers have shown moderate reliability coefficients for all four scales in both racial groups (Bekhuis et al.). For both racial groups, the scales demonstrated moderate-to-high reliability in the present study: for God, Cronbach's  $\alpha$  for Blacks = .94,  $\alpha$  for Whites = .96; for Powerful Others,  $\alpha$  for Blacks = .79,  $\alpha$  for Whites = .76; for Chance,  $\alpha$  for Blacks = .66,  $\alpha$  for Whites = .75; for Self,  $\alpha$  for Blacks = .69,  $\alpha$  for Whites = .83.

We measured Symptom Attribution by the Symptom Interpretation Questionnaire (SIQ; Robbins & Kirmayer, 1991). The SIQ asks respondents to indicate the extent to which they attribute each of 13 common somatic symptoms to three different types of causes—emotional distress (psychological attributes), somatic illness (somatizing attributes), and external transitory environmental events (normalizing attributes)—on a 4-point scale. An example of a typical item is, "if I had trouble sleeping, I would probably think that it is because: (a) some kind of pain or physical discomfort is keeping me awake (somatizing); (b) I'm not tired or I had too much coffee (normalizing); (c) I am worrying too much or I must be nervous about something (psychologizing)." Responses for each type

of attribute are summed to generate scores of psychologizing, somatizing, and normalizing attributions on a range from 13 to 52. In previous studies, the SIQ scales had moderate reliability and validity (Gijbers van Wijk & Kolk, 1996; Kirmayer & Robbins, 1996). However, no investigator has studied its psychometric qualities with Blacks. In the present study, scales demonstrated moderate-to-high reliability in both groups: for Somatic symptom attribution, Cronbach's  $\alpha$  for Blacks = .81,  $\alpha$  for Whites = .75; for Psychological symptom attribution,  $\alpha$  for Blacks = .82,  $\alpha$  for Whites = .84; for Normalizing symptom attribution,  $\alpha$  for Blacks = .78,  $\alpha$  for Whites = .74.

## Results

We found significant differences in religious preference and in the importance of spirituality, with Blacks indicating that spirituality plays a significantly more important role in their lives than did Whites.

The present results indicated that 24.3% of the Black sample and 30.03% of the White sample had GSI greater than or equal to the mean GSI reported for psychiatric outpatients. Of the services that we assessed in the present study, religious services were most likely to be used by both groups at least once in the past year (87.1% of Blacks, 74.2% of Whites), followed by medical services (72.9% for Blacks, 74.2% for Whites), psychological services (34.3% for Blacks, 53.0% for Whites), psychiatric services (24.3% for Blacks, 24.2% for Whites), and alternative services (22.9% for Blacks, 30.3% for Whites). Emergency services (15.7% for Blacks, 10.6% for Whites), clergy services (15.7% for Blacks, 10.6% for Whites), prescribed medications (5.7% for Blacks, 13.6% for Whites), and over-the-counter medications (10.6% for Whites, 7.1% for Blacks) were least likely to be used in the past year. Table 1 summarizes these results.

To assess the roles of mental health locus-of-control beliefs and symptom attribution as mediators of racial group differences in help-seeking behaviors, we conducted a three-step mediating regression analysis. In Step 1, we evaluated group differences in help-seeking behaviors. In Step 2, we evaluated group differences in the cognitive-affective variables. In Step 3, we evaluated whether the group differences in help-seeking behaviors that we identified were mediated by the cognitive-affective variables that demonstrated significant group differences (Baron & Kenny, 1986).

First, to evaluate racial group differences in help-seeking behaviors, we conducted regression analysis with frequency of help-seeking behavior as a dependent variable, racial group as an independent variable, and overall psychological and physiological distress as control variables. We conducted this analysis separately for each type of help-seeking behavior that demonstrated a group difference (e.g., religious help-seeking behavior and psychological help-seeking behavior). The results indicated that Blacks significantly more frequently used religious services— $B = .82$ ,  $SE B = .25$ ,  $\beta = .27$ ,  $p < .01$ —and significantly less

frequently used psychological or social services— $B = -.44$ ,  $SE B = .22$ ,  $\beta = -.15$ ,  $p < .01$ —than Whites, after controlling for overall level of psychological distress— $B = -.04$ ,  $SE B = .18$ ,  $\beta = -.02$ , *ns*;  $B = -.06$ ,  $SE B = .13$ ,  $\beta = -.04$ , *ns*, respectively—and physiological distress— $B = .76$ ,  $SE B = .16$ ,  $\beta = .37$ ,  $p < .01$ ;  $B = -.05$ ,  $SE B = .11$ ,  $\beta = -.03$ , *ns*, respectively.

Second, to identify group differences in the cognitive–affective variables that we studied, we conducted *t* test analyses with group as the dependent variable and each of the cognitive–affective variables as independent variables. The results indicated significant racial group differences in external locus-of-control beliefs (in God, Powerful Others, and Chance) and in normalizing symptom attribution, with Blacks reporting beliefs in external control significantly more strongly than Whites and reporting beliefs in normalizing symptom attributions less strongly than Whites (see Table 1).

Third, we evaluated whether the group differences in help-seeking behaviors that we identified were mediated by the cognitive–affective variables that demonstrated significant group differences (i.e., it was only appropriate to assess mediation if racial group was related to the help-seeking behavior and to the mediator). We conducted regression analyses with frequency of help-seeking behavior as a dependent variable, the cognitive–affective variables as mediators, group as an independent variable, and overall levels of psychological distress and physiological distress as control variables. We conducted this analysis separately for the two types of help-seeking behaviors that demonstrated group differences (e.g., those of psychological services and religious services). Lack of significance for group would indicate full mediation. Belief in the power of God— $B = .02$ ,  $SE B = .01$ ,  $\beta = .3$ ,  $p < .01$ —and normalizing symptom attributions— $B = -.03$ ,  $SE B = .01$ ,  $\beta = -.17$ ,  $p < .05$ —mediated (i.e., accounted for) group differences in religious help-seeking behaviors— $B = .34$ ,  $SE B = .27$ ,  $\beta = .11$ , *ns*. None of the cognitive–affective variables that we studied mediated group differences in psychological or social help-seeking behaviors.

## Discussion

### *Group Differences in Help-Seeking Behaviors*

Despite the general notion that a college population is likely to report both low levels of need and of help-seeking behaviors, the present results indicated that 24% of Blacks and 30% of Whites reported distress symptoms that are similar to or higher than the mean norm of outpatient psychiatric clients. Use of psychological or social services also was high, with 34% of Blacks and as many as 50% of Whites reporting use of psychological or social services at least once in the past year. For both groups, religious services were most likely to be used, with 87.1% of Blacks and 74.2% of Whites reporting use of these services at least once in the past year.

We found no significant group differences in the use of medical, emergency, clergy, and psychiatric services. However, as we hypothesized, Blacks used psychological or social services less frequently and religious services more frequently than did Whites. The present study suggests that even after controlling for the level of education and the level of distress, Blacks are less likely to use psychological or social services than Whites. Furthermore, the entire sample had relatively easy access to services through student health facilities, and therefore, access barriers cannot explain the difference. Similarly, Padgett et al. (1994) found that Blacks are less likely than Whites to use outpatient mental health services even when access barriers are controlled for.

The present finding that Black college students are more likely to use religious services than White college students is in accordance with Taylor, Chatters, Jayakody, and Levin, (1987, 1996) and with Taylor, Thornton, and Chatters (1987), who argued that religious services capture a major role in the lives of Blacks. Interestingly, in the present study we found high-frequency use of religious services, but relative low-frequency use of clergy services. The context in which we placed the question could have primed a different set of responses. The question about religious services came immediately after a set of questions about religious beliefs and the importance of spirituality, whereas the question about clergy visits was among questions about other medical and mental health services. It appears that Blacks are likely to use religious services for spiritual or religious purposes but not to ease their distress. This finding is supported by the fact that psychological distress level did not predict either religious or clergy help-seeking behaviors in the present study. Similarly, Van Hook (1999) and Levkoff, Levy, and Flynn (1999) have reported that, despite high religious involvement, ethnic minorities do not tend to seek religious services when distressed.

Flaskerud (1986) referred to psychopharmacology as a culture-compatible component of therapy, arguing that medications would be an expected and acceptable component of treatment among certain ethnic minority groups, such as Blacks, Latinos, and Asians. In the present study, we did not find racial group differences in the use of psychiatric services, medical services, prescribed medications, or over-the-counter medications, and therefore, the present results do not support Flaskerud's hypothesis. However, in contrast to Flaskerud, in the present study we focused on a nonclinical population, which likely exhibited less need for psychiatric medications.

#### *The Role of Cognitive–Affective Variables in Group Differences in Help-Seeking Behaviors*

The initial hypotheses of the present study were that group differences in psychological or social help-seeking behaviors are due to beliefs in internal control and to psychological symptom attributions. The present results did not support these hypotheses. None of the cognitive–affective variables that we studied

explained the group differences that we identified. However, the striking finding of higher levels of psychological or social help-seeking behaviors among White students relative to Black students, even after controlling for level of distress and education, still remains unclear and therefore justifies future efforts into the identification of cognitive–affective variables that are responsible for such differences in help-seeking behaviors. The use of qualitative research with Blacks and Whites at this stage is particularly important and is likely to help generate hypotheses about a cognitive–affective style that is responsible for the findings.

As we expected, belief in God as the locus of control accounted for group differences in religious help-seeking behaviors. This finding indicates the possibility that because Blacks are more likely than Whites to believe in the control of God over their lives, they also are more likely than Whites to actively use religious services. In addition, we found that normalizing symptom attributions predicted religious help-seeking behaviors. Possibly, people who use religious services are less likely to attribute their symptoms to normalizing causes but instead tend to attribute their symptoms to divine ones (i.e., God as locus of control). Future researchers should target the relationship between religiousness and symptom attribution in Blacks.

The present study has several limitations. First, despite the fact that participants had similar levels of education, there are many other socioeconomic indicators that we did not control for. Future researchers should use multiple indicators of socioeconomic status when evaluating variations in help-seeking behaviors among ethnic minorities. Second, studying a nonclinical population has disadvantages as well as advantages. The advantage of studying a nonclinical population is that participants are not preselected because of their attendance of specific service types. The disadvantage lies in the possibility that a nonclinical population has fewer mental health needs and therefore differs from a clinical population. However, in the present study, we found that a relatively high proportion of the participants in both groups reported high levels of clinical need and a broad range of responses. A more thorough understanding of racial group differences in help-seeking behaviors could be gained by studying both clinical and nonclinical populations. Last, the assessment of the frequency of help-seeking behaviors retrospectively with a self-report questionnaire is less than ideal. However, the assessment of help-seeking behaviors by studying the records of different agencies is cumbersome and limits the study to specific agencies. The use of diaries in addition to retrospective reports of help-seeking behaviors may provide a more accurate estimate of such behaviors.

In summary, in the present study we provide insights into racial group differences in help-seeking behaviors by evaluating an explanatory model to account for the differences that we identified. To explain racial group differences in help-seeking behaviors, previous researchers have focused primarily on financial and structural barriers or on perceived need. In the present study, in contrast, we focused on cognitive–affective variables as possible mediators of

group differences. An additional advantage of the present study was its "neutral" setting, unrelated to any mental health agency. This setting provided a less biased estimate of help-seeking behaviors. The control for both psychological and physical distress and the distinguishing between the two types of distress were additional advantages of the present study.

The present study has important implications for the development of mental health services for Blacks. The study found that even though Black college students are more likely than White college students to use religious services, they are just as unlikely as White college students to use these services for mental health purposes. These findings are unfortunate and suggest that, currently, Black college students do not use religious outlets to meet their mental health needs. Because of the high levels of religious help-seeking behaviors among Blacks, clergy have a unique opportunity as gatekeepers to the mental health services system (Taylor et al., 2000). To better meet the needs of Blacks, collaboration between mental health services and religious services may be beneficial. Education and outreach efforts should address not only Blacks in general but Black clergy and religious leaders in particular. In addition, on the basis of our findings among Black college students of high levels of beliefs in the power of God over one's life, spirituality and religiousness should be important themes in the mental health treatment of Black college students. Possibly, current low levels of use of mental health services by Black college students are due to a lack of culturally competent services. Mental health services should pay particular attention to the role of spirituality and religiosity in Blacks and should adapt services accordingly.

## REFERENCES

- Alvidrez, J. (1999). Ethnic variations in mental health attitudes and help-seeking behaviors among low income African American, Latina, and European American young women. *Community Mental Health Journal, 35*, 515-530.
- Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51*, 1173-1182.
- Bazargan, M., Bazargan, S., & Baker, R. S. (1998). Emergency department utilization, hospital admissions, and physician visits among elderly African American persons. *Gerontological Society of America, 38*, 25-36.
- Bekhuis, T., Cook, H., Holt, K., Scott-Lennox, J., Lennox, R., Price, L., & Fryer, J. G. (1995). Ethnicity, church affiliation and beliefs about the causal agents of health: A comparative study employing a multivariate analysis of covariance. *Health Education Research, 10*, 73-82.
- Blank, M. B., Tetric, F. L., Brinkley, D. F., Smith, H. O., & Doheny, V. (1994). Racial matching and service utilization among seriously mentally ill consumers in the rural south. *Community Mental Health Journal, 30*, 271-280.
- Cooper-Patrick L., Gallo, J. J., Powe, N. R., Steinwachs, D. M., Eaton, W. W., & Ford, E. (1999). Mental health service utilization by African Americans and Whites: The Baltimore epidemiologic catchment area follow-up. *Medical Care, 37*, 1034-1045.

- Derogatis, L. R. (1977). *SCL-90-R: Administration scoring and procedures manual I*. Baltimore: Clinical Psychometric Research.
- Derogatis, L. R. (1994). *SCL-90-R: Administration scoring and procedures manual*. Minneapolis, MN: National Computer Systems.
- DeVellis, R. F., DeVellis, B. M., Revicki, D. A., Lurie, S. J., Runyan, D. K., & Bristol, M. (1985). Development and validation of the child improvement locus of control (CILC) scales. *Journal of Social and Clinical Psychology, 3*, 307-324.
- Flaskerud, J. H. (1986). The effects of culture-compatible interventions on the utilization of mental health services by minority clients. *Community Mental Health Journal, 22*, 127-141.
- Galanos, A. N., Strauss, R. P., & Pieper, C. F. (1994). Sociodemographic correlates of health beliefs among Black and White community dwelling elderly individuals. *International Journal of Aging and Human Development, 38*, 339-350.
- Garcia, C., & Levenson, H. (1975). Differences between Blacks and Whites expectations of control by chance and powerful others. *Psychological Reports, 37*, 563-566.
- Gijsbers van Wijk, C. M. T., & Kolk, A. M. (1996). Psychometric evaluation of symptom perception related measures. *Personality and Individual Differences, 20*, 55-70.
- Hillman, S. B., Wood, P. C., & Sawilowsky, S. S. (1992). Externalization as a self-protective mechanism in a stigmatized group. *Psychological Reports, 70*, 641-642.
- Hillman, S. B., Wood, P. C., & Sawilowsky, S. S. (1994). Attributional style of African American adolescents. *Social Behavior and Personality, 22*, 163-176.
- Kirmayer, L. J., & Robbins, J. M. (1996). Patients who somatize in primary care: A longitudinal study of cognitive and social characteristics. *Psychological Medicine, 26*, 937-951.
- Kirmayer, L. J., Young, A., & Robbins, J. M. (1994). Symptom attribution in cultural perspective. *Canadian Journal of Psychiatry, 39*, 584-595.
- Kolk, A. M. M., Hanewald, G. J. F. P., Schagen, S., & Gijsbers van Wijk, C. M. T. (2002). Predicting medically unexplained physical symptoms and health care utilization: A symptom perception approach. *Journal of Psychosomatic Research, 52*, 35-44.
- Levkoff, S., Levy, B., & Flynn, W. P. (1999). The role of religion and ethnicity in the help seeking of family caregivers of elders with Alzheimer's disease and related disorders. *Journal of Cross-Cultural Gerontology, 14*, 335-356.
- Maynard, C., Ehreth, J., Cox, G. B., Peterson, P. D., & McGann, M. E. (1997). Racial differences in the utilization of public mental health services in Washington state. *Administration and Policy in Mental Health, 24*, 411-424.
- Millet, P. E., Sullivan, B. F., Schwebel, A. I., & Myers, L. J. (1996). Black Americans' and White Americans' views of the etiology and treatment of mental health problems. *Community Mental Health Journal, 32*, 235-242.
- Nickerson, K. J., Helms, J. E., & Terrell, F. (1994). Cultural mistrust, opinions about mental illness, and Black students' attitudes toward seeking psychological help from White counselors. *Journal of Counseling Psychology, 41*, 378-385.
- Padgett, D. K., Patrick, C., Burns, B. J., & Schlesinger, H. J. (1994). Ethnicity and the use of outpatient mental health services in a national insured population. *American Journal of Public Health, 84*, 222-226.
- Pumariega, A. J., Glover, S., Holzer, C. E., & Nguyen, H. (1998). Utilization of mental health services in a tri-ethnic sample of adolescents. *Community Mental Health Journal, 34*, 145-156.
- Robbins, J. M., & Kirmayer, L. J. (1991). Attributions of common somatic symptoms. *Psychological Medicine, 21*, 1029-1045.
- Rosenheck, R., & Stolar, M. (1998). Access to public mental health services: Determinants of population coverage. *Medical Care, 36*, 503-512.

- Rotter, J. B., Seeman, M., & Liverant, S. (1962). Internal versus external control of reinforcement: A major variable in behavior theory. In N. F. Washburn (Ed.), *Decisions, values and groups* (pp. 473–516). New York: Macmillan.
- Scheffler, R. M., & Browne Miller A. (1991). Difference in mental health service utilization among ethnic subpopulation. *International Journal of Law and Psychiatry*, *14*, 363–376.
- Singh-Manoux, A., Adler, N. E., & Marmot, M. G. (2003). Subjective social status: Its determinants and its association with measures of ill-health in the Whitehall II study. *Social Science and Medicine*, *56*, 1321–1333.
- Taylor, R. J., Chatters, L. M., Jayakody, R., & Levin, J. S. (1996). Black and White differences in religious participation: A multisample comparison. *Journal for the Scientific Study of Religion*, *35*, 403–410.
- Taylor, R. J., Ellison, C. G., Chatters, L. M., Levine, J. S., & Lincoln, K. D. (2000). Mental health services in faith communities: The role of clergy in black churches. *Social Work*, *45*, 73–87.
- Taylor, R. J., Thornton, M. C., & Chatters, L. M. (1987). Black Americans' perceptions of the socio-historical role of the church. *Journal of Black Studies*, *18*, 123–138.
- Van Hook, M. P. (1999). Women's help-seeking patterns for depression. *Social Work in Health Care*, *29*, 15–34.
- Vecchio, R. P. (1981). Workers' belief in internal versus external determinants of success. *The Journal of Social Psychology*, *114*, 199–207.
- Wade, J. T. (1996). An examination of locus of control/fatalism for Blacks, Whites, boys, and girls over a two-year period of adolescence. *Social Behavior and Personality*, *24*, 239–248.
- Wallston, K. A., Wallston, B. S., & DeVellis, R. (1978). Development of the multidimensional health locus of control (MHLC) scales. *Health Education Monographs*, *6*, 160–170.
- Young, T. W., & Shorr, D. M. (1986). Factors affecting locus of control in school children. *Genetic, Social, and General Psychology Monographs*, *112*, 407–417.

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