2023

Everything won't be okay: The impact of therapists' justification of the mental healthcare system on their racially minoritized patients

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EVERYTHING WON'T BE OKAY:
THE IMPACT OF THERAPISTS' JUSTIFICATION OF THE MENTAL HEALTHCARE SYSTEM ON THEIR RACIALLY MINORITIZED PATIENTS

BY

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A DOCTORAL DISSERTATION SUBMITTED TO THE GRADUATE FACULTY OF THE SCHOOL OF HEALTH PROFESSIONS OF LONG ISLAND UNIVERSITY, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

APRIL, 2023

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Abstract

Despite advances in mitigating explicit biases, research finds that therapists' implicit bias has not significantly decreased in magnitude or impact on their clinical work over the past several decades. This bias propels, among other harms, misdiagnosis and overdiagnosis, weaker therapeutic alliances, poorer quality of care, and re-activation of racialized trauma among patients of color. Because of these disparities, many individuals develop experience-based cultural mistrust toward the healthcare system, which clinicians often misinterpret as psychopathology, perpetuating the mistreatment-to-mistrust cycle. This dissertation was the first to apply system justification theory to clinical process research, investigating whether and how therapists' justification of the mental healthcare system impacts their patients' cultural healthcare mistrust within the alliance. To this end, participants reported on their racialized stress, cultural mistrust, and healthcare system distrust, then were exposed to an experimentally manipulated vignette "therapist" at one of three levels of system justification (low, high, non-responding), and described their working alliances with their assigned therapist. The negative effect of racialized stress on working alliance was found to be partly mediated by healthcare system distrust, though not by cultural mistrust. Low therapist system justification emerged as significantly beneficial to working alliances, particularly for participants with more racialized stress and healthcare system distrust. Non-responsiveness to patients' mistrust had the most significant negative effects across all analyses. These results speak to the importance of therapists' capacity to openly address minoritized patients' mistrust and to manage their own instinct to justify the systems within which they operate. Exploratory results, clinical implications, and future directions for research are discussed.

Acknowledgements

This dissertation and the five years behind it were possible only because of my family – immediate, extended, communal – and especially my parents. You have been my source of unwavering support, belonging, hugs, niche memes, Shabbat dinners, and faith in me throughout this journey. I very literally could not have done it without you.

My incredible dissertation committee: Ben, for being such a present, emboldening force in bringing this project to life, from counseling me through the early planning stages, to fielding my panicked mid-data-collection emails (Subject Line: HELP!!!), to your gentle feedback and joyful satisfaction in the final product. Kevin, for keeping me grounded when I had the research zoomies, and motivated when I felt allergic to my own writing; for always seeing my project's "good bones," even when they were hidden under layers of weird empirical wallpaper. I have been so lucky to have you both as my guides throughout the doctoral process. This dissertation – and I – would not be what we are without your incisive observations and commitment to your craft. Marie, for being my brilliant ally and guide into system-critical psychology. I dream of doing a fraction of all you've done to move our field towards enabling each of us to define our own experience.

My PSC advisors: Lisa, my model of female leadership in our field, for enriching my study as only the Clinical Process Queen could; and Matt, my immeasurably generous mentor and friend, for being a steadfast agent of freedom and a living case study of what trustworthiness looks like. My dear LIU family, faculty and friends: I am blessed to have found you. For keeping me going (and well-stocked with legal substances). Thank you.

And finally, to God: for allowing me to care for Your precious children; for giving me every person and experience I needed. I have never gone a moment unloved.

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Chapter I

Introduction

"We need to place [racial and systemic] challenges in context. What happens is we tell people they are very broken and we try to fix them. And it's impossible to fix someone when what's broken is the system."

– Chaya Babu, *VICE* (2017)

In her article "*Why I Left My White Therapist,"* Chaya Babu describes her treatment with a White female therapist who was very helpful to Babu in exploring interpersonal and familial dynamics, and even in discussing racial inequalities in the world at large. Yet, when Babu put words to the racial and social imbalances in the room between them, she was disappointed and hurt to find her therapist become defensive, distant, and combative. The author decided to leave treatment, concluding that the mental healthcare system is fundamentally motivated to avoid seeing systemic inequities in their own work, due to the true threat posed by realities of racism to their professional self-image. To become vulnerable to the ethnocentric mental healthcare system, she suggests, is to be racially retraumatized. The starkness of this evaluation earned criticism from mental health professionals. However, the article's online virality, including millions of upvotes, comments of agreement, and disclosure of similar therapy experiences among readers of color, spoke to a divide between the views of the predominantly White mental healthcare system and the racial minority members who use it – or decline to use it.

In recent years, the field of clinical psychology has made substantial improvements in research, education, and clinical integration of sociocultural factors in psychotherapy, leading to higher quality of treatment with a more diverse range of clients

(Nickerson, Helms, & Terrell, 1994; Ratts & Pederson, 2014. The realities of personal and intergenerational racialized trauma have increasingly earned attention in clinical practice (Snowden, 2001). Most therapists agree that clients' race, nationality, culture, gender, sexual orientation, and other identity factors are important considerations for effective treatment (Campbell, 2014).

Yet, as Babu noted, this nuanced theoretical awareness of racial, social, and systemic dynamics in mental healthcare can often remain distinct from its actual practice. Treatment disparities are maintained through the still-persistent sentiment that sociopolitical concerns are "not the work of therapy"; that mental healthcare can somehow stay outside looking in on society's foibles (Danzer et al., 2016; Hall & Yee, 2015). But therapists – as any other group of individuals – bring their social, political, and systemic biases into their interpersonal judgments, often without their conscious awareness (Aryan & Carlino, 2011; DiAngelo, 2011; Greenwald & Banaji, 2017).

A meta-analysis by Boysen (2010) found that though White counselors now show stronger explicit values of equality, inclusivity, and social justice as compared to thirty years ago, implicit biases have not changed significantly in magnitude or impact on their clinical work. Despite advances in sensitivity training, therapist microaggressions and other markers of weak multicultural competence continue to damage interracial therapeutic dyads leading to weaker therapeutic alliances with patients of color, poorer quality of care, and active perpetuation of patients' racialized trauma (Gómez, 2015; Lee et al., 2018; Owen et al., 2014; Sue et al., 2019). A number of recent studies have found that many (particularly White) therapists in fact feel actively defensive toward the idea

that racial and systemic factors may impact their own therapeutic work (Bartoli et al., 2015; Constantine, 2007; Danzer et al., 2016; DiAngelo, 2011; Sotero, 2006).

One of the most researched manifestations of therapist racial bias is the over-representation of patients of color who are misdiagnosed with severe mental illness or involuntarily hospitalized (Augsberger et al, 2015). Loring and Powell's well-known 1988 study split 290 psychiatrists into groups and presented them with identical case summaries, differing only in the patient's described race. The "African American" patient was diagnosed with paranoid schizophrenia nearly *twice as often* as the "European American" patient, by White and Black psychiatrists alike. In real-life clinical practice as well, Black Americans are nearly twice as likely as White Americans to be diagnosed with schizophrenia, and half as likely to be diagnosed with mood disorders including depression (U.S. Department of Health, 2001). These results have been replicated well into the twenty-first century, with social desirability around appearing culturally competent rising more appreciably than actual cultural competence (Haskins et al., 2013; Hayes, Prosek, & McLeod, 2010). Black Americans are more often prescribed antipsychotic medication than White Americans and less often prescribed antidepressants (Schwartz & Blankenship, 2014). These disparities persist despite largescale epidemiological reviews finding no significant differences in the actual prevalence or severity of psychiatric symptomatology between races (Snowden, 2001).

As a result of these biased, pathologizing historical and current practices, many patients develop experience-based mistrust of White-dominated healthcare systems, including mental healthcare. This coping response is known as *cultural mistrust* (Grier & Cobbs, 1963; Terrell & Terrell, 1981). Research into cultural mistrust spanning the last

forty years has found it to be remarkably consistent, durable, and unresponsive to intervention. Multiple studies have actually found healthcare-specific cultural mistrust to *strengthen* under direct corrective efforts, known as the "backfire effect" (Nyhan et al., 2014). In addition to being strikingly resilient and stable over time, mistrust of the healthcare system is also frequently misinterpreted by (particularly White) therapists as paranoia or other idiosyncratic psychiatric experiences, at the expense of racial and systemic explanations (Keating & Roberson, 2004; Poussaint & Alexander, 2000; Sanguineti, 2017; Whaley, 2001a). These biased interpretations serve to perpetuate the mistreatment-to-mistrust cycle, as culturally mistrustful Black clients are significantly more likely – even beyond other Black clients – to receive misdiagnosis and poor treatment, which validate their mistrust (Constantine, 2007; Whaley, 2001a, 2001c).

In part, viewing treatment mistrust as an individualistic problem removes possible blame from the mental healthcare system itself, allowing therapists to continue to view their work as effective, just, and fair for all patients, despite evidence otherwise (Sue & Sue, 2008). This *system justification* (the motivation to cling to beliefs reinforcing and maintaining the social status quo) serves a palliative, anxiety-reducing function (Jost, 2019; Jost & Banaji, 1994). The incentive to system-justify is particularly strong for those benefiting from or dependent upon the accused system (Jost, 2019; Jost & Thompson, 2000), of which therapists are arguably both. To this end, the present research examined how system justification influences therapists' working alliances – a key component of outcomes (Horvath & Greenberg, 1989) – with their racially minoritized and culturally mistrustful patients.

This paper begins with a literature review that first outlines the mental healthcare system's history of racism, the etiology of cultural mistrust, and its impacts on the therapeutic dyad. Next, it describes system justifying therapist stances that are at odds with principles of multicultural competence and contributory to cultural mistrust. It then highlights low-system-justifying clinical strategies, such as system-oriented practices, and their various alliance effects. Within this context, the statement of the problem highlights limitations of previous research on therapists' responses to cultural mistrust and suggests system justification as an important, largely unexamined factor. Next, a method is proposed for investigating the impact of system relationships – and match of patient-therapist system relationships – on the working alliance. Finally, preliminary and primary results of the present study are reported, discussed, and framed in connection to both previous clinical psychology literature as well as promising future investigation.

Chapter II

Review of the Literature

"How could they treat Black clients? They didn't know about the Tuskegee Experiment or Jim Crow. They don't get the history, the historical context of why we don't trust."

—Chicago mental health provider, *interview* (Juzang & Weddington, 2009)

The History and Legacy of Racism in Mental Healthcare

It has been increasingly recognized that the U.S. mental healthcare system is imitative of the political institutions and societal power structures in which it exists (Fernando, 2010; Ridley & Mendoza, 1994). Mental health fields such as psychology, counseling, and psychiatry are prone to the same pitfalls of systemic racism and unrecognized privilege as other sociocultural institutions, such as the medical healthcare and law enforcement systems. These discriminatory values have been causative to some of the field's foundational ideologies and, in turn, to the research, theory, and practice that define it still today (Cohen et al., 2017; Fernando, 2010).

Thomas and Sillen's seminal book *Racism and Psychiatry* (1972) highlights the historical use of behavioral "science" as justification for pathologizing and oppressing people of color. Building on fantasies of "psychologically healthy" Black people as being simple, carefree, hardworking, and most comfortable in roles of subordination, early psychologists deemed Black individuals insufficiently sophisticated or verbally competent to benefit from psychotherapy (Carothers, 1953; Carstairs & Kapur, 1976). It was accepted that Black people possessed juvenile, unidimensional inner worlds relative to White people, and that this simplicity protected them from more complex emotional states like depression and anxiety (Thomas & Sillen, 1972). G. Stanley Hall, founding

president of the American Psychological Association and "Father of Child Psychology" stated that African, Chinese, and Indian adults could mentally develop no further than the White adolescent (1904; cited by Sue & Sue, 2008). This "scientific racism" was used to argue that non-White people were genetically inferior. Twentieth-century clinicians claimed to find higher rates of psychopathy in their non-White patients, which they attributed to their smaller and more immature brains, relative to the European brain (Carter, 1995). As recently as 1995, Plous and Williams found that 20% of participants contacted in a random-digit telephone survey (N = 686 Connecticut residents) endorsed beliefs that White people have superior abstract thinking skills than Black people. Almost half of the participants endorsed at least one racist body stereotype (19% said Black people have thicker skulls than White people, and 23.5% that they have longer arms).

However, the growing recognition of the bigoted "research methods" behind these theories, alongside the Civil Rights movement of the 1960s, brought a shift in the social scientific dialogue from blaming minorities' biological defects to blaming their cultures, lifestyles, and beliefs (Sumada, 1998). In *The Culturally Deprived Child* (1962), Riessman rationalizes that non-White groups' poor performance on cognitive and personality assessments was due to their lack of White, middle class culture and the privileges it afforded (e.g. education, lower rates of divorce); this "cultural deprivation" was meant to explain White perceptions of minorities' cognitive weaknesses and psychopathology (Ward, 2002; White & Parham, 1990).

From the 1980s to current day, social science has subscribed to the "culturally diverse," or "multicultural," model of psychology, which aims to legitimize and appreciate cultural difference rather than viewing it as deviance, deficiency, or pathology

(Sue & Sue, 2008). A central piece of this model is the acknowledgement and the appreciation of differences, pluralism, and the ability to competently move between multiple sociocultural environments. Alongside these ideas has emerged the concept of multiculturally competent practice, which builds on the understanding that people of all racial and cultural backgrounds can benefit from psychotherapy, and that the field of psychotherapy is enriched by a diversity of patients. Rather than attributing therapeutic snafus with minority clients to clients' deficits, the ethos of multicultural competence makes therapists responsible for exercising openness, perspective-taking, and empathy with those different from them (Ridley & Mendoza, 1994). Even so, this shift is still in its infancy: the first study evaluating therapeutic outcomes associated with therapists' cultural competence (or lack thereof) was just twenty years prior to this writing (Fuertes et al., 2001), and there is much within the field yet to be explored.

Moreover, the work of unlearning the system's deeply engrained racial prejudices has proven painstaking and dilatory. Historical discrimination against minorities endures within present-day mental health practice (Constantine, 2007; Danzer et al., 2016). Judgments of health and pathology are often based on ethnocentric, Western, and/or patriarchal ideals of independence, compliance with social norms, and culturally acceptable expressions of emotion (Bradshaw, 1990; Sue et al., 2019). Unspoken (and sometimes spoken) questions of whether financially disadvantaged people are sufficiently sophisticated for therapy are common. Many trainee therapists are taught that these clients may be capable only of concrete, present-focused, "un-psychological" thought; externalizing or enacting their inner experience; and unable to self-regulate and tolerate the frustration necessary to introspect (Javier & Herron, 2017).

As stated, recent meta-analytic data have found therapists' implicit racial biases to continue to pose a significant and far-reaching impediment to their therapeutic work despite stated values of equality, inclusivity, and integrity (Boysen, 2010). Notably, implicit bias continues to propel over-diagnosis and misdiagnosis of minorities (Cohen et al., 2017; Terwilliger et al., 2013). A contemporary replication of Loring and Powell's 1988 vignette study asked psychologists to diagnose either a "European American" or "African American" client with an otherwise identical case vignette. The original study's results were recreated, with the "African American" clients being diagnosed with psychotic disorders significantly more often than the former (Gushue, 2004).

A meta-analysis of racial disparities in real-life diagnosis found that Latino and African American clients are diagnosed with psychotic disorders approximately three times more often than White American clients. When minoritized patients were immigrants, this disparity was yet more significant (Schwartz & Blankenship, 2014). Minoritized patients are also more likely to be prescribed antipsychotic medications even without a diagnosed psychotic condition, and are less frequently referred for mood-focused treatments even after diagnosis of a mood disorder (Black-Parker et al., 2021; Snowden, 2001). These higher rates of over-diagnosis among minoritized patients – and Black clients in particular – contribute to disproportionate hospitalization rates, including involuntary hospitalization (Davis, 2020).

Once in treatment, Black patients can expect less effective care and worse therapeutic outcomes (Holden et al., 2014; Owen et al., 2012). Follow-up surveys with 925 individuals one year after discharge from a psychiatric hospital found that Black people across gender, age, diagnosis, and social class reported significantly lower

functioning on a wide range of emotional, behavioral, and social domains (Eack & Newhill, 2012); for example, Black participants were more likely to be unemployed one year following treatment. Along similar lines, Moore and colleagues (2016) observed that Black Veterans discharged from rehabilitation counseling were much less likely to have returned to work at follow-up compared to their White counterparts.

Racialized Stress

In this light, we turn to the effect of structural racism on racially minoritized individuals' engagement with the mental healthcare system. Repeated interaction with discriminatory conditions like those described above – scant access to support, low quality of treatment, and likelihood of suffering active psychic injury such as misdiagnosis or microaggressions – make mental health system encounters rife with racialized stress. Brown (2008) notes that the mental healthcare system lacks insight into racialized stress and how this stress can lead to pathology (Anglin et al., 2011; Baldwin, 1984; Clark & Clark, 1939; Delgado, 1982; Outlaw, 1993). That said, there are strong and consistent correlations between perceived experiences of racism and psychiatric symptoms including depression, anxiety, and psychological distress, $r = .20$ (see meta-analysis by Pieterse, Todd, Neville, & Carter, 2012).

One of the most commonly used and psychometrically sound measures used for assessing perceived experiences of racism, racialized stress, and associated methods of coping is the Racism and Life Experiences Scale (RaLES) (Pieterse et al., 2012; Pugh et al., 2021; Utsey, 1998). Peters (2006) observed that Black participants living in the midwestern American housing projects ($N = 162$) reported unusually frequent and severe racist experiences on the RaLES, with these stressors predicting higher rates of chronic

stress. Among Southeast Asian American participants (N = 201), higher reported experiences of racism on the RaLES has been strongly negatively associated with psychological wellbeing (Xiong, 2020). Further, parents' helplessness and denial regarding RaLES-measured racism is related to more depression, anxiety, and reported problem behaviors in their young children (O'Brien, O'Campo, & Muntaner, 2004).

The RaLES was developed specifically to assess how racism and racialized stress influenced healthcare engagement in minoritized populations, with an initial sample of 139 African and Latin American adolescents at a substance abuse treatment program (Harrell, 1994). Since then, the scale continues to be utilized and validated across a diverse range of populations to assess perceived racism in healthcare, racialized stress, and their effect on treatment engagement (Hammond, 2010). Powell and colleagues (2019) used the RaLES to measure racism as a factor of medical mistrust in a sample of 610 Black adults recruited from barbershops across the U.S. (a = .96). They found that experiences of racism and medical mistrust significantly predicted delays in routine medical checkups such as blood pressure screenings.

Another study, using a sample of 154 low-income African American patients at two primary care clinics in Detroit, showed that RaLES-measured perceived racism was positively correlated with healthcare mistrust on the Health Care System Distrust scale (HCSD), r = 0.58, p < 0.001, and negatively correlated with treatment satisfaction and trust in providers, r = -0.47, p < .01 (Benkert et al., 2006). Pugh and colleagues (2021) studied 134 African American individuals (76 male, 58 female; mean age 45.4) at an outpatient clinic, finding a significant negative relationship between RaLES scores (a =

.88) and psychiatric medication adherence. Specifically, as patients' racialized stress increased, their medication adherence decreased.

In sum, mental health research, theory, and treatment is inextricable from the historical contexts in which they were conceived. Psychotherapy has reflected and continues to reflect the racial ideologies, beliefs, and projections of the sociocultural environment it operates in (Cohen et al., 2017; Constantine, 2007; Hall et al., 2015; Sue & Sue, 2008). In the words of Moodley and Kleiman (2018), like a sociocultural Rorschach, "skin color, particularly the color black… becomes a privileged site for the projective interpretations of psychopathology." The clinical and social psychology literature reveals a legacy of prejudice spanning from mental healthcare's roots to present-day, wherein therapists' implicit biases continue to perpetuate racial disparities and consequently, racialized stress (Barksdale, Kenyon, Graves, & Jacobs, 2014). As such, this study will focus on the interaction of clients' racialized stress and therapists' implicit biases, through the lens of system justification, which will be elaborated below.

Because of factors such as racialized stress and awareness of therapist bias, minoritized individuals are less likely to seek out and stay in psychotherapy, even when they have access to it (Holden et al., 2014; Suite et al., 2007). When they do engage in mental health services, they are likely to be wary and vigilant for potential threats from providers and the treatment systems broadly. This wariness is known as *cultural mistrust.*

Cultural Mistrust in the Healthcare System

The stark underutilization of mental health services by racial-ethnic minorities has been well-documented – and quite steadfast – over the past six decades (Anglin, Alberti, Link & Phelan, 2008; Augsberger, Yeung, Dougher, & Hahm, 2015; Hall et al, 2020;

Snowden, 1999; Sue, 1977; Sussman, Robins, & Earls, 1987). A recent survey of over 4 million respondents found that Black, Latino, and Asian Americans were far less likely than European Americans to seek mental health support over the course of their lifetimes (Smith & Trimble, 2016). While most (52%) White Americans seek some form of behavioral services after being diagnosed with a mental disorder, this is true of only about one-third of Black, Asian, and Latino Americans (Jackson et al., 2007; Meyer, Zane, Cho, & Takeuchi, 2009; Villatoro, Morales, & Mays, 2014). Once in treatment, approximately 50% of Black and Hispanic clients will terminate prematurely, in contrast to about 30% of White clients (Terrell & Terrell, 1984; Kilmer et al., 2019).

In their book *Black Rage* (1968), African American psychiatrists Grier and Cobbs explained this pattern in terms of "cultural paranoia"; that is, African Americans' wariness of becoming vulnerable to social systems that have historically abused them. In particular, they contextualized Black individuals' suspicion of mental healthcare within the discriminatory, pathologizing, and exploitative treatment they had come to expect (Boulware et al., 2003; Hays, Holden et al., 2014; Prosek, & McLeod, 2010; Whaley 2001a). Central to the concept of "cultural paranoia" is its adaptiveness, as this mistrust is understood to protect Black people from naively engaging with White-dominated spaces and White individuals that would endanger them (Bell & Tracey, 2006; Terrel & Terrell, 1981; Whaley, 1997). It is worth noting that Grier and Cobbs' push for the recognition and normalization of Black individuals' healthcare mistrust was published four years before the public discovery of the Tuskegee Experiment.

Cultural paranoia – later reformulated as *cultural mistrust* to distinguish it from pathological paranoia – remains a strong barrier to seeking psychotherapy to this day

(Terrell & Terrell, 1981). Historical racial trauma, current systemic toxicity towards minoritized individuals, and cultural mistrust continue to be some of the most salient barriers to Black Americans seeking mental health treatment (Burkett, 2017). Recent studies have identified it as an important factor for Latino immigrants, Asian American students, and religious minorities as well (Bague et al, 2019; Hall et al, 2020; Kim, Kendall, & Cheon, 2017; Schnall et al, 2013). That said, Black Americans and Indigenous peoples consistently report the highest levels of cultural mistrust compared to other U.S. minority groups (Townes, Chavez-Korell, & Cunningham, 2009).

This cultural and systemic healthcare mistrust can be transmitted intergenerationally, but personal experiences of discrimination and long-term racialized stress are cited as its main contributors (Anglin et al, 2011; Whaley, 2001a). For example, Bague et al (2019) showed that personal discriminatory healthcare experiences were the primary predictor of cultural mistrust, hesitance toward mental health services, and treatment dropout in immigrant Latino patients. Although cultural mistrust is understood to be a healthy, adaptive response to a relentlessly unjust and oppressive environment (Benkert et al., 2006; Terrell & Terrell, 1981; Whaley, 2011), high levels of cultural mistrust are associated with isolation, internalized maladjustment, and difficulty identifying and connecting with trustworthy others (Bell & Tracey, 2006; Rotenberg, Boulton, & Fox, 2005), especially in cross-cultural dyads (Brown & Grothaus, 2021).

One expression of cultural mistrust that has been centered in the health psychology literature, particularly throughout the COVID-19 pandemic, is vaccine hesitancy. Studies conducted during the heart of the pandemic found that Black, Latino, and Asian Americans were significantly more likely than White Americans to understand

COVID-19 to be a significant and personal threat to their health (Nino et al, 2021). Black Americans have experienced a particularly devastating impacted from the pandemic, both medically and socially. In 2020, the Pew Research Center found that African Americans were much more likely to know someone who died or required hospitalization due to COVID-19, compared to other racial/ethnic groups. Black Americans describe their experience with the COVID era as marked by acute awareness of inequity in law enforcement (e.g., the murder of George Floyd), healthcare policy (e.g., establishment of testing and vaccination sites non-proximally to Black neighborhoods), and interaction with medical professionals and systems (e.g., being dismissed or infantilized by doctors and government health officials) (Dembosky, 2021).

Several studies examining intersecting factors of cultural mistrust during COVID-19 found that healthcare mistrust was positively associated with concerns about police violence and government institutions (Bogart et al., 2021; Cokley et al, 2021). This racial experience-based mistrust has also been found to impact minoritized individuals' thoughts and hesitations around vaccines. Many racial minorities – and chiefly among them, African Americans – report greater mistrust of the COVID-19 vaccine and more healthcare distrust than other ethnic groups (Thompson et al., 2021). Interestingly, a multi-state needs assessment of Black Americans (N = 2480 adults) suggested that participants who had chosen to receive the vaccine reported lower cultural mistrust but higher perceived discrimination than those who were unvaccinated (Cokley et al, 2021).

Research across social and clinical psychology has examined the effect of cultural mistrust on the therapeutic alliance in particular (Terrell & Terrell, 1981; Whaley, 2001a, 2001b, 2012). Since John Bowlby's work on attachment theory, trust has been

established as a central component of healthy development of both sense of self and relationships with others (Holmes & Slade, 2017; Larsson, 2012; Skourteli & Lennie, 2011). Trust is considered by many to be one of the metrics of therapeutic relationship quality, a core common factor of effective therapy (Fonagy & Allison, 2014; Safran & Kraus, 2014). Trust both sustains the treatment and creates the safe and affirming space for clients to be vulnerable, and therefore open to new relational possibilities (Frank & Frank, 1993; Jordan, 2009; Laughton-Brown, 2010). However, most culturally mistrustful people will never enter therapy, or terminate too early in the process to see positive outcomes; a survey of Black college students (N = 105) found that cultural mistrust was significantly associated with poor opinions of White therapists and low expectations of mental healthcare more broadly. It was also the single strongest predictor of low help-seeking behaviors (Nickerson et al., 1994). In particular, culturally mistrustful patients are most likely to terminate treatment after session one. This suggests that what therapists do in their very first session is a crucial piece of their ability – or failure – to engage minoritized and culturally mistrustful patients (Kilmer et al., 2019).

Overall, cultural mistrust has been strongly and consistently linked to underutilization of mental health services even after clinical diagnosis (Grant-Thompson & Atkinson, 1997; Keating & Robertson, 2004; Smith & Trimble, 2016), higher rates of early therapy dropout (Bague et al, 2019; Whaley, 2006), lower likelihood of recommending mental healthcare to vignette targets across the diagnostic spectrum (Anglin et al, 2008), and more mistrust of medical treatment, including vaccine hesitancy. Within the context of therapy, cultural mistrust predicts weaker alliance (King, 2021; Nickerson et al, 1994), more defensiveness toward interventions (Bruwer et al, 2011;

Hall et al., 2020), and more externalized (e.g., angry) emotional responses to racism both subtle and overt (Moon, 2017). These responses increase the chance of culturally mistrustful patients being perceived as resistant, aggressive, or psychotic (Poussaint & Alexander, 2000; Suite et al, 2007), leading to pathologizing or punitive treatment that further fuels the cycle of mistrust (Keating & Robertson, 2004; Terwilliger et al., 2013). In other words, cultural mistrust is a key mediator of the relationship between patients' racialized stress and their weaker therapeutic relationships.

The following sections will review three main subfields of research on mental healthcare cultural mistrust: effects of therapist-patient racial match (or racial difference) on cultural mistrust; patterns of cultural mistrust toward different domains of the healthcare system; and effectiveness of specific therapeutic interventions as attempted conciliations of cultural mistrust.

Cultural mistrust and racial match. The earliest and most common empirical efforts to ameliorate cultural mistrust have looked to racial-ethnic match between patient and therapist as a core facilitator of the alliance. Yet, there is considerable disagreement in the literature about the degree to which racial-ethnic match strengthens the willingness to seek and stay in counseling. A survey of Black college students found a significant preference for – and reported likelihood of using – mental health services delivered by a Black therapist (Thomas & Cimbolic, 1978). Likewise, Terrell and Terrell (1984) conducted a quasi-experimental study over 14 months with 135 Black patients at a community outpatient mental health clinic, discovering a significantly higher likelihood of terminating after one intake session when assigned to a White counselor as opposed to a Black counselor. In a second controlled experiment, all participants (N = 143 African

American clients) completed the Cultural Mistrust Inventory (CMI; Terrell & Terrell, 1981) before being randomly assigned to one of six clinic therapists – three Black men and three White men. They found a significant relationship between cultural mistrust and premature termination, such that 43% of highly mistrustful patients terminated after one session with one of the White therapists, versus early termination rates of 25% with one of the Black therapists (Terrell & Terrell, 1984). Yet, at higher levels of cultural mistrust, the effect of therapist's race on their early termination became non-significant; neither group of therapists, Black or White, was likely to earn these patients' trust. Terrell and Terrell posit that these patients may have had a heightened awareness of the White-dominated treatment system in which the racially matched dyad existed.

One limitation of this study is that, though the authors found premature dropout among Black clients to be significantly predicted by the interaction of patients' cultural mistrust and "counselors' mistrust," the operationalization of counselors' mistrust was not specified. This exclusion is particularly important as the original version of the CMI is applicable only to Black Americans, and half the study's therapist participants were White. These results suggest that therapy engagement and alliance may be predicted not only by patients' system-mistrusting stances, but by therapists' system stances as well.

Watkins and colleagues (1989) used a therapy analog study to assess 120 Black HBCU students' (50% male, 50% female) comfort with and expectations about treatment with Black versus White counselors. Students completed the CMI and were randomly assigned to one of two therapy vignettes, differing only in one therapist descriptor ("Black" or "White"). Highly culturally mistrustful participants demonstrated lower expectations of the White therapist's capacity to help them navigate general anxiety,

shyness, dating difficulties, and feelings of inferiority, as compared to the Black therapist. However, similarly to Terrell and Terrell's (1984) findings, highly culturally mistrustful students reported that they did not believe any therapist, Black or White, could help them manage issues of sexual functioning. These results indicate that particularly high levels of cultural mistrust – or cultural mistrust heightened by self-consciousness – is an effective deterrent even to racially matched therapeutic engagement. A balder example of non-significant effects of racial match was found by Fyffe (2000), whose sample of Black female undergraduate students (N = 182) perceived their Black and White therapists as equally trustworthy and multiculturally competent regardless of their own levels of cultural mistrust. The exception was participants with very low levels of cultural mistrust, who judged their White therapists to be *more* trustworthy than their Black counterparts.

These results highlight the potential role of internalized racism or horizontal hostility (i.e., racist beliefs held by minorities, toward other minorities) operating in the reverse, decreasing perceptions of racial-minority therapists' competence. Benkert and colleagues (2006) found (N = 154 Black, Detroit-based outpatients) that, across levels of cultural mistrust, Asian healthcare providers were perceived as *less* trustworthy than either Black or White providers. In addition, interview data indicated that noticeably "foreign" healthcare providers (e.g., those with non-American accents) tended to garner more suspicion than either Black or White clinicians. In a particularly dramatic example, one process study (N = 100 Black female undergraduate students) found that culturally mistrustful students provided *more* self-disclosures with White female counselors than with Black female counselors (Thompson, Worthington, & Atkinson, 1994). Overall, the literature on racial match as a potential mitigator of cultural mistrust is mixed, with the

imagined effects of therapist-patient match on the alliance emerging as more significant than the alliance effects of racial similarity within real-life therapeutic dyads (Nickerson et al., 1994; Thomas & Cimbolic, 1978). In light of this evidence, the present study will circumvent the potential confounding variable of participants' perceptions of the alliance based on racial similarity, instead providing therapy conditions in written form without markers of the therapist's race or other demographics. Instead of match of patient-therapist racial identities, this study will elaborate on match of patient-therapist system orientations, a variable strongly associated but not synonymous with race.

Domains of cultural mistrust. Research exploring the characterology of cultural mistrust has consistently found that racial-ethnic minorities' mistrust of the healthcare system maps far more closely onto suspicions about the healthcare system's ethics and equitable practices, than about their competence. Whaley (2001b) surveyed 154 Black clients at a psychiatric inpatient unit at a Northeastern U.S. hospital (112 male, 42 female; mean age 38, SD=10). Eighty percent of the participants had been diagnosed with schizophrenia, 15% with other disorders (including anxiety, mood, personality, and substance-related disorders), and 5% had been given no diagnosis. As hypothesized, participants with higher levels of mistrust had more negative views of White therapists than their less mistrustful counterparts. More unexpectedly, however, these more culturally mistrustful patients also believed that White therapists were *more* competent and equipped with a higher quality of professional training.

Along parallel empirical lines, Anglin, Alberti, Link and Phelan (2008) randomly assigned a sample of 665 participants (583 White and 82 Black adults) to read one of three vignettes about an individual with schizophrenia, depression, or a non-clinical

control. They found that Black Americans were less likely to recommend therapy to any of the vignette individuals – a disparity significantly predicted by cultural mistrust. Interestingly, this fear of mental healthcare was distinct from participants' evaluations of psychotherapy's effectiveness, which Black Americans rated *more* highly than their White counterparts. Armstrong and colleagues (2008) found similarly that racial differences in HCSD-measured healthcare mistrust were significant only for mistrust in the healthcare system's *values*, but not for mistrust in its *competence* (N = 255 hospital patients, 144 Black, 92 White; competence distrust subscale: 10.4 vs 10.3, p = .85; values distrust subscale: 15.4 vs 13.8, $p < .01$). These results suggest that minorities' cultural healthcare mistrust may entail viewing the healthcare system as very effective for some (the majority of treatment-seekers, even) but less so for others (i.e., Black people), related particularly to lack of faith in providers' fairness and ethical values.

Clinical interventions for cultural mistrust. Despite being widely recognized as an important aspect of minority patients' treatments, there is limited research on the clinical effects of interventions focused on mitigating cultural mistrust. Those studies evaluating the alliance impacts of specific cultural mistrust-focused interventions have produced non-significant results. That said, those studies will be described below in some detail both to demonstrate cultural mistrust's steadfastness and relative unresponsiveness to a variety of well-founded clinical interventions, and to highlight gaps in the literature that the present research will hope to address.

Within the small body of empirical research on clinical interventions for cultural mistrust, the use of therapy vignettes as experimental manipulations is common for evaluating outcome differences. King (2021) posited that Black individuals' cultural

mistrust would be alleviated by therapists who overtly acknowledged patients' cultural mistrust and exacerbated by therapists who ignored it, and that these would have positive and negative effects on the therapeutic alliance, respectively. King conducted a process-outcome study [i.e., research that seeks to identify specific variables at play in psychotherapy interactions (process) and measure their effect on client change (outcome)] with a sample of 67 African American adults. Participants completed the CMI and were randomly assigned to one of two therapy vignette conditions. In one vignette, the therapist directly acknowledged the client's cultural mistrust; in the other, the therapist did not acknowledge the mistrust overtly. Last, all participants completed the Working Alliance Inventory (WAI), which measures perceived strength of the therapeutic relationship. Higher cultural mistrust was a significant predictor of lower reported alliance; however, there was no significant effect of the therapist's response on participants' perceptions of the alliance.

A similar process-outcome study was conducted by Ward (2002) using 15 clinician-patient pairs, where the patient was a self-identified person of color (clinicians: 84.6% female, 15.4% male; 76.9% White; gender demographics for patients not reported). All patient participants completed the CMI prior to treatment, and therapists' self-reported multicultural competence was evaluated across four separate measures. Like King, Ward found cultural mistrust to be the single most significant predictor of clients' lower perceptions of the working alliance on the WAI. With cultural mistrust controlled for, therapists' multicultural competence had no significant effect on clients' reported perceptions of the alliance.

In further support of cultural mistrust as a powerful – even overriding – factor in interpersonal exchanges, participants in a vignette study (136 Black Canadian adults, ages 18-64, 27% male, 73% female) completed the CMI and were randomly assigned to one of three bias vignettes. The first vignette condition included overt discrimination and the second, more subtle (microaggressive) cues. The third, control, condition included no discrimination cues at all. Cultural mistrust significantly predicted externalized emotional responses (e.g., anger) to all vignette conditions without any other significant moderating effects (Moon, 2017).

One consistent limitation of this previous research is that the samples they utilize are quite small – King's (2021) experiment included only 33-34 participants per condition. Ward (2002) studied 30 people altogether; and Moon's (2017) sample studied 45-46 participants per condition. Another limitation is that these studies have typically measured either cultural mistrust broadly *or* healthcare mistrust in particular (Brooks & Hopkins, 2017; Hall et al., 2020; King, 2021; Moon, 2017; Ward, 2002), leaving a gap in regard to how these domains of mistrust interact. While some studies on healthcare-specific mistrust use larger samples, they have typically included few people of color (Armstrong et al., 2008). On the other hand, most prior studies into cultural mistrust in the working alliance use only the CMI (Hall et al., 2020; King, 2021; Moon, 2017; Ward, 2002). This scale is highly specific to the Black experience and has been used only rarely with other non-White populations (e.g., Ward, 2002). The phraseology of the CMI has also been criticized for synonymizing Black individuals' perceptions of "White people" (or "White friends") with their experience of White-dominated social systems (Fields, 2014). As such, research into cultural mistrust using measures that are both precise and

normed on diverse samples is warranted. Finally, experimental studies of cultural mistrust in therapy have typically evaluated the roles of specific therapeutic behaviors, such as microaggressions, avoiding topics of race, and focusing on individualistic explanations for clients' concerns (Hall et al., 2020; King, 2021; Moon, 2017; Pomales et al., 1984; Thompson et al., 1994; Ward, 2002). However, research has yet to be conducted on the role of the overarching ideologies informing these therapeutic behaviors, which the present study hopes to address.

System Justification

In exploring why dramatic increases in theoretical knowledge of multicultural issues have made a comparatively limited impact on clinical practice, system justification theory [SJT] explains that there is a consistent motivation within individuals to defend and reinforce the status quo of their social systems (Jost & Banaji, 1994; Jost, Banaji, & Nosek, 2004; Jost & Hunyady, 2005; Wakslak, Jost, & Bauer, 2011). System justification is activated and amplified by various relational, epistemic, and existential factors (such as aversion to relinquishing power, discomfort with ambiguity, etc.) and often outside conscious awareness, particularly when it conflicts with self-reported beliefs (Mentovich & Jost, 2007). This system-justifying motivation is powerful enough to persist despite evidence to the contrary or even opposition to one's self-interests (Jost, 2019; Jost & Banaji, 1994). As such, people who are themselves marginalized by a particular system can be prone to justifying it (Stets & Burke, 2000), particularly when they are system dependent (Kay et al., 2009), and/or when faced with a challenge, threat, or criticism to that system (Ullrich & Cohrs, 2007).

Vignette primes and manipulations activating various aspects of system justification have been used reliably in over twenty studies (see review by Jost et al., 2015). Recently, Strupp-Levitsky (2021) used an experimental manipulation comparing participants' system justifying reactions to either a paragraph about White privilege or a control paragraph about chairs (N = 500 White participants via Amazon MTurk Prime/"Cloud Research"), including the effect exerted by participants' White racial identity, social dominance orientation, and self-regard. Results showed that participants with low White racial self-regard tended to defend the racial status quo when confronted with evidence of White privilege, while those who were racially secure were more open to acknowledging systemic racism and incorporating information about White privilege.

System justification theory builds on several social psychological findings, including Festinger's (1957) cognitive dissonance theory, which states that cognitive inconsistencies produce an uncomfortable tension known as dissonance, naturally inciting efforts to reduce that dissonance by resolving the inconsistencies. Like all types of motivated reasoning, this process is propelled by the wish to reinforce favorable beliefs and to refute unfavorable beliefs, particularly about oneself (Aronson, 1968). An extensive history of research has investigated the functions of dissonance-resolution as an ego defense (Stone & Cooper, 2001). These dissonance responses can be motivated by desires to preserve an established self-image (e.g., Aronson, 1968), to maintain a sense of being "good" (e.g., Steele & Liu, 1983; Stone et al., 1994), and/or to absolve oneself of guilt after seeing negative consequences of one's actions (e.g., Cooper & Fazio, 1984).

Within this framework, SJT focuses specifically on the conflict between deeply engrained, majority-serving beliefs that societal structures are essentially fair and

evidence of systemic injustice, such as the oppression of minoritized groups (Jost & Banaji, 1994). One way that people maintain their belief in the justness of the system's status quo when faced with evidence of the opposite is by presuming that those disadvantaged by the system deserve their inferior status – thereby restoring cognitive consistency (Jost & Hunyady, 2005). This intransigent faith in society's fairness, to which new information must conform, soothes a variety of epistemic, existential, and relational anxieties, such as decreasing ambiguity, bolstering perceptions of a commonly shared reality, and allaying fears of being themselves hurt by a capricious, unjust system (Jost et al., 2007; van den Bos, 2009; Vargas-Salfate et al., 2018). System justification is related, though not interchangeable, with just-world beliefs (Lerner, 1980) – that is, the assumption that society is generally fair and individuals get what they each deserve (i.e., bad things happen to bad people and good things happen to good people). Murray (2014) found that, when primed with an ethical dilemma, people who were higher in just-world beliefs were more likely to take on system justifying stances such as victim blaming.

This palliative work is an effective method reducing emotional distress, if not an empathic one (Napier et al., 2020). System justification allows individuals to discount abuses and see the world as predictable, rational, moral, trustworthy, and safe (Jost & Hunyady, 2005; Lerner, 1980). In this way, both advantaged and disadvantaged individuals can be motivated to defend a given system at the expense of its victims when exposed to evidence of its injustices (Jost, 2019). However, this orientation to social structures may have significant ramifications when interacting with people who have been marginalized by those systems, particularly if they have insight into these abuses

and/or are less system justifying. For these reasons, it is important to examine the effects of therapist system justification on their culturally mistrustful patients.

The SJT literature asserts that justification occurs at three distinct levels: the ego (micro) level, the group (meso) level, and the system (macro) level (Jost & Banaji, 1994). At the ego level, one is motivated to justify their perception of themselves as a fair, good, and just person. At the group level, they are motivated to see their immediate group – racial, religious, proximal, etc. – as fair, kind, and generally superior. And last, at the system level, predominant social systems within which one participates are defended and viewed as equitable, effective, and just. Threats and their system-justifying responses may occur on a specific system level (ego/micro, group/meso, or system/macro), or they may activate a generalized justification across multiple structural levels known as spreading rationalization. A principal example of spreading rationalization was found in a sample of 167 Canadian college students in romantic relationships. Participants who were primed with material challenging the ideal of committed relationships showed more justification for committed relationship systems. They also reported more justification for the Canadian government than controls. In other words, threats to micro-level interpersonal systems activated justification at the larger political level (Day, Kay, Holmes, & Napier, 2011). Challenges to social orders such as workplace hierarchies, high school networks, and family systems are found to activate similar justification patterns across multiple system levels (Thomas & Meglich, 2019; Wakslak, Jost, & Bauer, 2011).

Neither are medical and mental healthcare providers immune to system justifying processes. Perceptions of immigrants as threatening the healthcare system predicted medical providers' system justification when asked to evaluate a series of vignettes of

discriminatory treatments of immigrant patients (Gama & Dias, 2018). Therapists prompted to prove their effectiveness (for example, while building a client base for private practice or applying for research funding) were more likely to justify colorblind treatment systems (Hall & Yee, 2011). Aryan and Carlino (2011) theorized that therapists' emotional investment in their chosen theoretical orientation could make them more reactive to criticisms of those treatment systems and less willing to account for the modalities' weaknesses and areas of stagnation (Mehler & Mehler, 2003; Safran & Messer, 1997); in other words, more system justifying.

Racially and systemically charged stimuli have been found to induce anxiety, doubt, guilt, and dissonance stress, which individuals – especially those who benefit from the status quo – may soothe using system justifying ideologies (Jost & Hunyady, 2005). Cultural mistrust may be conceptualized as a similar system threat for therapists, with implications across the ego, group, and system levels. Questioning the fairness, equity, and effectiveness of psychotherapy can evoke a wide range of anxieties in therapists, who are heavily invested in, and reliant on those systems. System-justifying ideologies, then, would serve the function of reassuring the therapist that their individual treatments – and the broader treatment systems more generally – are in fact fair and effective, alleviating their dissonance stress. Voicing these ideologies in session may also serve to control or decondition clients' doubts about the therapeutic process.

Taken together, system justification can help explain why, despite conscious values of honoring cultural mistrust, it is still often pathologized and divested of its environmental contexts in therapy (Hays & Iwamasa, 2006). A patient's expression of cultural mistrust may be perceived as a challenge to the healthcare system at the ego,

group, and systemic levels (e.g., the healthcare structure [system], the treatment modality [group], and the effectiveness and fairness of individual psychotherapists [ego]). If perceived as a multi-level system threat, therapists may be activated to justify any or all of those systems to mitigate the discomfort of encountering their biases and weaknesses, as well as perceived weaknesses with the mental healthcare system broadly. The hierarchical and change-resistant therapist responses that subsequently emerge may serve to only further fortify their marginalized patients' mistrust.

Therapeutic Implications of System Justification

Research on system justification in mental health care has typically focused on one of three strongly related and at times overlapping phenomena: color-blind racial ideologies (CBRI), victim-blaming, and mismatch of therapeutic focus ("misattunement"). As noted, although these facets of SJ have been studied within mental healthcare, SJ itself has never been studied empirically as a component of the therapeutic process. Thus, the clinically relevant research on these SJ subdomains will be reviewed here in some detail to outline the models previously used to examine SJ-based phenomena within mental healthcare. Specifically, it will highlight established research methods that the present study will draw upon to explore SJ itself, and in particular, the way SJ may activate and limit therapists' responsiveness to patients' mistrust.

Color-blind racial ideologies. Perhaps the system-justifying belief that has earned the most attention within clinical psychology research is the effect of color-blind racial ideologies (CBRI) on therapeutic alliances and outcomes. In one of the first studies on CBRI in mental healthcare, Schofield (1986) defined racial color-blindness as the "view which sees racial and ethnic membership as irrelevant to the ways individuals are

treated" (p. 232; as cited by Neville et al., 2000). Like all types of system justification, people of any racial group or level of privilege can adopt CBRI to mollify anxiety about being benefited by and/or dependent on unjust social hierarchical structures, and to allay fears that these structures may be worthy of criticism (American Psychiatric Association, 2012; Jost & Banaji, 1994; Neville et al., 2013; Neville & Thompson, 1999; Yogeeswaran et al., 2018).

CBRI is significantly related to racial prejudice and discriminatory conduct (e.g., Apfelbaum, Sommers, & Norton, 2008; Neville et al., 2000; Norton et al., 2006). Multiple studies have found that in conflictual or threatening social interactions, CBRI increases racialized hostility toward minority targets, whereas multicultural perspectives are associated with more reflective efforts to make sense of the other's behaviors (Correll et al., 2008; Vorauer & Saski, 2011). White college students who avoided the topic of race while working together with a Black peer were judged as less friendly, partly due to making less eye contact (Apfelbaum et al., 2008; Norton et al., 2006). Furthermore, less awareness of racial privilege and other racial issues among White undergraduates was associated with weaker empathy and perspective taking more broadly (Mekawi et al., 2017). CBRI can also lead to victim blaming as a means of legitimizing social inequalities (Neville et al, 2009). Marshall (2012) found that high-CBRI police officers, court officials, and child welfare workers were more likely to attribute disproportionate rates of Black children moving from foster care to the juvenile justice system on individual factors – the families or the children themselves. Low-CBRI participants were more likely to use macro-level (system) explanations of the disparity.

CBRI has similarly destructive ramifications for the therapy process. Clinical research has consistently found a significant negative relationship between CBRI and multicultural competence (Burkard & Knox, 2004; Chao et al., 2011; Spanierman et al., 2008). Thompson, Worthington, and Atkinson (1994) conducted a quasi-experimental study with 100 Black female college students (17-23 years old) who attended a therapy session with a female therapist under either a cultural condition (wherein the therapist would openly discuss race) or a CBRI condition (wherein the therapist would deflect conversation of race). Participants in the cultural condition disclosed more deeply and rated the counselor higher on the Working Alliance Inventory than the CBRI-adherent counselor. Consistent with the findings of other studies, therapists' ignorance or avoidance of racial material registered as a noticeable misattunement that had significant negative implications for the therapeutic alliance (Manuppelli, 2000; Sue et al., 2019).

Most research into CBRI (e.g., Holoien & Shelton, 2012; Richeson & Nussbaum, 2004; Wolsko et al., 2000) has used experimental manipulations with at least two conditions (such as "colorblind" v. "color-conscious"); a model that the present research will apply to system justification more broadly (using "high SJ" v. "low SJ" conditions).

Victim blaming. As noted, system justification involves not only defense of the systemic status quo but deflection of blame for inequalities to disadvantaged individuals (Jost & Banaji, 1994; Thompson et al., 1994). For example, CBRI argues that race and power differences have little impact on interpersonal outcomes, and thus that "any failure to achieve is therefore the fault of the person of color themselves" (p. 14, Frankenberg, 1993). Similarly, system justification is associated with blaming victims, as a means of reducing the dissonance between an innocent person being hurt and a society that is

presumed to be inherently just (Gawronski, 2012; Lerner, 1980). Stahel, Eek, and Kazemi (2010) conducted two studies presenting participants with a vignette of a fictional rape victim to assess the relationship between system justification and victim blaming. The first found that modern sexism, a type of gender-based system justification, was positively related to men's, but not women's, victim blaming. The second experiment found that exposing participants to primes of stereotypically female traits ("sensitive", "weak", "emotional", etc.) both positive and negative, increased women's rape victim blaming. These exposures did not have any significant effect on men's victim blaming. These studies demonstrate the association between socially charged material and deflection of blame to victims of injustice in defense of the idea of a just world.

In therapy, system justifying attitudes may also turn into blame of those disadvantaged by the system, in order to maintain the image of an equitable and effective treatment system. In a sample of 247 psychologists, Burkard and Knox (2004) demonstrated that higher levels of CBRI predicted higher rates of attributing Black patients' – but not White patients' – mental health difficulties to the patients themselves. Salter and Adams (2013) argue that system justifying ideologies like CBRI are inherently inappropriate with systemically marginalized clients as they locate their psychological distress in "isolated individuals abstracted from social context" (p. 781). These individualistic positions assume that if something in the treatment is not working, the problem – and the power to mitigate the problem – is located in the individual (Salter & Haugen, 2017). Attributing difficulties to failures of choice or effort within the patient may assuage therapists' self-blame, anxiety, and doubt in the treatment system, but may jeopardize alliances with clients whose stressors are systemic (Neville et al., 2012; Salter

& Adams, 2013). Based on these results showing that system justification is common within both system-advantaged and -disadvantaged groups, this study will hypothesize that minority identity alone will not mediate response to system justification in therapy. Instead, subjective distress from racial/systemic stressors (as measured by the RaLES) and resulting cultural mistrust may be more meaningfully connected to one's experience of mental healthcare system justification.

Misattunement. Complicating these concerns is that disadvantaged individuals – those whose lived experience is most likely to activate system threat and resultant system justification – also tend to be those for whom system issues are most central to their presenting problems (Sue & Sue, 2008). For example, Javier and Herron (2017) found that people at lower socioeconomic statuses are more likely to bring cultural and systemic concerns into their treatments. They also tend to report higher rates of general interpersonal mistrust, which can impact the early therapeutic alliance (Fyffe, 2000). Similarly, gender and sexual minorities' experiences of school and workplace discrimination, guilt for not meeting prevailing cultural standards, and poor social support related to their identities are leading reasons they present to therapy (Dworkin & Yi, 2003; U.S. Surgeon General, 2001).

Numerous studies attest to the impact of sociocultural stressors on minoritized individuals' emotional distress, including higher rates of poverty, incarceration, barriers to healthcare access, racialized stress, and physical, domestic, and sexual violence (Cho et al., 2020; Hays et al., 2008; Keating & Roberson, 2004; U.S. Department of Health, 2001). These lead to higher rates of trauma- and stress-related disorders, depression, anxiety, substance abuse, and suicide, as well as heart disease, cancer, and hypertension

(Assari et al., 2019; Williams et al., 2018). Racially minoritized patients also tend to have a clearer awareness of the mental healthcare system's connections to law enforcement and hospital systems (e.g., mandated reporting, involuntary commitment), within which people of color continue to be disproportionately incarcerated, institutionalized, and brutalized (Sue et al., 2019). Accordingly, exploring sociocultural issues is frequently a priority for minoritized patients' treatments and effective alliances (e.g., Atkinson & Lowe, 1995; Zhang & Burkard, 2008). For instance, research has found that compared to White male participants, Black male participants are more likely to see exploring race and historical racism as a vital component of successful therapy (Thompson et al., 2004).

System considerations may be especially relevant in the context of cultural mistrust. Maultsby (1982) found that, for African American clients, mistrust in the treatment relationship was closely associated with their mistrust of other systems, such as the government, healthcare, and law enforcement. Over twenty years later, Rose, Peters, Shea, & Armstrong (2004) found the same: that healthcare mistrust was highly correlated to mistrust of other social systems in their participants of color, whereas that was not the case among their White participants. Armstrong and colleagues (2013) conducted a random-digit phone survey (N = 2,179; 762 Black adults and 1,267 White adults) across 40 U.S. metropolitan areas. They observed that cultural healthcare mistrust as measured by the Health Care System Distrust scale (HCSD) was significantly and positively related to experiences of racial discrimination for Black participants ($B = 0.86$, $SE = 0.05$, $p < 0.001$) but not for White participants. Another study conducted semi-structured interviews with 37 Black and Hispanic individuals with HIV in New York City. They found that more awareness of structural racism informed more healthcare system distrust,

which limited the degree to which participants felt they could trust their doctors to help them make treatment decisions (Freeman et al., 2017). These support the conceptualization of the therapeutic alliance as a "microcosm of the larger society" in regard to cultural mistrust (Whaley, 2001, p. 515).

Overall, these patterns – color blind racial ideologies, victim-blaming beliefs, and misattunement or mismatch of therapeutic focus – are three established manifestations of system justification in mental health care. These have been found to decrease friendliness, reflectiveness, and perspective-taking in interracial therapy dyads, increase the change of retraumatizing victims of personal and systemic abuse, and limit therapists' ability to grasp and respond to disadvantaged clients' treatment needs; empathic failures that have significant ramifications for therapists' ability to build alliances with those clients. These therapist behaviors have been established as gaps of clinical competency with important ramifications for the alliance, often facilitating emotional disengagement, alienation, feelings of unsafety, and higher rates of early treatment termination among clients of color (e.g., Ancis & Szymanski, 2001; Plaut et al., 2009; Salter & Adams, 2013; Thompson & Neville, 1999). This study poses the argument that the system justifying ideologies underlying these color-blind, victim-blaming, and misattuned perspectives may be a vital piece of culturally insensitive treatment as well, with similarly grave clinical consequences. Ancis and Szymanski (2001) found that therapists' familiarity with issues of privilege, prejudice, and power are more equipped to recognize them in session, and to know how to intervene when they come up. The present research hopes to add to the field's growing understanding of these systemic issues so they can be more readily recognized and responded to in the therapy room.

In service of this argument for the relevance of system justification to multiculturally competent practice, a number of studies have found that counselors who are more capable of reflecting on system threats such as undue privileges or structural racism are stronger in several important domains of multicultural competence (Arredondo, 1999; Case, 2015; Hays et al., 2008; Mindrup et al., 2011; Pewewardy, 2004; Tummala-Narra & Kaschak, 2013), including less use of ethnocentric principles and racial stereotypes, more awareness of systemic contexts of clients' experiences, more openness to alternative perspectives, and more client-centered methods of inquiring about culture (Neville et al., 2006; 2013; Shin et al., 2005; Sue et al., 1992). A cyclical pattern also exists between power-consciousness and multicultural competence: in a sample of 370 clinical psychology students, Chao and colleagues (2011) found that CBRI moderated the effect of multicultural training on therapists' competence such that the impact of multicultural training decreased as CBRI increased; as race reflectiveness increased, the effect of multicultural training increased. In turn, multicultural fluency in therapists has been found to contribute robustly to the likelihood of a positive therapeutic alliance with patients of color (Ancis & Sanchez-Hucles, 2000; Moss & Singh, 2015). Therapists with lower levels of CBRI are better at perspective taking with minority clients, more skilled with cultural interventions, and better at navigating interracial issues in therapy and supervision (Arredondo, 1999; Utsey et al., 2005).

Moreover, awareness of how one's own cultural values, beliefs, and biases impact the alliance is considered a basic criterion of multicultural competence (Sue et al., 1992). A meta-analysis by Moss and Singh (2015) stressed the role of White therapists' knowledge of how racism and privilege factored into their own work as critical to their

ability to establish positive alliances with culturally different clients (Ancis & Sanchez-Hucles, 2000; Garcia, 2019; Mindrup et al., 2011). A qualitative study of Black doctoral student mentees (N = 10) found that awareness of power imbalances in the mentee-mentor relationship itself, in addition to color-consciousness in society more broadly, was necessary for trust (Brown & Grothaus, 2021). Awareness of power imbalances between therapists and patients implies the capacity to manage threats not only to the larger mental healthcare system, but to the ego system (one's own goodness, fairness, and competence as a clinician). This reflective capacity may be particularly relevant to cultural mistrust, which can be seen by therapists as a more personal accusation than the existence of bias more generally, and therefore a greater ego or system threat.

Gawronski (2012) asserts that the avoidance of system justification is made possible by system ambivalence – the recognition of both positive and negative characteristics of a given system. Whereas system justification is used to resolve inconsistencies between one's positive representation of society and indications of its more negative attributes, ambivalence makes such efforts unnecessary, allowing both positive and negative features to coexist (van Harreveld, van der Pligt, & de Liver, 2009). To the degree that individuals are able to maintain ambivalence that recognizes and puts system flaws into context, they are capable of sustaining system threats without resorting to individualizing negative outcomes (i.e., victim blaming) to restore consistency (Gawronski, 2012). Ambivalence, then, can be viewed as a vital part of acknowledging imbalances of power and privilege, which is necessary for system-conscious alliance building (Arredondo, 1999).

Overall, the individualistic, color-blind, and power-evasive ideologies of system justification are related to weaker empathy, poorer clinical competence and therapeutic alliances with people of color, and potential damage to these clients' psychological wellbeing. Conversely, fluency with systemic (rather than individualistic) positions on clients' difficulties is a crucial aspect of working effectively with disadvantaged clients. Therapists must be able to address racial dynamics and power imbalances not only in society at large, but in the therapeutic dyad itself (Hays et al., 2008). To achieve this, they must be capable of scrutinizing their own cultural identities, attitudes, beliefs, and system relationships (Neville et al., 2013). Maintaining ambivalence, which accounts for both negative and positive system attributes, can facilitate reflectiveness and empathy when faced with evidence of structural failings (Gawronski, 2012). This may help therapists respond productively to challenges to the ego, group, or macro-level systems they operate in, such as patients' cultural mistrust, rather than resorting to system justification to resolve the dissonance (Arredondo, 1999). As such, therapists' system justification may demarcate their effectiveness in alliance-building with racially minoritized clients.

Therapist system justification may be particularly relevant with culturally mistrustful clients because system relationships are more linked to their alliances and more central to their presenting problems (Ridley, 1984). Cultural mistrust may also be interpreted by therapists as a treatment system threat, engendering retaliation (Keating & Robertson, 2004). However, though many subsets of system justifying attitudes have been empirically examined in a therapy context, therapist system justification itself has been studied only rarely (see Hall & Yee, 2011; Sitrin, 2022 in preparation), and its effect on patients studied not at all. This study aims to contribute to that research using a similar

experimental model to prior studies of SJ beliefs, like CBRI (Ancis & Sanchez-Hucles, 2000; Moss & Singh, 2015). As such, it will evaluate the alliance effects of system-justifying practices and their opposite, which will be elaborated in the next section.

System-Oriented Practices

The preceding sections provided a synopsis of the pitfalls of system-justifying (i.e., individualist, color- and power-evasive) clinical approaches and highlighted the need for system ambivalence, particularly when addressing cultural mistrust. This section will review the current literature on system-oriented practices – methods of resisting system justifying ideologies such as individualism and CBRI in therapy – as first articulated by Thompson and Neville (1999). These guidelines were used to create the vignette conditions – and particularly the "low system justification condition" validated in the pilot study and administered in the principal study.

In their 1999 article "Racism, Mental Health, and Mental Health Practice," Thompson and Neville outline two elements of system-oriented practice: (1) *recognition of power imbalances and racial inequalities* as an objective reality that impacts interactions, including in the therapeutic alliance; and (2) *promotion of patient autonomy*, dignity, and self-determination in treatment. These map closely onto Metzl and Hansen's (2014) model of "structural competency," which views medical healthcare through the lens of societal and racial hierarchies. It involves similar core competencies of (1) acknowledging oppression and its structures that inevitably inform the framework of medical care; and (2) developing "structural humility," or deference to the patient to determine if and in what ways treatment fits their needs. Each of these elements will be

detailed below, specifically in regard to cultural mistrust, which Metzl and Hansen highlight as a prime example of structural dynamics brought into the clinical encounter.

Recognition of power imbalances and racial inequities. Rather than viewing patients' symptoms as primarily internal to them, the system-oriented/structural competency model of therapy views symptoms as inextricable from their external social, cultural, and political contexts (Ali & Sichel, 2013). This entails centering the impact of historical and current racism, gendered oppression, and other imbalances that frame patients' mental health difficulties (Neville et al., 1999; 2013). As described in earlier sections, system-justifying clinical approaches individualize treatment by defending or overlooking race, power, and structural systems, instead locating the need for change in the patient themselves and essentially blaming them for their own subjugation (Ortiz & Jani, 2010; Salter & Adams, 2013). In contrast, system-oriented practices involve recognizing the realities of racism as a living, important influence that may inform the patient's experience, and their mistrust (Akhtar, 2018; Ortiz & Jani, 2010).

Along parallel lines, Brown and Grothaus (2021) conducted an in-depth qualitative study into the traits of doctoral program mentors (N = 10, 5 White, 5 Black) that contributed to or detracted from their perceived trustworthiness per their Black mentees. He observed that mentors' willingness to initiate and engage in potentially difficult conversations about the realities of race was one of the most important indicators of a trusting relationship with Black mentees. Similar results have been found in psychotherapy research; White counselors who are able to "broach" (i.e., initiate conversation about race and culture) have been rated more highly on scales of credibility and working alliance with patients of color (Zhang & Burkard, 2008). One such study

asked African American adults at a local community center (N = 53) to "scientifically" assess one of two White counselors they were told were under consideration for hire by the center. The two bios differed only in that one was described as preferring to address racial and cultural differences directly and the other preferred not to; the former was evaluated as significantly more effective than the latter (Poston et al., 1991).

While it is vital to be mindful and honest about systemic racism in the world at large (e.g., Constantine, 2007; Hays et al., 2008; Neville et al., 2013), system-oriented practice must recognize the power dynamics in the room as well, such as race, gender, and role differences between therapist and client. Salter and Adams (2013) emphasize reflecting imbalances and inequities to the patient as they are, rather than operating from an aspirational view of the healthcare field. Instead, structural competency models recommend meeting patients in their valid mistrust of the healthcare system's Eurocentric values, historical abuses, and current color-blind practices (Ortiz & Jani, 2010).

Promotion of patient autonomy. That said, solely acknowledging reasons to mistrust is not sufficient. From a system-oriented perspective, the patient must also feel empowered to delay, refuse, or adjust the treatment frame based on their needs and concerns (Freeman et al., 2017); in Waite and Hassouneh's (2021) words, to "live a good life as they define it" (p. 94). Structural competency models challenge the hierarchy of clinician-as-expert and uplift the patient's self-knowledge as it pertains to their treatment planning (Ali & Sichel, 2014).

System-oriented practices are geared toward creating space for negativity within a complex treatment system that is understood to be both potentially helpful and potentially harmful – that is, within system ambivalence. As mentioned, research into the "backfire

effect" (see meta-analysis by Sato & Takasi, 2020) suggests that when healthcare-mistrusting individuals are presented with direct refutations of their fears, the more fortified their fears become. One classic study into cultural mistrust-based vaccine hesitancy separated MMR vaccine-hesitant parents (N = 1,759 caregiver pairs) into condition groups and presented each with one of four educational, emotional, and relational exposures with the goal of increasing intent to vaccinate. The now-infamous abstract reads: "None of the interventions increased parental intent to vaccinate a future child. Refuting claims of an MMR/autism link successfully reduced misperceptions that vaccines cause autism, but nonetheless *decreased* intent to vaccinate" (p. 835, Nyhan et al., 2014). Similarly, Metzl and Hansen (2014) suggest that emphasizing only the mental healthcare system's positive attributes may in fact increase patients' sense of unsafety. In contrast, multiple studies into doctoral mentorships have showed that the ability to express negative feelings without adverse consequences can increase satisfaction with the (ego-level) mentoring dyad and the (group-level) University structure (Brown & Grothaus, 2021; Farrell, 2007; Harper, Patton, & Wooden, 2009). This suggests that negative system representations may in fact become more positive when responded to with system ambivalence and recognition of legitimate reasons to mistrust.

To this end, the "low system justification" condition used in the present research will seek to reflect not only system justification in its simplest form, but the system-oriented practices of recognition of inequities, promotion of patient autonomy (e.g., transparency into mental healthcare processes), and system ambivalence.

A prominent limitation of system-oriented practice is its recency, and therefore the dearth of empirical research supporting it. The research that does exist is in the

medical healthcare field. A sample of 154 Black outpatients with high cultural mistrust, as measured by the CMI, reported significantly greater levels of trust with nurses whose training emphasized "listening to [clients'] stories and sharing decision-making" than with controls, $t(143) = 3.62$, $p = 0.000$ (Benkert et al., 2006). A qualitative study on these topics suggested that nurses with higher levels of structural competency were more effective at navigating issues of mistrust and integrating social determinants of health in their assessments of Black and Latino patients with HIV-AIDS (Freeman et al, 2017). Further, several process-outcome studies (Calvert, 1984; Chowdhary et al., 2014; Mahrer, 1975) have found alliance to be predicted by patient-therapist agreement on the degree to which patients' stressors are internal (i.e., based in the patient's sensations and feelings) versus external (i.e., based in their interaction with the outside world). This research supports the promise of system-oriented practice as a potential piece of multicultural intervention, well-suited to issues of cultural mistrust, particularly when taken together with the robust evidence of the weaknesses of its opposite, system-justifying practice.

System-oriented practices that emphasize structural competency (that is, the trained capacity to locate patients' presenting problems, experiences, and clinical encounters within the greater systemic contexts they occur in) may prove beneficial as a blueprint for navigating patients' cultural mistrust (Freeman et al., 2017; Metzl & Hansen, 2014). This involves shifting the lens from particularistic, subjective reasons for mistrust to objective, societal reasons, and advancing patient autonomy and self-determination in the treatment process (Ortiz & Jani, 2010). However, these theories are currently limited by a scarcity of empirical support; the present study would be the first to quantitatively assess the alliance effects of system-oriented practices.

Alliance differences in system-oriented practices. As noted, working effectively with racially and ethnically diverse clients often involves color-conscious, power-conscious, and system-oriented interventions (e.g., Atkinson & Lowe, 1995; Thompson & Neville, 1999; Zhang & Burkard, 2008). At the same time, mainstream, color- and power-evasive psychotherapy treatments have demonstrated reliable and robust effectiveness for most (i.e., predominantly White) clients (Horvath & Greenberg, 1989; Hall & Yee, 2015; Sue & Sue, 2008). While disadvantaged clients specifically may benefit from an ambivalent clinical perspective that allows space for system criticisms, a meta-analysis by Hall and colleagues (2016) found that color-blind, non-critical orientations to therapeutic treatment were consistently and significantly effective for non-minoritized patients. Perhaps relatedly, research finding therapists' confidence in the effectiveness of their therapy approach (CBT) and their own skill to be the strongest predictors of patients' engagement and perceived improvement in therapy have typically used samples that were overwhelmingly Caucasian (Johnson, 2006: N = 157 clients, 154 [98%] White; Clemence et al., 2005: N = 125 clients, 122 [97.6%] White).

Taken together, these results suggest that a non-critical approach to operative treatment systems appear to work very well for individuals whom the system does not disadvantage. This implies a potential divergent effect of therapist system justification: as Hall and Ibaraki (2015) highlight, the current default of individualistic treatments (those that emphasize internal stressors and changing individual behaviors) may be best for patients whose needs are generally well-met by their societal structures. However, effective work with clients who face more sociocultural stressors may demand a more external/societal, non-system justifying stance (Sue et al., 2012).

Though the latter group does characteristically include patients of color and vice versa (Hall & Yee, 2015; Sue et al., 2012), divergent alliance effects of individualistic versus system-oriented practices are not necessarily reducible to race. Thompson and Neville (1999) warn that system-oriented practices can be destabilizing to some patients of color and therefore must be applied according to the individual's needs and level of system consciousness. Similarly, they found several years later (Thompson et al., 2004) in a sample of African American male outpatients that therapists who initiated discussions of race without the patient's prompting were perceived as *more* racist and less comfortable within the dyad. Moreover, Pomales and colleagues (1986) conducted an experimental manipulation with Black college students ($N = 54$) who watched a video of an interracial therapy session that was either culture-sensitive (focusing on sociocultural facets of the patient's difficulties) or culture-blind (focusing on individualistic factors to the exclusion of culture and race). Overall, there was no significant difference in participants' evaluations of the therapist's competence across conditions. However, a significant effect emerged between participants' stage of racial identity development and their competence evaluations: participants who felt more secure in their minority identity and were less focused on sociocultural threats (internalization stage) did not see a significant competence difference between conditions. However, participants compelled by life events to focus more on the impacts of racism, and on themselves as a person limited and harmed by racism (encounter stage), rated the race- and culture-focused therapist significantly more highly (Pomales et al., 1986).

In other words, the effect of system-oriented/system-justifying interventions may be most directly related to the salience of an individual's systemic concerns. As Salter

and Adams (2013) asserted, individualism and "identity neutrality" are afforded by a sense of systemic security that makes one's external context less salient; this security is highly related but not interchangeable with race. As such, a client's level of cultural mistrust – i.e., their awareness of systemic abuses and how those could be recreated in the clinical encounter – may be a more defining factor of the alliance effects of system-oriented/system-justifying therapist responses than their race alone.

In support of trust as an organizing factor between these disparities, Das and Teng (2001) cite research demonstrating that people with lower levels of trust often feel a stronger need for control and autonomy when they are in dependent positions, resulting in preferences for control structures such as contracts and greater treatment transparency (Madhok, 2006; Ring & van den Ven, 1992). Fors and McWilliams (2016) state similarly that increased transparency into treatment system workings can powerfully enhance the therapeutic alliance with traumatized, fearful, and paranoid clients. Conversely, more trusting people often preferred when power was not evenly distributed (that is, when there was a clearly hierarchical, dependent relationship) than when both parties had more equal levels of control (Das & Teng, 2001). In these dyads, increased transparency and control mechanisms actually *decreased* trust and heighten perceptions of relational risk, related to the implication that trust was not a given. This suggests that for people with reason to believe that they can be safely vulnerable, dependency is a significant component of what makes the therapeutic alliance meaningful. In sum, equalizing power imbalances may help mistrustful clients feel more comfortable in the alliance but activate a sense of risk for clients for whom mistrust was not initially salient (Das & Teng, 2001). This research will take these hypothesized differences into account while evaluating the

alliance effects of system-oriented practices such as transparency, focus on client autonomy, and recognition of the mental healthcare system as worthy of criticism (i.e., lower levels of SJ).

Overall, alliance building appears to rely partly on a "match" between patients' and therapists' conceptualization of the clients' difficulties, whether individualistic or systemic. This idea has been reflected in the clinical literature on "goodness of fit" of patient-therapist personality and focus (Dolinksy et al., 2014; Mahrer, 1975) and in the social psychological literature on "elective affinities" between individuals' epistemic needs and their societal beliefs (Jost, Federico, & Napier, 2009). Specifically, alliance may be predicted by patient-therapist agreement on an internal (focusing on the patient's beliefs, behaviors, and feelings) versus external (focusing on the patient's interactions with the outside world) treatment emphasis (Calvert, 1984; Chowdhary et al., 2014; Mahrer, 1975). Because of this, system-justifying treatment approaches may be ill-suited or actively deleterious for marginalized clients, including many patients of color (Arredondo, 1999; Case, 2015; Chao et al., 2011; Hays et al., 2008), but effective for patients who are less troubled by systemic abuses (Hall & Yee, 2015).

In sum, the literature on cultural mistrust speaks to many minoritized individuals' acute awareness of the discriminatory beliefs that have informed the past and current state of psychotherapy. Because of this, they are less likely to seek out mental health services and more likely to terminate treatment prematurely, have weaker alliances, and feel more wary and vigilant for potential systemic and interpersonal threats (King, 2021; Nickerson et al., 1994). Although cultural mistrust is a widely acknowledged concept in theory, in practice these self-protective patient behaviors often activate pathologizing and

punitive therapist responses (Terwilliger et al., 2013) and misinterpretation as resistance, aggression, or psychosis (Suite et al, 2007; Whaley, 2001a). More broadly, therapists are often not comfortable or multiculturally competent enough to know how to address systemic and racial dynamics, despite the vast majority of therapists reporting that such dynamics are central to successful therapy with minority clients (Ancis & Szymanski, 2001; Moss & Singh, 2015). Therapists' implicit or explicit system-justifying ideologies can have significant negative ramifications for alliances with their clients of color, including less reflectiveness, more victim blaming, and higher levels of misattunement.

Therefore, system ambivalence and system-oriented positions to treatment are often an important piece of effective work with marginalized clients (Gawronski, 2012; Hays et al., 2008; Neville et al., 2013). These practices locate patients' concerns in their racial and societal contexts, acknowledge realities of oppression in the world at large and the therapeutic relationship, and promote clients' self-determination in the treatment process (Ortiz & Jani, 2010). That said, system justification may be benign or even beneficial with clients who are more secure in their social systems, less beset by system abuses, and more focused on internal stressors (Hall & Yee, 2015; Sue et al., 1992). However, therapist system justification has been studied only rarely (see Hall & Yee, 2019; Sitrin, 2023 in preparation), and the direct effects of system justification on psychotherapy patients studied not at all. While specific therapeutic interventions have been evaluated as potential triggers of – or responses to – cultural mistrust, the role of therapists' broader system ideologies (such as system justification) has yet to be empirically investigated.

Thus, investigation is warranted into the effect of therapists' system justification on patients' racialized stress as contributory to their cultural mistrust, and in turn to their weaker therapeutic alliances. To these ends, the following sections (Chapters 3 and 4) will describe the rationale, hypotheses, and empirical methodology of the proposed study addressing the described gaps in the literature. Further, to lay groundwork for the primary study, pilot studies were conducted to: (1) validate vignettes at significantly different levels of system justification which reliably represent therapists' actual practices per self-report, and (2) to justify the present conceptualization of therapist system justification as, at times, distinct from therapists' overall clinical effectiveness. The need for this pilot research and the results thereof are provided in Chapters 3 and 4, respectively.

Chapter III

Statement of the Problem

Mental healthcare has long grappled with treatment underutilization and dropout by people of color. While psychotherapy has made great strides in mitigating explicit bias, clinicians' implicit bias continues to pose considerable risks to cultural competence, and there is evidence that separation often exists between clinicians' theoretical beliefs around best practices in treatment and their actual competencies (Bartoli et al., 2015; Constantine, 2007; DiAngelo, 2011). In particular, therapists may overlook political, racial, and systemic aspects of patients' mistrust, instead viewing it as idiosyncratic or even pathological (Keating & Roberson, 2004; Sanguineti, 2017). These prejudiced perspectives have been linked strongly, and across several decades, to racial disparities in treatment and, in turn, to racially minoritized patients' cultural mistrust (Burkett, 2017; Jackson et al., 2007; Meyer et al., 2009). Research suggests that most culturally mistrustful patients will never enter psychotherapy, and most of those who do enter therapy will terminate after one or two sessions. However, there is a minority of therapists who are able to establish and maintain alliances with these clients, and much of the cultural mistrust literature has focused on identifying factors that distinguish these successful therapists from others (King, 2021; Moon, 2017; Terrell & Terrell, 1984).

System justification provides important context for the disconnect between therapists' explicit values and their actual practices, demonstrating that clinicians may be implicitly pulled to affirm their healthcare systems (Day et al., 2011; Gama & Dias, 2018). This may be especially true in the face of patients' mistrust, which can be perceived by clinicians as system threats. This defensive system justification can occur

despite – and in contrast to – therapists' conscious system beliefs and knowledge of multicultural competence skills (Bartoli et al., 2015; Mindrup et al., 2011; Neville et al., 2006). For some clients, appeals to maintain the societal, treatment, and/or ego systems can exacerbate pre-existing systemic concerns (Hays & Iwamasa, 2006). The instinct to system-justify, then, can be particularly damaging to therapeutic alliances with racially and ethnically diverse clients who face more systemic stressors which may be at the core of their presenting problems (Hall & Yee, 2015; Neville et al., 2013). Therefore, therapists' ability to endure system threats, such as cultural mistrust, without obliging their justification may be an important piece of multiculturally competent treatment.

However, there are several important limitations of the previous literature. First, research into cultural mistrust in psychotherapy has often been limited by small sample sizes; Hall (2020), King (2021), Moon (2017), Poston and colleagues (1991), and Ward (2002) and all sampled between 30-67 participants. These samples have typically included only Black individuals, to the exclusion of other people of color, and used the Cultural Mistrust Inventory (King, 2021; Moon, 2017; Pullen et al., 2004; Whaley 2001a; b), which is highly specific to Black individuals' micro-level interactions. A second limitation is that research into healthcare-specific cultural mistrust has also typically studied either cultural mistrust *or* healthcare mistrust (Brooks & Hopkins, 2017; King, 2021; Moon, 2017; Ward, 2002) with few studies (e.g., Benkert et al., 2006) assessing interactions and overlaps between both. Lastly, therapist system justification has been studied only rarely, and its effects on therapy patients studied not at all. In particular, while much research has evaluated the impact of high system justification, the impact of low system justification remains an important and largely unexamined area.

The present study will expand upon the existing literature in three primary ways: by using a larger sample, including a broader range of racial-ethnic minority identities; by measuring both general cultural mistrust and healthcare system-focused mistrust, bridging the CMI-based and HCSD-based healthcare mistrust literature; and by proposing system justification as a key factor that may be activated in the face of system threats (such as cultural mistrust). Building on Hall and Ibaraki's (2015) work, it suggests that appeals to system integrity may be benign or beneficial to patients with less cultural mistrust. However, for patients with more racialized stress and subsequent cultural mistrust, SJ may come at the detriment of the alliance. In these cases, encounters wherein the therapist is able to manage the instinct to system justify and instead adopt a systemic view of mistrust may relieve cultural mistrust and build the alliance. However, for patients low in racialized stress and with little reason for cultural mistrust, justification of the treatment system may bolster the alliance, while system ambivalence may activate anxieties not previously salient (Gawronski, 2012; Hall & Yee, 2015). In other words, while affirmation of societal systems in therapy may be beneficial for some patients, others may benefit from being given permission to mistrust.

This study seeks to identify the clinical applicability of these social psychological concepts using a sample exposed to therapy vignettes replicating a culturally mistrustful encounter. As outlined, therapy vignettes involving cultural and systemic issues have been reliably used in several recent studies (e.g., Anglin et al., 2008; King, 2021; Moon, 2017), whose procedures will be drawn from here. In doing so, this study aims to answer the following questions: does system justification play meaningfully into the dynamics of cultural mistrust in the therapeutic alliance? Does match of patient-therapist system

relationships (i.e., high-mistrust patients with low-SJ therapists, and vice versa) strengthen the alliance? The answers may allow therapists to attend more productively to their marginalized patients' fears of being vulnerable to the therapeutic process.

Variable List

Independent (Predictor) Variable: Racialized stress. Operationalized as the lasting psychic impact of negative system experiences related to one's race. Racialized stress will be assessed using the racism stressors subscale of the Racism and Life Experiences Scale **(**RaLEs; Harrell, 1997; 20 items). Total and subscale (frequency and stress) scores will be obtained using mean scores. The RaLEs was chosen partly because it has been normed on diverse populations and can be used by people of any race.

Proposed Mediator: Cultural mistrust. Operationalized as mistrust toward White-majority social systems (Katapodi, Pierce, & Facione, 2010) – in this case mental healthcare –including two components: cultural mistrust overall, and healthcare-specific mistrust. These will be measured using the Cultural Mistrust Inventory (CMI; Terrell & Terrell, 1981; 48 items) and the Health Care System Distrust Scale (HCSD; Rose et al., 2004; 9 items), respectively. Both will obtain scale and total scores by summing item responses. The CMI includes four subscales (education/training, interpersonal relationships, business/work, and politics/law) and the HCSD includes two (trust in the healthcare system's *efficacy* and trust in its *values*). Several studies have administered the CMI and HCSD to assess cultural mistrust and treatment outcomes (Benkert et al., 2006; Jefferson et al., 2011; Pullen, Perry, & Oser, 2014) with good external reliability, a = .73-86 and a significant positive correlation (r = .31, p < .05). These results suggest that CMI-based cultural mistrust and HCSD-based healthcare mistrust are related, but not

synonymous. As the CMI has most often been used with African American-only samples, this study will utilize a modified, validated CMI used across racial minority groups.

Proposed Moderator: Therapist system justification. Operationalized as therapists' support for the status quo of the prevailing social order, represented by clinical vignettes validated by psychotherapists as being significantly different in system justification *and* not significantly different in clinical effectiveness (see Pilot Study, chapter 4). Participants in all three groups were asked to imagine that they were a therapy patient hesitating to trust their therapist. Participants were then randomly assigned to a response transcript from their "therapist" from one of three groups:

Experimental 1: High system justification: Participants in the high SJ group read a response vignette wherein the therapist took an individual view of mistrust, emphasizing the benefits of trusting the therapeutic treatment system.

Experimental 2: Low system justification. Participants in the low SJ group read a response vignette wherein the therapist took a systemic view of mistrust, emphasizing treatment system ambivalence and the benefits of trusting one's own instincts.

Experimental 3: No response. Participants read a response vignette wherein the therapist did not address the mistrust (asking about the client's week).

These vignette conditions are in accordance with manipulations used in previous studies on system relationships and multicultural competence (Anglin et al., 2008; King, 2021; Nivette & Akoensi, 2019). Vignettes were adapted from the literature on responding to therapy mistrust (e.g., Akhtar, 2018) and transcripts of trainee therapists' responses to patients' cultural mistrust at a college counseling clinic. Results of the pilot

study finding these conditions to be valid representations of high and low system justification are provided in the following chapter.

Dependent (Outcome) Variable: Therapeutic alliance. Operationalized as the strength of the imagined therapeutic alliance with the assigned therapist from the vignettes above, based on three domains: agreement on therapeutic task, goals, and interpersonal bond (Hatcher & Gillaspy, 2006). This was measured with the Working Alliance Inventory Short Revised (WAI-SR; Hatcher & Gillaspy, 2006; 12 items). Subscales and total scale scores will be obtained using summed item responses.

Potential Covariate: Demographics. Race/ethnicity, gender, age, sexual orientation, political ideology, whether participants are currently or have been in therapy, and the quality (subjective helpfulness) of those therapeutic experiences will be assessed. We accounted for these variables to determine any impact they may have on the main effect of the overall analysis.

Primary Hypotheses

Broadly, it was hypothesized based on the literature that therapeutic alliance would rely partly on goodness of fit – or elective affinities – between therapist and patient, such that high-mistrust patients would demonstrate stronger alliances when paired with low-SJ therapists, and low-mistrust patients would demonstrate stronger alliances when paired with high-SJ therapists.

Hypothesis 1. A substantial body of literature attests to the role of racialized stress in weakening patients' experiences of the working alliance (Barksdale et al., 2014; Constantine, 2007; Sue et al., 2019). Therefore, it was hypothesized that there would be a

significant negative main effect of racialized stress on the working alliance; such that as racialized stress increased, client-reported working alliance would decrease.

Hypothesis 2. Cultural mistrust would significantly mediate the effect of racialized stress on therapeutic alliance, such that as cultural mistrust increased, the negative effect of racialized stress on the working alliance would increase as well.

Hypothesis 3. Similarly, it was hypothesized that healthcare system distrust would significantly mediate the effect of racialized stress on the therapeutic alliance, such that as healthcare system distrust increased, the negative effect of racialized stress on the working alliance would increase as well.

Hypothesis 4a. Research on multicultural competence process and outcomes (Arredondo, 1999; Hays et al., 2008; Neville & Thompson, 2013) suggests that, for those who experience their social systems as more rejecting and discriminatory, the strength of the alliance will be based on therapists' attention to patients' structural/environmental stressors (i.e., a non-system justifying stance). Therefore, it was hypothesized that therapist system justification would moderate the relationship between racialized stress and the therapeutic alliance, such that as system justification decreased, the negative effect of racialized stress on the therapeutic alliance would decrease as well. **Hypothesis 4b.** Based on the literature on the therapeutic importance of attunement to clients' signals of discomfort, whether system-related or otherwise (Hall & Yee, 2015, Thompson & Neville, 1999), it was hypothesized that working alliances would be most negatively affected by a therapist response wherein the therapist does not directly address the participant's expression of mistrust in any way (i.e., the "non-response condition,"

Vignette 3). Particularly as the literature suggests that this is the most common response to cultural mistrust, it was determined an important impact to evaluate empirically.

Hypothesis 5a. Process-outcome on cultural mistrust in the therapeutic alliance (e.g., Cook et al., 2009; Hall & Yee, 2015; Moon, 2017; Neville & Thompson, 2013) has identified cultural mistrust as a central piece of patients' experience of the therapeutic alliance, propelled both by past experiences of discrimination as well as responsiveness to current interventions. Therefore, it was hypothesized that the mediating effect of cultural mistrust on the relationship between racialized stress and the therapeutic relationship would also depend on the level of therapist system justification present in a given clinical encounter. Specifically, it was hypothesized that the negative indirect effect through cultural mistrust would increase significantly in the presence of higher therapist system justification. To that end, participants higher in cultural mistrust-mediated racialized stress would report significantly stronger working alliances when presented with a low (v. high) system justifying response to cultural mistrust, whereas participants with lower cultural mistrust-mediated racialized stress would report significantly stronger working alliances when presented with a high system justifying response. **Hypothesis 5b.** It was hypothesized that the mediating effect of healthcare system distrust on the relationship between racialized stress and the therapeutic relationship would similarly depend on the level of therapist system justification present in a given clinical encounter; specifically, that low system justification in particular would significantly moderate the indirect effect of racialized stress on the working alliance through the path of healthcare system distrust. Similarly to the expectations around cultural mistrust, it was predicted that participants higher in healthcare distrust-mediated racialized stress would report significantly stronger

working alliances when presented with a low (v. high) system justifying response to cultural mistrust, whereas those with lower healthcare system distrust-mediated racialized stress would report stronger working alliances with the high system justifying response.

See Appendix 1 for proposed model.

Exploratory Hypothesis

As noted, vaccine hesitancy has emerged through the COVID-19 pandemic as a key domain of cultural mistrust in the healthcare system (Cokley et al, 2021), which may bear resemblances to patients' concerns about trust in mental health encounters. Therefore, it was hypothesized that vaccine hesitancy would be significantly, negatively associated with working alliance, as well as significantly moderated by level of therapist system justification presented. Specifically, similar to Hypothesis 3, it was expected that as system justification decreased, the negative effect of vaccine hesitancy on working alliance would decrease as well.

Chapter IV

Method

This section describes the procedures and results of the two pilot/exploratory studies preceding the primary study, as well as adjustments made to the main study based on results of each preliminary study. Both of these pilots were done to validate a set of vignette conditions representing therapists' high- and low-system justification, respectively, in an early therapy session. These pilot studies entailed, first, a survey of mental health professionals responding to adapted, real-life therapy vignettes by rating them on scales of system justification and therapeutic effectiveness. This was done to identify a set which were significantly different in system the former and similar in the latter. Second, a process-outcome study was conducted to ascertain that therapist system justification did not inherently come at the expense of therapeutic effectiveness, to validate our use of these vignettes with similar ratings of therapeutic effectiveness.

Following the results and consequential adjustments of these pilot studies, the primary study's recruitment and eligibility standards will be reviewed, followed by descriptive demographic data, and a summary of all measures used, with evidence of reliability and validity of each. Then, study procedure will be described in detail and choice of statistical analysis to address each of the study's main hypotheses 1-5 outlined. Finally, exploratory analyses and results are described, and illustrations of each provided.

Pilot Studies

For the primary study, therapy vignettes of differing levels of system justification were used to replicate the effect of therapists' actual system justification within the therapeutic dyad. Some studies into cultural mistrust in the therapy room have used

videos as their experimental conditions (e.g. Donatelli, 2006; King & Borders, 2019). However, this study utilized written vignettes similar to previous studies on cultural mistrust in therapy (e.g., King, 2020; Moon, 2017; Ward, 2002). This was also done to avoid potentially confounding attributions made by participants on the basis of the actors' race or gender, as previous video-vignette studies have found (Donatelli, 2006).

To create these vignettes, two pilot studies were conducted: first, an archival analysis of a counseling clinic's therapy transcripts of trainee therapists' responses to patients' cultural mistrust, followed by a survey of practicing mental health professionals responding to adapted versions of these therapy vignettes to identify two that were evaluated as valid representations of therapeutic encounters reflecting distinct levels of system justification. Next, a process-outcome study was conducted to assess the real-life impacts of therapist system justification on patients' treatment engagement to validate these vignettes as reflecting distinct levels of system justification, but similar levels of therapeutic effectiveness. The procedures and results of each are described as follows.

Pilot 1: System Justification in the Therapy Room (Self-Report)

As a starting point for examining therapists' responses to cultural mistrust in real-life therapy encounters, an archival analysis was conducted of an urban college counseling clinic's transcript archive. This included 280 transcribed sessions between doctoral-level trainee therapists and their patients from the same university. Key words were searched to identify therapy episodes involving trust/mistrust and system relationships (e.g., trust, politics, police, healthcare, system, government, etc.), and each episode (19; 6.3% of the transcript library) noted in an encrypted log. Three thematic patterns emerged in trainee therapists' responses to mistrust and systemically-charged

session content: **high system justification** (characterized by reinforcing the mental healthcare system or the patient's past/current treatment), **low system justification** (characterized by acknowledging and leaning into patients' wariness of their treatment or social systems), and **no response** (characterized by changing the topic or ending the conversation). In these transcripts, the "no response" condition was the most common reaction to mistrust among these trainee therapists (11 of 19 episodes identified, 58%) reflecting observations in the clinical literature that less experienced therapists tend to avoid or deflect from clients' gestures toward culturally and racially relevant content (Cohen, 2017; Sue et al, 1992). In order to test these hypotheses while replicating the realistic configurations of cultural mistrust in psychotherapy, this study set out to create three validated vignette conditions for use in the primary study, patterned after the three themes identified here.

As noted, this study used therapy vignettes of differing levels of system justification to replicate the effect of therapists' system justification in the real-life therapeutic dyad. To this end, this pilot study sought to validate therapist vignettes reflecting distinct levels of system justification conditions, as well as to validate a scale of Mental Healthcare System Justification, as several studies have done by adapting the General System Justification scale (GSJ; Jost & Thompson, 2000) to the specifications of their studies (see Jost, 2019 for review). This pilot study used a sample of 51 therapists (54 responses, 3 excluded), recruited through online mental health professional networking groups. In total, 76.5% percent of participants identified as female, 13.8% as male, 2% as nonbinary/other, and 7.7% did not report their gender. In terms of race, 62.7% identified as White, 9.8% as Jewish (self-specified through the "Other" category),

5.9% as Asian/Pacific Islander, 3.9% as Middle Eastern, and 2% as Multiracial. A clear limitation in this pilot is a lack of representation from Black and Latino/Hispanic therapists. In terms of education, 57.1% reported degrees in clinical psychology, 20.7% in social work, and 8% in school psychology. Forty-three point one percent reported being student- or trainee-therapists, while 13.7% were licensed Master's level therapists, and 7.8% were licensed doctoral level therapists. Twenty-nine point four percent of participants identified their primary theoretical orientation as psychodynamic, 19.6% as CBT (second- and/or third-wave), 5.9% as humanistic, 3.9% as psychoanalytic, 2% as existentialist, and 2% as systemic (family systems or IFS).

After entering the Qualtrics-hosted survey and giving informed consent, participants completed the 10-item Mental Healthcare-specific System Justification scale under review (see Appendix 2). Then, they were provided with a definition of system justification and asked to evaluate a set of vignettes in terms of (1) system justification and (2) therapeutic effectiveness. Participants read six vignettes of a therapist's response to cultural mistrust in a therapy session (3 hypothesized "high SJ" and 3 hypothesized "low SJ" examples). These vignette conditions were created by adapting the counseling center's session transcripts described in the Archival Analysis and merging them with vignettes from previous literature on responding to cultural mistrust (Akhtar, 2018; Anglin et al., 2008; King, 2021), so that they were no longer recognizably connected to the original episodes. Participants rated each domain (SJ and therapeutic effectiveness) separately on Likert-type scales from 1-10. This within-participants design presented all conditions to all participants, in randomized order.

Reliability analyses found that the MHSJ scale had good internal consistency (a = .73). Paired-sample t-tests were run to identify combinations of vignettes that were significantly different in level of system justification, but similar in level of therapeutic effectiveness. Two combinations of vignettes emerged as fitting these criteria, and one combination of a high-SJ and low-SJ vignette condition was chosen for use in the primary study for two reasons: first, these vignettes were evaluated by the therapist sample as significantly different in level of system justification, $t(84) = 3.62$, $p < .001$, and similar in level of therapeutic effectiveness, $t(84) = 1.73$, $p = .09$. Further, these vignettes were similar at face-value, with the only word changes between them being relevant to the manipulation (see Measures section). Overall, this study validated experimental conditions of a high-system justifying therapist and a low-system justifying therapist, while maintaining similar levels of therapeutic effectiveness across conditions. These vignettes were used in the primary study to represent high therapist SJ and low therapist SJ, respectively, and evaluate their effects on participants' working alliances.

Pilot 2: System Justification in the Therapy Room (Process-Outcome)

Prior to the launch of the primary study, a formal presentation of the proposal was provided to Dr. John Jost (original theorist of system justification theory) and his resident graduate researchers of New York University's Social Justice Lab. Dr. Jost suggested a concern regarding the validity of these vignettes – which were created to be significantly different in SJ but similar in therapeutic effectiveness – based on a hypothesis that real-life therapist system justification may definitionally come at the expense of therapeutic effectiveness (Jost, personal communication, 2022). An exploratory process-outcome study was conducted of real-life therapist system justification to address these concerns

and further validate the use of vignettes rated as significantly different in system justification but similar in therapeutic effectiveness.

This study was conducted during the academic year of September 2021 through July 2022 at an urban university's college counseling clinic, which is staffed by trainee therapists in their second to fifth years of their doctoral program in clinical psychology, providing supervised psychotherapy to the university's student body. This pilot was modeled after Terrell and Terrell's seminal 1984 study finding that Black patients' cultural mistrust predicted premature dropout from treatment, moderated partly by their therapists' "mistrust," though the nature and operationalization of this mistrust was not elaborated. To this end, therapists completed a brief survey including demographic information such as gender identity, age, year in the doctoral program, and whether they were currently in psychotherapeutic treatment, as well as the General Scale of System Justification (GSJ; Jost & Thompson, 2000) before beginning their treatments.

Patients provided informed consent to be part of the counseling clinic's research and completed several intake measures before beginning their treatments including, most centrally for this study, demographic information regarding their age, gender, sexual orientation, and racial-ethnic identity, and several measures of their current symptom distress and emotional/interpersonal difficulties. Patients also completed the Racism and Life Experiences scale (RaLES) and Health Care System Distrust scale (HCSD) prior to being assigned to a therapist. After intake, both therapist and client would complete the WAI at regular intervals; for patients receiving treatment weekly, these surveys would be administered after every fourth session (i.e., sessions 4, 8, 12, etc.). For those receiving treatment bi-weekly, they would be administered after every eighth session (i.e., sessions

8, 16, 24, etc.) After 12 (for weekly patients) or 24 (for bi-weekly patients) sessions, repeated measures of the intake's measures of symptom distress and emotional and interpersonal difficulty would be administered. For the purposes of this study, premature dropout is defined as unexpected patient termination prior to this 12- or 24-session mark.

Overall, 64 dyads participated in this study and completed all necessary measures in entirety. Twenty-eight student therapists were involved in this study; while clients were included only once (i.e., they could only have one therapist), most therapists were included in at least two dyads in this study (i.e., many therapists had multiple clients who consented to research and completed all necessary measures). Of the 64 patients included, 29 were White or Caucasian, and 35 identified as POC (specifically: 14 identified as Asian, 11 as Black/African American, four as Arab/Middle Eastern, four as Multiracial, and two as Hispanic/ Latino). Ten client participants (16%) identified as LGBTQ, two (3%) chose not to disclose their sexual orientation, and the remainder (81%) identified as heterosexual or straight. The majority of client participants described their gender as female (53, 83%), nine (14%) as male, and two as non-binary or another gender (3%). Patients' ages ranged from 18 to 30, with the mean client age being 22 years old. Of the 28 student therapists included, 21 identified as White/Caucasian, three identified as Asian, three as Arab/Middle Eastern, and one as Hispanic/Latino. Twenty-three of these student therapists (82%) described their gender identity as female, four (14%) as male, and one (4%) as non-binary. Therapists' age at the start of this study ranged from 24 to 35 (M = 28.14) and their year of doctoral training ranged from second to fifth year (M = 2.52). Seventeen of these student therapists (61%) reported being in their own therapeutic treatments during this study.

Due to the low sample size, the primary study's moderated mediation was not possible to conduct, nor was a simple moderation model. Therefore, the sample was split into separate data sets (one including therapeutic dyads wherein the patient identified as White, and the other with dyads wherein the patient identified as a person of color), and point-biserial correlation tests were run on each to examine relationships between GSJ-measured therapist system justification and patients' premature dropout from treatment. Point-biserial correlations mathematically most resemble the Pearson correlation, but rather than evaluating two continuous variables, are used where one variable (X) is continuous (in this case, therapist GSJ) and the other (Y) is dichotomous (premature dropout, measured in categories of yes/no). Results found that therapists who reported higher levels of system justification had significantly higher rates of premature dropout among their clients of color than therapists reporting lower system justification (r (34) = .40, p = .018). Conversely, therapists who reported lower levels of system justification actually experienced *more* premature dropout among their White patients (r (29) = -.31, p < .05 (albeit at a significance level of 0.049). These results suggest that therapist system justification may not have a uniformly negative clinical effect across all patients – specifically, that therapist system justification may have a positive *or* negative relationship with patients' engagement in treatment depending on the patient's racial identity, experiences, and related treatment needs. This is in support of the main study's use of therapy vignettes rated by therapists as being similar in therapeutic effectiveness, in addition to representing significantly different levels of system justification. These results also continue to make the case that therapist system justification seems to have a

meaningful impact on the therapeutic relationship and therefore warrants further investigation on its implications with both racial-ethnic minority and White patients.

These preliminary results also informed the decision to use only the RaLES severity scale as the primary study's measure of racialized stress. Notably, while reported *severity* of racism was higher among participants of color in this sample [F (5, 59) = 2.82, p = .029], White participants reported similar *frequency* of racialized stress as their POC peers [F (5, 59) = 2.17, p = .08]. This suggests that the racialized stress frequency subscale may be more prone to external validity issues per participants' self-report. In this light, the RaLES severity subscale emerged as a more valid measure of racialized stress and was therefore utilized on its own in the primary study.

Exploratory mean-comparison analyses were run to evaluate therapist factors related to their levels of system justification, for consideration in regard to possible areas of future research in this topic (see Chapter VI). Those further along in their doctoral training [F (3, 25) = -4.61, p = .001] and those who themselves were engaged in psychotherapy [t (26) = 3.91, p < .001] were found to be significantly less system justifying. ANOVAs examining therapist gender and race as associated with levels of system justification were not significant, possibly due to the study's low sample size.

Primary Study

Participants. This experiment aimed for a sample of approximately 750 participants. Meta-analyses on psychological research in general (Funder & Ozer, 2019) and social psychological research in particular (Funder et al., 2014) have shown a mean published effect size of r = .21, and d = .43 for differences between experimental groups such as the ones proposed here (Richard et al., 2003). The sample (N = 750) was chosen

in keeping with these targets for statistical power, allowing sufficient effect sizes to emerge between independent and dependent variables.

This study ultimately used a sample of 737 U.S. adults whose primary language was English, of ages ranging from 18 to 71 (M = 36.05, SD = 10.55). The sample's gender identity makeup was as follows: 287 male (38.8%), 433 female (58.6%), 2 transgender (0.3%), 12 non-binary (1.6%), 2 genderqueer (0.3%), and 1 respondent who preferred not to say (0.1%). The ethnic background was as follows: 280 participants were Black/African American/African Caribbean (37.9%), 141 were Latino/a or Hispanic (19.1%), 98 were Caucasian or White (13.3%), 88 were Asian or Pacific Islander (11.9%), 88 were biracial or multiracial (11.9%), 29 were Native American or Alaskan Native (3.9%), 12 were Arab/Mizrahi, Middle Eastern, or North African (1.6%), and 1 who wrote in their identification as "other POC" (0.1%). Overall there were 639 participants of color (86.7%). In response to an item asking whether they had engaged in psychotherapy, 127 participants responded "Yes, and currently attending" (17.2%), 395 responded "Yes, only in the past" (53.5%), and 215 said "No" (29.1%). Of the 522 respondents who reported having been to therapy, length of longest consecutive treatment ranged from one week to 20 years (M = 15.16 months, SD = 22.78), with 13 participants attending for less than one month and 39 attending for over 3 years. Table 1 below shows demographic data for this study sample.

Recruitment was conducted through CloudResearch, previously known as TurkPrime, the premium participant-sourcing platform through Amazon Mechanical Turk (MTurk). MTurk has been used widely across behavioral sciences research (Buhrmester, Kwang, & Gosling, 2011), including clinical psychology (Chandler &

Shapiro, 2016), particularly for the collection of social and psychological data from diverse populations (Goodman, Cryder, & Cheema, 2013). For an additional fee, Cloud-Research further enhances the data quality of MTurk-hosted studies by ensuring that participants report their demographic information consistently across surveys, as well as preventing participation of members whose responses are found to be inattentive, duplicative, or from unreliable IP addresses (Litman, Robinson, & Abberbock, 2017).

CloudResearch members were first provided with the MTurk HIT (Human Intelligence Task) advertisement, including a brief study description, estimated time for completion, and compensation rate. Participants were included if they were (a) above the age of 18; (b) English-speaking at a native level of fluency; and (c) residents of the United States. Participants of any race were eligible for the study, though the survey was split into two separate MTurk Human Intelligence Tasks (HITs): one larger-sample study for POC and another smaller for non-POC, to ensure that the vast majority of participants would be racial minorities and able to complete the CMI. All eligible participants first read and signed a consent form detailing the procedure and payment for the study. Within the study, participants were randomly assigned to one of three vignette conditions, each including about 250 participants (see Table 1 below). The expected and advertised completion time was 25-30 minutes. After all data had been submitted, the average completion time calculated by CloudResearch was 29 minutes. Upon completion of the study, following confirmation of eligibility and attention checks, participants received compensation of $3.00, comparable to U.S. minimum wage rates as of 2021 ($7.25, as per the U.S. Department of Labor, 2021).

Measures

Demographics. All participants completed a self-report demographic questionnaire assessing age, gender identity, race/ethnicity, sexual orientation, political affiliation, immigration status, relationship status, employment status, whether participants are currently or have been in therapy, and their overall satisfaction with those treatments ("Overall, I found my time in therapy to be helpful").

Cultural Mistrust Inventory. The Cultural Mistrust Inventory (CMI; Terrel & Terrel, 1981) is a 48-item self-report scale that measures mistrust and suspiciousness among Black Americans toward White Americans and White-majority systems. It includes four subscales: education/training, interpersonal relationships, business/work, and politics/law. The CMI uses a 7-point Likert-type scale (*disagree* to *agree*), with higher sum subscale/total scale scores representing greater mistrust of White people and systems. Mizock and Harkins (2009) found high test-retest reliability (.86) and external validity in the CMI as measured against the Racial Discrimination Index (RDI), such that participants with higher scores on the RDI had higher scores on the CMI as well. Higher scores on the CMI have also been significantly related to higher rates of premature dropout among Black therapy clients (Mizock & Harkins, 2009; Whaley, 2001a). The CMI has demonstrated high-to-excellent reliability (a = .87 - .94) in recent studies on treatment mistrust (Jefferson et al, 2011; Pullen et al., 2014; Hall et al., 2020).

Ward's (2002) adapted version of the CMI, which replaced every instance of "Blacks" with "racial-ethnic minorities" (a = .86), was used here (see Appendix 4). Items include, "Racial-ethnic minorities should be suspicious of a White person who tries to be friendly" and, "White people are usually honest with racial-ethnic minorities." Ward's adaptation of the CMI also excludes one item due to prejudiced language ("Whites are

Table 1

Descriptive Statistics of Study Sample Demographics (N = 737), By Experimental Condition

Sociodemographic Characteristics	Condition 1: Low SJ		Condition 2: High SJ		Condition 3: No Response		Full sample	
	n	%	*n*	%	*n*	%	*n*	%
Assigned condition	243	32.9	243	32.9	251	34.0	737	100
Gender								
Female	141	40.3	144	59.3	148	59.0	433	58.6
Male	98	58.0	91	59.3	98	39.0	287	38.8
Non-binary	2	0.8	5	2.1	5	2.0	12	1.6
Transgender	1	0.4	0	0	0	0	2	0.3
Genderqueer	0	0	2	0.8	0	0	2	0.3
Prefer not to say	1	0.4	0	0	0	0	1	0.1
Race-ethnicity								
Black/African American/African Caribbean	105	43.2	84	34.6	91	36.3	280	37.9
Latino/a or Hispanic	40	16.5	49	20.2	52	20.7	141	19.1
Asian or Pacific Islander	26	10.7	34	14.0	28	11.2	88	11.9
Native American or Alaskan Native	8	3.3	12	4.9	9	3.6	29	3.9
Arab, Middle Eastern or North African	3	1.2	5	2.1	4	1.6	12	1.6
Biracial or Multiracial	31	12.8	29	11.9	28	11.2	88	11.9
Caucasian or White	30	12.3	30	12.3	38	15.1	98	13.3
Sexual orientation								
Heterosexual	193	79.4	190	78.2	195	77.7	578	78.2
Gay or Lesbian	9	3.7	3	1.2	3	1.2	15	2.0
Bisexual	25	10.3	32	13.2	35	13.9	92	12.4
Pansexual	3	1.2	5	2.1	7	2.8	15	2.0
Queer	4	1.6	2	0.8	3	1.2	9	1.2
Questioning	2	0.8	3	1.2	0	0	5	0.7
Asexual	4	1.6	5	2.1	7	2.8	16	2.2
Other	1	0.4	0	0	0	0	1	0.1
Prefer not to say	2	0.8	3	1.2	1	0.4	6	0.8
Political affiliation								
Extremely Liberal	28	11.5	36	14.8	40	15.9	104	14.1
Liberal	57	23.5	65	26.7	48	19.1	170	23.0
Slightly Liberal	29	11.9	28	11.5	31	12.4	88	23.0
Moderate	70	28.8	50	20.6	64	25.5	184	24.9
Slightly Conservative	20	8.2	23	9.5	22	8.8	65	8.8
Conservative	25	10.3	33	13.6	29	11.6	87	11.8
Extremely Conservative	14	5.8	8	3.3	17	6.8	39	5.3
Previous therapy [a]	176	72.4	171	70.4	175	69.7	522	70.8
Length of treatment (months)	*M* = 13.62, *SD* =18.97		*M* = 18.19, *SD* = 27.64		*M* = 13.74, *SD* = 20.79		*M* = 15.16, *SD* = 22.78	
Age	*M* = 35.93, *SD* =10.32		*M* = 36.05, *SD* = 10.53		*M* = 36.15, *SD* = 10.83		*M* = 36.05, *SD* = 10.55	

Notes. n = # of participants; *%* = percentage of sample; *M* = mean; *SD* = standard deviation

[a] Reflects the number and percentage of participants answering "yes" to this question.

similarly modified versions of the CMI for non-African American samples and with this item removed, with good reliability, ranging from *a* = .89 to *a* = .96 (Kim, Kendall & Cheong, 2016; Kohatsu et al., 2000). In the present study, the alpha for the 47-item adapted CMI was .97. Due to lack of evidence of its validity for non-minority populations, White respondents were not administered the CMI, and so this result was found among the sample's 640 respondents of color. Analyses of cultural mistrust including White participants utilized the Health Care System Distrust Scale exclusively.

Health Care System Distrust Scale. The Health Care System Distrust Scale (HCSD; Rose et al., 2004) is a 9-item self-report measure that assesses mistrust toward the healthcare system based on previous negative experiences, particularly in regard to bias and discrimination. The HCSD uses a 5-point Likert-type scale (*strongly disagree* to *strongly agree*) to assess level of agreement with statements about trust in healthcare providers, particularly on the basis of their own past treatment. It includes two subscales measuring respondents' perceptions of the healthcare system's competence (C scale; e.g. "patients receive high quality medical care from the health care system") and values (V scale; e.g. "the health care system lies to make money"). In a diverse sample (*N* = 404 adults from the Greater Philadelphia area), the overall scale demonstrated excellent reliability (*a* = .83 - .85), with both subscales showing high individual internal consistency as well (C-scale, *a* = .77; V-scale, *a* = .73 - .75).

Significant inverse correlations were found across races between both subscale scores with the Trust in Physician scale and the Global Healthcare Trust scale. Like the CMI, healthcare mistrust as measured by the HCSD is powerfully related to African American experience specifically, with an association of *r* = 0.94 (*SE* = 0.30, *p* = .002)

between Black racial identity as measured by the Black Racial Identity Attitude Scale and HCSD distrust (Armstrong et al., 2008). Research also shows the HCSD's positive correlations with minority racial identity overall, $r = 0.86$, $p < .001$, and experiences of discrimination across minority groups (Armstrong et al., 2013; Chen & Yang, 2014) and convergent validity with the CMI, $r = .30$ - $.55$ (Armstrong et al., 2008; 2013; Jefferson et al., 2011; Pullen et al., 2014; Shea et al., 2008). In the present study, the alpha for the overall HCSD was .85. The subscales of the HCSD demonstrated good reliability individually as well; C-scale $a = .80$, V-scale $a = .73$.

Racism and Life Experiences Scale. The Racism and Life Experiences Scale (RaLEs; Harrell, 1997) is a 20-item self-report measure using a 6-point Likert type scales. The RaLEs includes items such as, "Your ideas or opinions being minimized, ignored, or devalued," with each item measured along subscales of (1) frequency and (2) severity of racialized stress. With a sample of 286 racially and ethnically diverse Los Angeles sample (including both White people and people of color), the scale received internal consistency and test-retest reliability ranging from $a = .75$ - $.96$. The primary scale and subscales all have high convergent validity with cultural mistrust as measured by the Cultural Mistrust Inventory (Whaley, 1998; $a = .80$). In the present study, the alpha for the overall RaLEs was .97. The alphas for both the RaLEs' subscales, F (frequency) and S (severity), were each .96.

Therapist System Justification – Manipulation (High SJ, Low SJ, No Response). All participants were prompted to imagine themselves as a therapy client, hesitating to share something vulnerable in therapy, with the script below:

For this final segment of the study, please imagine that you are a therapy client in a new counseling relationship. Imagine that during one of these sessions, *you find yourself feeling worried and hesitant to open up to your therapist* about something vulnerable, based on your previous social or cultural experiences. In the space below, please write briefly *how you may be likely to express this worry and mistrust to your therapist (verbally and/or non-verbally),* if you felt this way during a therapy session.

All participants wrote brief descriptions of the verbal and non-verbal cues they were likely to provide in this scenario. Then, they were randomly assigned to one of the three response conditions below.

High SJ/Individual Focus: Participants randomly assigned to the High SJ condition received a therapist "response" as follows:

Now, imagine that your therapist responds to your mistrust in the following manner:

"I understand that sharing your vulnerabilities with me feels very uncomfortable, risky, even dangerous. If there were any way to do this work without such discomfort, I would certainly offer it. But just as you can't get help from a dermatologist without showing your warts, there is no way to offer psychological help without the unpleasant feelings of exposure and vulnerability. But once we can go there, treatment really does work, and the mental healthcare system does operate as it should."

Low SJ/System Focus: Participants randomly assigned to the Low SJ condition received a therapist "response" as follows:

Now, imagine that your therapist responds to your mistrust in the following manner:

"I understand that sharing your vulnerabilities with me feels very uncomfortable, risky, even dangerous. It is more than likely that your discomfort is based on your lived experience, which makes it important that we do not ignore or downplay it. After all, just as you have the final say about whether or not to show your warts to a dermatologist, you have the final say about how much exposure and vulnerability to engage in with your psychologist. Because unfortunately, not every therapist is trustworthy, and the mental healthcare system does not always operate as it should."

No Response: Participants randomly assigned to the No Response condition received a neutral therapist "response" that did not substantively address the mistrustful content, as follows:

Now, imagine that your therapist responds to your mistrust in the following manner:

"Well, in any case, how was your week?"

Vaccine Hesitancy Item. Following the Credibility of Science Scale (CSS, Hartmann et al, 2017), one face-valid item was used to evaluate vaccine hesitancy per this study's exploratory hypothesis; specifically, this item read: "I believe vaccines are more dangerous than beneficial." This single-item measure has been used in medical mistrust research by the New York State Department of Health since 2018 in context of MMR vaccine mistrust and continues to be used regarding COVID-19 vaccine hesitancy (New York State Department of Health Vaccine Task Force, 2019). Like the CSS, this

item uses a Likert-type scale from 1 (*not at all like me*) to 7 (*extremely like me*), with higher scores indicating more self-reported vaccine hesitancy.

Working Alliance Inventory. The Working Alliance Inventory Short Form (WAI-SR; Hatcher & Gillaspy, 2006) is a 12-item inventory of three domains: agreement on therapeutic task, goals, and interpersonal bond. The WAI is rated on a Likert-type scale from 1 (*seldom*) to 5 (*always*), with higher sum scores indicating stronger alliance. Items include, "I felt confident in [the therapist's] ability to help me." It has demonstrated strong psychometric properties (a =.77 - .98) in a wide range of studies with diverse samples of clients (see reviews by Hatcher & Gillaspy, 2006; Owen et al., 2011) and strong correlations to both therapist and client-rated improvement (Hatcher & Gillaspy, 2006). Experimental manipulations asking participants to rate imagined therapeutic alliance have also used the WAI with good results (Anglin et al, 2008; King, 2021; Stevens, 2008). Similar to this study, King and Borders (2018) instructed participants (N = 575) to imagine themselves as a client of a therapist described by randomly assigned vignette (with conditions representing varying levels of cultural competence). The WAI-SR was used to assess imagined alliance with a Cronbach's alpha of .95. In the present study, the alpha for the WAI-SR for the imagined alliance was .98.

Attention Check (Curran, 2016). In accordance with methodology for detecting careless, invalid survey responses, three conventional attention check items were used to assess the attention level of participants throughout the measures. Example items were, "If you are paying attention, please select 'Disagree'", and "Please respond, 'Always.'"

Procedure

This study used a Qualtrics survey hosted on CloudResearch (previously MTurk Prime). Compensation was $3.00 for completing all measures of this 25-30-minute study, in accordance with current national minimum wage rates (~$7/hour). The survey first collected informed consent, then demographic measures (age, gender, race/ethnicity, sexual orientation, religion, marital status, political affiliation, employment status, previous engagement in psychotherapy, barriers to engaging in psychotherapy). All participants completed the HCSD (9 items) and RaLEs (40 items) in random order, and all non-White participants completed the CMI (47 items). In order to progress through the survey, participants were required to respond to all items in these essential scales. All participants completed several other measures regarding their relationship with the healthcare system including the Mental Healthcare System Justification scale (MHSJ, 10 items), the Credibility of Science Scale including the vaccine hesitancy item (CSS, 13 items), and the Conspiracy Mentality Questionnaire (CMQ, 5 items). All participants then completed a number of interference measures (personality scales unrelated to this study); viz., the Brief Pathological Narcissism Inventory (B-NPI, 28 items), the Paranoia Check List (PCL, 18 items), and the Adverse Childhood Experiences Questionnaire (ACEs, 10 items). Participants were not required to respond to every item in these auxiliary scales in order to progress through the survey. In particular, each item of the ACEs included a response option of “Do not wish to respond.”

Finally, all participants were randomly assigned to one of the three manipulation conditions (high SJ; low SJ; non-response), each of which included about 250 participants. All were asked to imagine that they were a new therapy client experiencing cultural mistrust during a session and to write briefly how they might express that

mistrust, verbally or non-verbally, to their therapist. Participants they read their "therapist's" response, which varied according to their assigned condition (high SJ, low SJ, non-response). All participants then filled out the WAI-SR (12 items) for their assigned "therapist." Attention checks (3) were presented throughout the study. All participants were debriefed and provided with the contact information of the primary researchers for any questions or requests.

Data Analytic Plan

Data was checked and cleaned according to recommended online data collection practices (Sisso, 2018). This included checking for IP address and geotag validity for "bots" and removing participants who failed 2 or more attention checks. After data cleaning, items were reverse coded as needed, total scores calculated for each scale and subscale, and reliabilities calculated. Descriptive statistics of all measures were evaluated. Data missing at random and univariate/bivariate normality were analyzed, with MAR addressed and transformations conducted as appropriate if data was found to be overly skewed or kurtotic. Preliminary analyses consisted of descriptive statistics and a correlation matrix to determine that the relationships between primary variables were in the directions hypothesized. Correlations and mean comparison analyses between possible covariates and the dependent variable (WAI) were run to inform consideration as to whether they should be included in the main analyses. To assess if the proposed moderating and mediating variables significantly impact the dependent variable, multivariate hierarchical regression analyses and moderated mediations (including the simple mediations and moderations underpinning them) were conducted using SPSS. Because one mediator - cultural mistrust - applied only to participants of color and the

other mediator - healthcare system distrust - applied to all participants, two separate analyses were run to capture the hypotheses related to each of those variables and their respective samples. Preliminary and primary results are detailed in Chapter 5.

Chapter V

Results

This section will review preliminary analyses including participant exclusion, treatment of missing data, descriptive statistics of main variables, univariate and multivariate normality, inter-variable correlations, and covariate analyses. Last, main analyses of Hypotheses 1-5 will be described.

Preliminary Analyses

Missing data. While 880 individuals met inclusion criteria for the experiment, 143 were excluded from analyses due to missing data and other factors. Specifically, 55 participants failed either 2+ attention checks or a consistency check following the demographics section; 34 did not meet criteria for the study including U.S. residency, native English fluency, or racial identity for chosen survey; 27 attempted to complete the POC survey first self-reporting as a White individual, then completing the survey again self-reporting as a person of color; 11 participants were excluded due to "bot-like" markers including proxy/bad hosting IP addresses and write-in answers copied-and-pasted in full from the internet; 6 did not fully complete the survey; 6 submitted their IDs for compensation but were not found in the data file suggesting either fraudulent submission or technical error; 3 mistakenly completed the study twice and were compensated and included only once; and 1 person contacted the researcher afterward asking that their data not be included. In order to be eligible for this study, participants were informed via Qualtrics that they must complete in entirety the measures necessary for the study's main analyses (i.e., CMI, HCSD, RaLEs, WAI). Therefore, no missing data was found in these essential measures and MAR was not an emergent issue. Because

the CMI was administered only to respondents of color, sample sizes varied across analyses based on the variables evaluated. Therefore, samples sizes are provided throughout this section. The main *N* for the current study is 737.

Descriptive statistics. Descriptive statistics were obtained using SPSS Version 26 and presented in Table 1 above and Table 2 below. Preliminary analyses revealed that all variables were normally distributed and fell within the acceptable range of skewness and kurtosis (< +/- 2.0). Multivariate assumptions were confirmed using normal P-P plots, correlation matrices, and scatterplots. Additionally, multivariate outliers were identified using a Cook's Distance greater than one and probability of Mahalanobis Distance less than .001. Two outliers were identified in the regression model including racialized stress, cultural mistrust, healthcare system distrust, and working alliances. These two outliers were removed prior to running the primary analyses, leaving the study sample of 737 as noted above.

Inter-variable correlations. Correlations were performed among the main variables of the study using Pearson's *r*. Results are provided in Table 3 below.

Severity of racist experiences was significantly correlated with cultural mistrust ($r[638] = .41$, $p < .001$) with a moderate effect, as well as with healthcare system distrust ($r[737] = .19$, $p < .001$), with a small effect. Severity of experiences of racism was not significantly correlated with working alliance with the imagined therapists in this experiment ($r[737] = -.01$, $p = .83$) or with vaccine hesitancy ($r[730] = -.07$, $p = .052$). Cultural mistrust had a moderate, significant correlation with healthcare system distrust ($r[638] = .40$, $p < .001$). Cultural mistrust was not significantly correlated with working alliance with the imagined therapist in this study ($r[638] = -.01$, $p = .75$) or with vaccine

Table 2
Descriptive Statistics of Measures

Measure	Observed range	Mean (*SD*)	Skewness (*SE*)	Kurtosis (*SE*)
RaLEs (n=737)	0.00-195.00	67.02 (42.74)	0.38 (0.10)	-0.51 (0.19)
Severity of racist experiences (n=737)	0.00-100.00	34.52 (26.42)	0.43 (0.10)	-0.70 (0.18)
Frequency of racist experiences (n=737)	0.00 - 97.00	27.93 (20.61)	0.86 (0.10)	0.26 (0.19)
Cultural Mistrust Inventory (*n*=638)	49.00 – 329.00	179.50 (52.12)	0.09 (0.10)	-0.01 (0.19)
Health Care System Distrust Scale (*n*=737)	9.00 – 45.00	29.61 (7.19)	-0.10 (0.09)	-0.25 (0.18)
Distrust of healthcare competence (*n*=737)	4.00 – 20.00	11.54 (3.78)	0.38 (0.10)	-0.48 (0.19)
Distrust of healthcare values (*n*=737)	5.00 – 25.00	18.23 (4.25)	-0.52 (0.10)	-0.10 (0.19)
Working Alliance Inventory (*n*=737)	13.00 - 65.00	42.50 (12.86)	-0.72 (0.09)	-0.11 (0.18)
Vaccine Hesitancy (*n*=730)	1.00 – 7.00	3.02 (0.08)	0.65 (.09)	-0.91 (0.18)

Note. *SD* = standard deviation; *SE* = standard error; RaLEs = Racism and Life Experiences scale

hesitancy (r [632] = .051, p = .20), while healthcare system distrust was significantly negatively correlated, with a small effect, with working alliance with both the study therapist (r [737] = -.17, p < .001), and vaccine hesitancy (r [730] = .16, p < .001). Finally, working alliance with the therapist in this study was moderately and significantly correlated with previous therapy satisfaction (r [521] = -.22, p < .001), as noted below.

Covariates. Several variables were tested as potential covariates regarding the outcome variable – that is, working alliance with the presented therapist vignette – in order to ascertain that differences in the evaluation of this "therapist" in this study were not attributable to factors outside those being investigated. Variables tested as covariates included the following: gender, age, sexual orientation, political affiliation, whether participants had previously attended therapy, treatment length of previous therapy, and satisfaction with previous therapy. Continuous variables were tested using correlation tests (Pearson's r) while potential categorical covariates were analyzed using mean comparison tests (t-tests and ANOVAs). No significant relationship was found between participants' working alliance scores and their age (r [733] = -.03, p = .38), nor with their gender (F [5, 731] = .84, p = .52), sexual orientation (F [8, 728] = 1.90, p = .06), or political affiliation (F [6, 730] = 1.97, p = .07) when all categories were included (see Appendix 3). To account for small sample sizes in some of these demographic categories (e.g., 2 genderqueer participants), sexual orientation and gender identity were dichotomized (sorted into gender/sexual minority vs. non-minority categories), and political orientation was simplified into three categories (liberal, moderate, conservative). Using categorical variables, mean comparison tests continued to find no significant relationship between working alliance and gender identity (t [718] = -0.47, p = .64) or

Table 3

Descriptive Statistics and Intercorrelations Among the Primary Study Variables

Variable	*n*	*M*	*SD*	1	2	3	4	5
1. Racism and Life Experiences Severity	737	34.52	26.42	—				
2. Cultural Mistrust	638[a]	179.50	52.12	.41***	—			
3. Health Care System Distrust Overall	737	29.61	7.19	.19***	.40***	—		
4. Working Alliance (Post-Manipulation)	737	42.50	12.86	-.01	.01	-.17***	—	
5. Vaccine Hesitancy	730	3.02	0.08	-.07	.05	.16***	.03	—

*$p < .05$. **$p < .01$. ***$p < .001$.

[a] = participants of color only

with political affiliation (F [2, 734] = 1.13, p = .33). However a significant relationship was found between working alliance and sexual orientation (t [735] = 2.08, p = .04), in that participants identifying as heterosexual reported stronger working alliances than sexual minority participants overall. For this reason, sexual orientation was included as a covariate in all primary analyses, as described below.

No significant relationship was found between participants' working alliance with the vignette therapists in this study and whether they had previously attended therapy (t[520] = .80, p = .42), nor their length of longest previous treatment (r [522] = -.06, p = .18). Participants' previous therapy had a small significant correlation with their working alliances in this study (r [521] = -.22, p < .001). However, previous therapy satisfaction appeared to be a downstream outcome effect, with a one-way ANOVA finding moderate racial differences in satisfaction with previous therapy (F [7, 505] = 3.17, p = .04). Specifically, participants of color reported lower previous therapy satisfaction than did White participants, and Black participants reported lower previous therapy satisfaction than did other participants of color. These results suggest that previous therapy satisfaction may be related to this study's operative variables of cultural and healthcare mistrust, and therefore that controlling for these effects may exclude variance that we aim to capture. Therefore, previous therapy satisfaction was not included as a covariate.

Hypothesis Testing

Hypothesis testing of regression analyses was conducted using Hayes' (2018) PROCESS Macro for SPSS, Version 4.0. Effects were bootstrapped with 10,000 samples and bias corrected bootstrap 95% confidence intervals were used to determine

significance. All primary models included racialized stress as the independent variable and working alliance with vignette therapist as the dependent variable. All regression models included sexual orientation as a covariate (see Figures 2, 3, and 4 below). Next, analytic procedures and results for each hypothesis will be described in more detail.

Hypotheses 1: Correlation

Hypothesis 1 predicted that racialized stress would be significantly and negatively associated with working alliance across all conditions. Correlational analyses, as described above, showed that this hypothesis was not supported, as severity of racialized stress was not found to be significantly associated with working alliance across the "therapists" in this study (r[737] = -.01, p = .83). This indicates that racialized stress does not necessarily have to produce lower working alliances across all intervention styles.

Hypotheses 2: Mediation - Cultural Mistrust Model

Hypothesis 2 predicted that cultural mistrust would significantly and positively mediate the effect of racialized stress on the working alliance; that is, that racialized stress would also be indirectly related to working alliance through cultural mistrust. This hypothesis was tested with PROCESS Model 4 to assess mediation effects of cultural mistrust; the model was significant, with a small effect [F (3, 634) = 3.59, p = .01], predicting 2% of the variance of the impact of racialized stress on working alliances with the vignette therapists.

This hypothesis was not supported. The association between cultural mistrust and working alliance was not significant in this model (b = 0.00, SE = .01, t (634) = 0.20, p = .84, 95% CI [-.02, .02]), nor was the indirect effect of racialized stress on working alliance through cultural mistrust (b = .00, SE = .02, 95% CI [-.03, .04]). Moreover,

cultural mistrust exerted negligible effect on the racialized stress-working alliance relationship ($\Delta R^2 = .003$). These findings indicate that cultural mistrust was not significantly related to perceptions of the working alliance in this study, nor was it indirectly implicated in the impact of racialized stress on the alliance.

Hypotheses 3: Mediation - Healthcare System Distrust Model

Hypothesis 3 predicted that healthcare system distrust would significantly mediate the effect of racialized stress on the therapeutic alliance; that is, that racialized stress would also be indirectly related to working alliance through healthcare system distrust. Specifically, it was hypothesized that higher racialized stress would be positively associated with healthcare system distrust which would in turn be negatively associated with working alliance.

Hypothesis 3 was tested with PROCESS Model 4 to assess mediation effects of healthcare system distrust. The model was significant [F (3, 733) = 8.62, $p < .001$] with a small effect, demonstrating the impact of racialized stress on these working alliances, and the healthcare system distrust mediation model predicting 3% of this variance.

This hypothesis was supported. Racialized stress was significantly and positively associated with healthcare system distrust ($b = .10$, $SE = .02$, t (733) = 5.16, $p < .001$, 95% CI [.06, .14]). While no significant direct effect was found between racialized stress and working alliance ($b = .03$, $SE = .03$, t (733) = 0.76, $p = .44$, 95% CI [-.04, .09]), there was a significant direct effect between healthcare system distrust and working alliance ($b = -.29$, $SE = .07$, t (736) = -4.41, $p < .001$, 95% CI [-.42, -.16]). Further, the indirect effect of racialized stress on working alliance through healthcare system distrust was significant and negative ($b = -.03$, $SE = .01$, 95% CI [-.05, -.01]), with a small effect ($\Delta R^2 = -.01$).

This suggests that higher racialized stress relates to higher healthcare system distrust, which in turn relates to lower working alliance.

Hypothesis 4a, 4b: Moderation

This study's primary hypotheses 4a and 4b were tested using PROCESS Model 1 for simple moderation with racialized stress as the independent variable, working alliance with vignette therapist as the dependent variable, and therapist system justification (i.e., assigned therapist condition) as the moderator. The moderation model was significant [F (4, 732) = 40.52, $p < .001$], demonstrating a small effect of racialized stress on the working alliance and predicting 18% of the variance in this relationship.

Hypothesis 4a predicted that therapist system justification would significantly moderate the relationship between racialized stress and the therapeutic alliance such that this negative relationship would become weaker and less significant as system justification decreased. This hypothesis was partly supported, in that higher therapist system justification had an overall significant and negative moderating effect (b = -4.64, SE = .85, t (732) = -5.44, $p < .001$, 95% CI [-6.31, -3.00]) on the relationship between racialized stress and working alliance. Analyses of conditional direct effects of racialized stress on the working alliance at various levels of this moderator showed that the positive relationship between racialized stress and working alliance was only significant in the presence of the "low system justifying" therapist condition (Vignette 1): b = -.10, SE = 0.50, t (732) = 2.00, p = .048, 95% CI (.001, .196) (Figure 1). The "high system justifying" therapist response (Vignette 2) produced a negative but non-significant relationship between racialized stress and working alliance (b = -.00, SE = 0.03, t (732) = -0.03, p = .97, 95% CI [-.06, .06]), and the "non-responding" therapist produced a

relationship between racialized stress and working alliance that was both negative and significant, as detailed below. These findings indicate that therapist system justification significantly moderates the relationship between racialized stressed and working alliance, such that low system justification contributes to a positive relationship between these variables whereas high system justification does not.

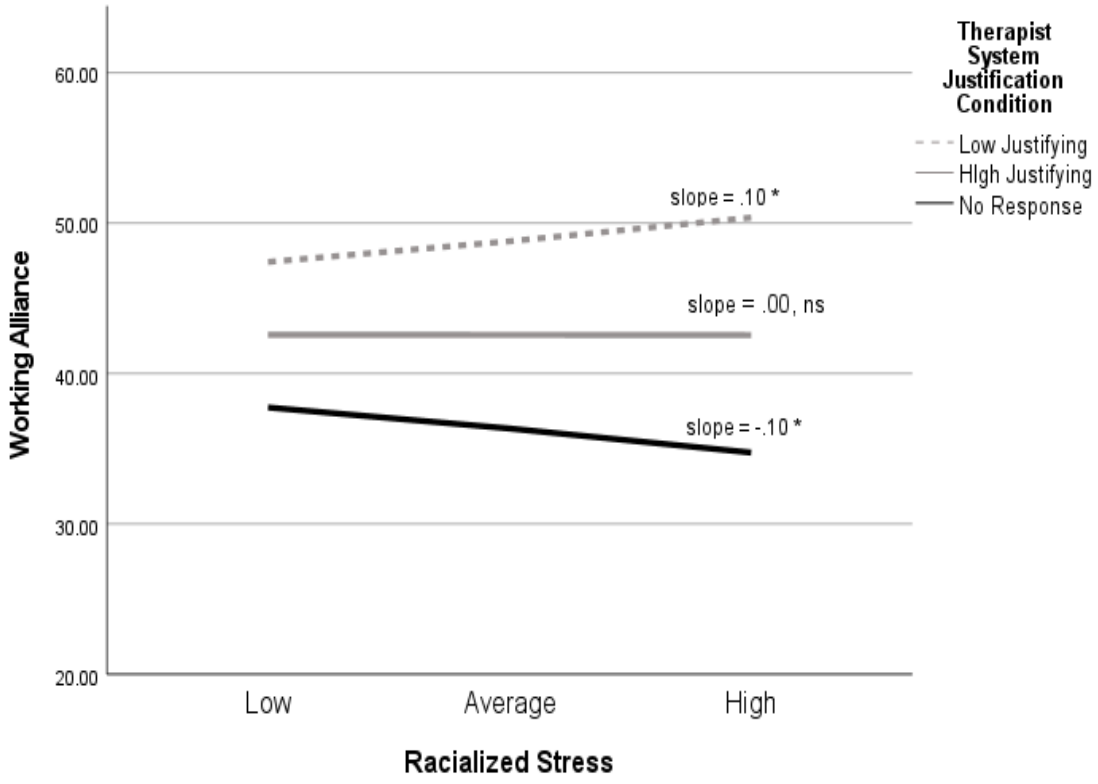
Hypothesis 4b predicted that working alliances would be most negatively affected by responses wherein the therapist did not address the participant's expression of mistrust in any way (i.e., the "non-response condition," Vignette 3). This hypothesis was supported, as the significant, negative moderating effect of therapist response on the relationship between racialized stress and working alliance was strongest for the non-response condition (b = -.10, SE = 0.50, t (732) = -2.03, p < .05, 95% CI [-.197, -.003]), as compared to the other two conditions. As noted, overall in this model, racialized stress was found to have a positive and significant relationship with working alliances, this effect was not found in the presence of the non-response therapist, with this condition producing a relationship between racialized stress and working alliance that was both negative and significant. These findings indicate that lack of any sort of response to the participants' mistrust was most predictive of the expected negative and significant relationship between racialized stress and low working alliance.

Hypothesis 5a: Moderated Moderation – Cultural Mistrust Model

Hypothesis 5a predicted that the mediating effect of cultural mistrust on the relationship between racialized stress and working alliance would also depend on the presented level of therapist system justification; specifically, it was hypothesized that the negative indirect effect through cultural mistrust would increase significantly in the

Figure 1

Relationship between Racialized Stress and Working Alliance by Therapist System Justification Condition



presence of higher therapist system justification. As the mediations upon which this analysis was based were not supported (see Hypothesis 2a), this moderated mediation was not conducted.

Hypothesis 5b: Moderated Mediation – Healthcare System Distrust Model

Hypothesis 5b predicted that the effect of racialized stress on working alliance through the pathway of healthcare system distrust would depend on level of therapist system justification; specifically that, at low levels of system justification, the healthcare system distrust-mediated relationship between racialized stress and working alliance would become significantly more positive. Conversely, it was hypothesized that at high levels of system justification, this relationship would become significantly more negative (i.e., those lower in racialized stress would report higher working alliances).

This hypothesis was tested using PROCESS Model 8 to analyze moderated mediation effects. The model included racialized stress as the independent variable, working alliance with vignette therapist as the dependent variable, therapist's experimentally-manipulated system justification (i.e., assigned therapist condition) as the moderator, and healthcare system distrust as the mediator. This model was significant [$F(5, 731) = 38.13$, $p < .001$], (Figure 2 and 3), indicating a moderate effect of racialized stress on the alliance, with this model predicting 21% of the variance in that relationship.

This hypothesis was partly supported: in addition to healthcare system distrust partially explaining the relationship between racialized stress and working alliance, this indirect effect was moderated by therapist system justification, such that at low levels of therapist system justification, the indirect effect of healthcare system distrust on the relationship between racialized stress and working alliance was significantly more

positive (*b* = .12, *SE* = .05, *t* (731) = 2.44, *p* = .015, 95% *CI* [0.02, 0.22]). However, the converse hypothesis was not supported: there was no significant effect of high system justification on the relationship between racialized stress and working alliance (*b* = .03, *SE* = .03, *t* (731) = 0.88, *p* = .38, 95% *CI* [-0.03, 0.09]). These results suggest that low therapist system justification, but not high therapist system justification, impacts the way that healthcare system distrust mediates the relationship between racialized stress and the working alliance. Specifically, low therapist system justification contributed to stronger working alliances, particularly for people with higher levels of racialized stress and healthcare system distrust, whereas high system justification exerted no such influence.

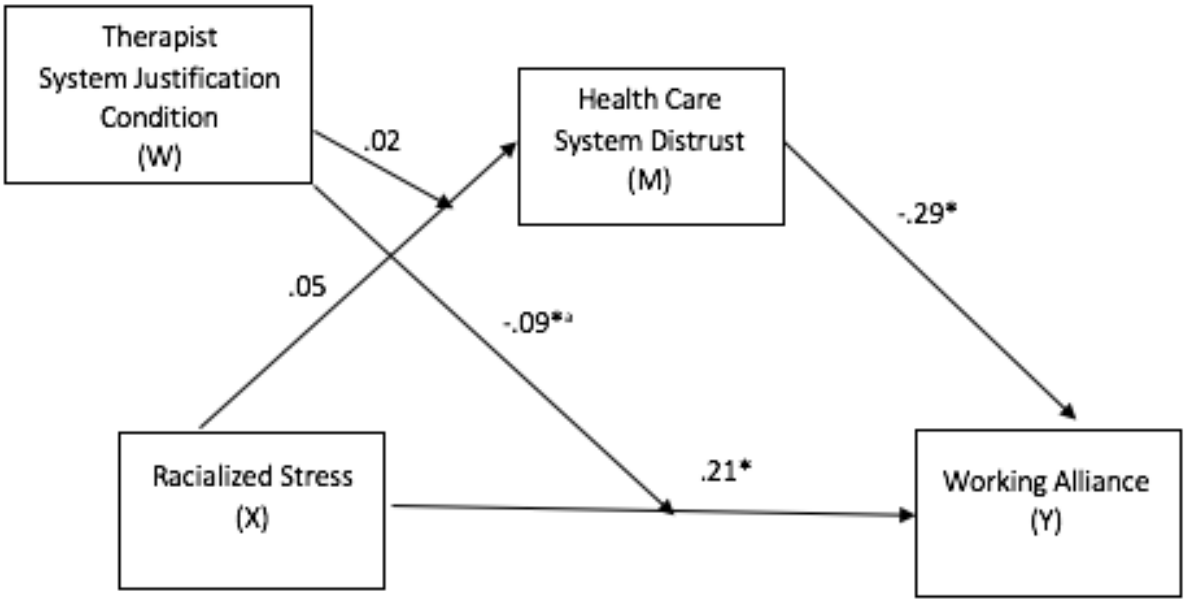
Exploratory Hypothesis

This study's exploratory hypothesis predicted that vaccine hesitancy would be significantly and negatively associated with working alliances, as well as significantly moderated by experimentally-manipulated level of therapist system justification (specifically, that this negative relationship would become weaker and less significant as therapist system justification decreased).

This exploratory hypothesis was tested using PROCESS Model 1 for moderation analysis. This model included vaccine hesitancy as the independent variable, working alliance with vignette therapist as the dependent variable, and experimentally-manipulated therapist system justification (i.e., assigned condition) as the moderator. Like the primary analyses, sexual orientation was included as a covariate. This model was significant, demonstrating the impact of vaccine hesitancy on the working alliances described in this study. The moderation had a moderate effect, with the model [*F* (4, 725) = 45.59, *p* < .001] predicting 45% of this variance.

Figure 2

Moderated Mediation – Healthcare System Distrust Model



Note. Values = unstandardized coefficients. Indirect effect through Health Care System Distrust ranged from -.021 to -.035, all significant but not significantly different from each other.

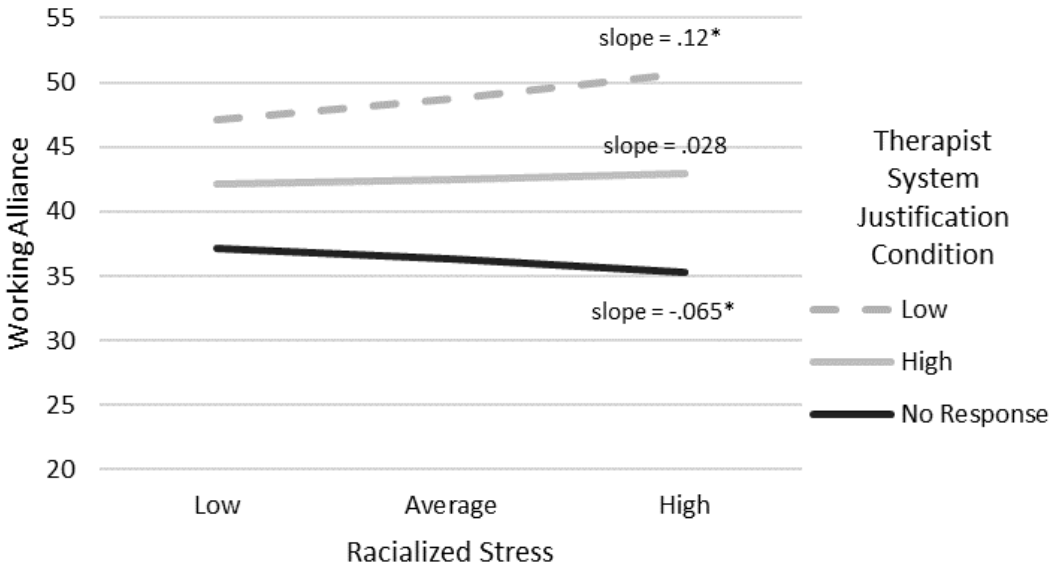
R^2 = .21, F (5, 731) = 38.13, p < .001.

[a] Conditional Direct effects: Condition 1 (Low SJ) slope between X and Y = .12, p = .01;
Condition 2 (High SJ) slope between X and Y = .03, p = .38;
Condition 3 (No Response) slope between X and Y = -.06, p = .19.

* p < .05

Figure 3

Conditional Direct Effects of Racialized Stress on Working Alliance by Therapist System Justification Condition, from Moderated Mediation Model.



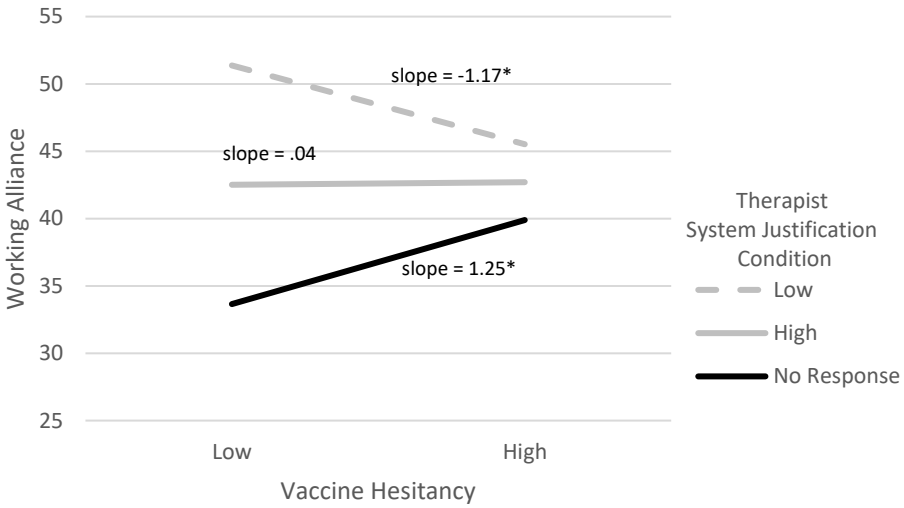
Note: Slopes differ from Figure 1 due to the current interaction being part of a larger model of moderated mediation.

* $p < .05$

The hypothesis was supported, as vaccine hesitancy was significantly and negatively associated with working alliance (b = -2.38, SE = .54, t (729) = -4.37, p < .001, 95% CI [-3.45, -1.31]), wherein the negative relationship between vaccine hesitancy and working alliance was lower in the "low system justification" condition and higher in the "non-responsive" condition. Therapist system justification had an overall significant and positive moderating effect (b = 1.21, SE = .25, t (729) = 4.79, p < .001, 95% CI [0.71, 1.71]) on the relationship between vaccine hesitancy and working alliance. Analyses of conditional direct effects of vaccine hesitancy on the working alliance at various levels of the moderator showed that the "low system justifying" therapist (Vignette 1) exerted a significant negative moderating effect on the relationship between vaccine hesitancy and working alliance : b = -1.17, SE = 0.33, t (729) = -3.59, p < .001, 95% CI (-1.81, -.53). The "high system justifying" therapist response (Vignette 2) had a positive but non-significant impact on the relationship between vaccine hesitancy and working alliance (b = .04, SE = 0.21, t (729) = 0.19, p = .85, 95% CI [-.37, .45]), while the "non-responding" therapist actually had a significant and positive moderating effect on this negative relationship (b = 1.25, SE = 0.33, t (729) = 3.81, p < .001, 95% CI [.61, 1.89]). (See Figure 4 below.) These findings indicate that therapist system justification significantly moderates the negative relationship between vaccine hesitancy and working alliance, such that low system justification decreases this relationship, high system justification has no significant effect, and therapist non-responsiveness increases it.

Figure 4

Relationship of Vaccine Hesitancy to Working Alliance by Therapist System Justification Condition.



* $p < .001$

Chapter VI

Discussion

This study was the first to apply the social psychological concept of system justification theory – and specifically, therapists' reflex to justify the mental healthcare system – to clinical process research. To this end, this study asked whether therapists' system justification was a meaningful factor within patients' cultural healthcare mistrust in the therapeutic alliance, with match of patient-therapist system relationships (e.g., high mistrust with low system justification) potentially strengthening the alliance, and mismatch potentially weakening it. This research question was tested using a study that assesses participants' racialized stress, cultural mistrust, and healthcare system distrust, then experimentally manipulated their exposure to a vignette therapist at one of three levels of system justification (low SJ, high SJ, and non-responding). Participants' reported working alliances with each of these imagined therapists were collected and analyzed, the results of which are discussed here.

This section will describe the key findings of this study and the clinical implications of each. Next, it will review the limitations of the study design and its potential contributions to psychology research and clinical implications. Finally, it will suggest directions for future research and expansion of these concepts to practice.

Review of Key Findings

System justification. Perhaps most centrally, this study sought to examine whether racialized stress and the therapeutic alliance (specifically, the negative impact of racialized stress on the working alliance) would become weaker in the presence of a low system-justifying therapist. This prediction was informed by the extensive literature

showing that therapists' individualistic, color-blind, and power-evasive approaches – in which system justification has been implicated but never directly studied – are related to weaker therapist empathy, poorer alliances, and more negative therapeutic outcomes with racially minoritized clients. Conversely, being able to acknowledge systemic factors of clients' difficulties and create space for their very real societal concerns within the therapeutic relationship has long been associated with stronger alliances and better outcomes for these patients (Hays et al., 2008; Neville et al., 2013). Indeed, in this study, low therapist system justification had the most beneficial effect on the relationship between racialized stress and working alliance, actually contributing to a significant *positive* relationship between racialized stress and working alliance. This speaks to the potential of non-system justifying stances to aid alliances affected by racialized stress.

Recent research has similarly highlighted system-focused intervention as a key facet of cultural competence deserving of greater clinical and empirical attention (see meta-analysis by Liu, Gill & Li, 2020). Redding and Cobb (2023) argue that sociopolitical values should be considered just as much an area for discussion and use in psychotherapy as any other type of values (e.g., interpersonal, ethical). They base this suggestion on a line of research demonstrating that sociopolitical values can be as important to individuals' sense of identity as their demographic factors, and are often used to provide meaning, community, direction, and social belonging in a similar way (e.g., Becker, 1971; Jost & Amodio, 2012). The authors also describe early research finding that the impact of therapist-patient racial-ethnic match becomes non-significant when sociopolitical values and cultural competency skills are controlled for (Redding & Cobb, 2023). In other words, therapists' sociopolitical values and attitudes – including

system justification – are emerging in the recent literature as a possible common factor of many other, more visible aspects of cultural competency, supporting this study's results.

It is worth noting that, contrary to our hypothesis, the effect of racialized stress was not, taken in absence of the therapist system justification condition, significantly associated with working alliance. In other words, greater severity of racialized stress did not in and of itself significantly impact perceptions of the working alliances with the "therapists" in this study. There are several possible factors contributing to this result: first, psychometric assessments of the racialized stress scale (RaLES) have found an average score of 40.47 (N = 104, SD not reported) among African American adults (Harrell, Merchant, & Young, 1997). The generally lower levels of racialized stress reported by this sample (M = 34.52, SD = 26.42), with observed scores truncated toward lower levels on the 0-100 scale, may have contributed to these results. This lower average was likely impacted both by the overall lower racialized stress scores of the White participants included in the study, as well as by the natural bias involved in a self-selecting sample that is engaged with behavioral health science and chooses to disclose their personal experiences around race and mental healthcare. In this light, it is plausible that this sample already held a fair amount of trust in psychotherapy; a belief itself facilitative of stronger working alliances (Horvath & Greenberg, 1989). As noted in limitations sections across the literature, those with the highest levels of cultural and healthcare mistrust will typically decline to participate in scientific research altogether (e.g., Olatunji et al., 2020; Scharff et al., 2010). Among those remaining, relatively higher racialized stress may actually be helpful for treatment-seeking and forming connection;

like the Yerkes-Dodson law, those with higher racialized stress within this lower-stress sample may be uniquely well-positioned to engage in tasks related to alliance building.

Interestingly, while the "high system justifying" therapist did not exert a significant influence on the relationship between racialized stress and working alliance, under this condition, too, there was a positive relationship between racialized stress and working alliance. In other words, both the high- and low-system justifying therapists, who directly addressed the mental healthcare system (whether in negative or positive terms), did not produce the expected negative relationship between racialized stress and working alliance. Only the condition wherein the participant's cultural mistrust was fully disregarded replicated this negative relationship as described in the literature. These findings appear to shine a light on the therapeutic value of straightforwardly addressing the system in which the treatment takes place, even in a more seemingly justifying way.

Non-responsiveness. On the other hand, the present results speak to the pitfalls associated with therapists' failures to be responsive to their patients' signals, particularly of worry and discomfort. We hypothesized that working alliances would be most negatively affected by therapists that were unable to meaningfully respond to the participant's expression of mistrust in any way. This prediction was based upon the clinical literature describing the centrality of therapists' ability to notice and attend to their clients' signals of discomfort, system-related or otherwise (Hall & Yee, 2015; Ornstein & Ornstein, 1995), with therapists' own avoidance of anxiety-provoking topics posing a potentially calamitous threat to such attunement (Shamoon et al, 2017).

We found that, as hypothesized, the non-responding therapist condition had the strongest negative effect on the relationship between racialized stress and working

alliance as compared to the other two conditions. As noted, both responses wherein the therapist identifies the client's mistrust and addresses the mental healthcare system (positively *or* negatively) did not produce the expected negative relationship between racialized stress and working alliance. The non-responding therapist condition, however, did produce this expected relationship. These findings indicate that, though there *are* alliance differences between different responses to clients' mistrust, lack of any attuned response from the therapist – that is, avoiding, deflecting, or going quiet in the face of clients' mistrust – is likely to wreak considerably more damage. This particular result is especially troubling given the previous literature (e.g., Cohen, 2017) and current pilot study (Chapter IV) finding non-responsiveness to be *the most common* therapist reaction to racial and systemic content in the therapy room, particularly among trainee clinicians.

Research on the damaging effects of non-responsiveness could arguably be traced back to Harlow's paradigm of the "blank-faced mother," the caregiver who is emotionally unreachable and reactionless to the child's signals for closeness, comfort, and reassurance that the child interpersonally "exists" (i.e., is capable of having an effect on others). Notoriously, persistent parental misattunement of this kind is known to create in the child a deep sense of confusion, dysregulation, and disconnection from oneself and others (Beebe et al., 2012). Cutting-edge clinical psychology research has begun to focus on the phenomenon of "cultural countrertransference"; that is, countertransference – the therapist's emotional reaction to the patient – specifically in regard to racial, social, and cultural aspects of the therapeutic relationship. These studies find therapists' cultural countertransference to be marked by strong feelings of ambivalence, a sense of being

"unable to think" (termed "ethno-cultural disorientation" in the emerging literature), and likelihood to lapse into silence or avoid the cultural topic at hand (Chichevo, 2021).

Like the findings in the present study, associations are being identified between these reactions and lower therapist empathy and, in turn, to impaired effectiveness (Meyerson, 2021). In addition to emotions of guilt, anxiety, clumsiness, and avoidance as reactions to cultural content in-session, some therapists actually reported declining to take on clients from certain dissimilar backgrounds, in part to avoid intense cultural counter-transference (Chichevo, 2021). This new research on culturally countertransferential silence and neutrality, and the damage they cause, further support the current finding. These ideas are poised to expand the field in interesting and clinically necessary ways. In fact, recent textbooks on psychodynamic practice have begun to counsel trainee therapists on becoming aware of cultural countertransference in particular (e.g., Cartwright, 2022).

Cultural mistrust. Another key area of exploration for this study was the hypothesis that racial minorities' cultural mistrust would partly explain the relationship between their racialized stress and their working alliances. Specifically, we expected that greater severity of racialized stress would be associated with more cultural mistrust, which in turn would be associated with lower reported strength of the working alliance. This was informed by the literature showing cultural mistrust to be strongly and consistently informed by experiences of racism, and linked to underutilization of mental health services, higher rates of premature dropout, more mistrust of a wide range of healthcare treatments including immunizations, and weaker therapeutic alliances in general (Bague et al, 2019; Grant-Thompson & Atkinson, 1997; Keating & Robertson, 2004; King, 2021; Whaley, 2006). Across many years and populations, cultural mistrust

has emerged in previous literature as a core mechanism of the relationship between patients' racialized stress and their weaker therapeutic relationships. Contrary to our expectations, cultural mistrust was not itself significantly associated with working alliances, nor did it help to explain the way that their racialized stress impacted their therapeutic relationships, in this experiment.

Unlike the racialized stress scores, this sample did not appear to have produced lower overall reports of cultural mistrust than previous studies in this area. Moseley and colleagues (2007) found that African American participants who described themselves as "comfortable" with completing research surveys demonstrated an average cultural mistrust score of 187.0 (*SD* = 52.0). Meanwhile those who reported themselves to be "uncomfortable" with participating in research (bearing in mind that these individuals were nonetheless willing to complete the study in question) produced an average score of 165.0 (*SD* = 44.6). The overall cultural mistrust reports of the current sample fall cleanly into this range (*M* = 179.50, *SD* = 52.12), contraindicating that the unexpectedly non-significant effect of cultural mistrust here was enabled by lower-than-usual mistrust than other comparable participants in previous studies.[1]

That said, as suggested by the "comfortable" participants reporting significantly higher cultural mistrust than the "uncomfortable" participants ($p = 0.01$, $N = 49$ African American adults; Moseley et al., 2007), it is possible that cultural mistrust is difficult to share, particularly for those who feel more guarded during research interactions. In this

[1] Independent-sample *t*-tests showed that the CMI levels of our sample does not differ significantly from Moseley and colleagues' "comfortable" group $t[685] = 0.97$, $p = 0.33$), nor the "uncomfortable" group, [$t(685) = 1.89$, $p = .06$), though our sample is more comparable to the "comfortable" group mean. As noted, this may be related in part to the selection bias of an MTurk-based sample open to engaging in online surveys inquiring into their racial and mental health experiences.

study, space was provided at the end for participants to free-write any thoughts or feedback they may have, and several participants noted concerns about how the Cultural Mistrust Inventory (CMI) was being used. One participant – a middle-aged African American male with no psychotherapy history and high self-reported levels of mistrust, who would in theory be the precise population that this study seeks to help – expressed worry that the CMI was fishing for incriminating responses from Black participants. As discussed further in the Limitations section below, it is possible that the CMI itself may trigger reactive cultural mistrust, impacting how participants interpret and respond to the measure, and subsequently, any analyses and results including the measure.

Finally, previous literature has found that racial match between therapist and patient can alleviate some of the negative impact of racialized stress and cultural mistrust on the alliance (e.g., Nickerson, Helms, & Terrell, 1994; Terrell & Terrell, 1984). As this study used written vignette conditions with no therapist race/ethnicity included, it is possible that participants imagined a therapist who was similar to themselves, softening some of the effect of their racialized stress and cultural mistrust on the interaction.

Healthcare system distrust. Last, we looked at healthcare system distrust as a mediator of the relationship between racialized stress and the therapeutic alliance, expecting that greater levels of racialized stress would be related to greater levels of healthcare system distrust, and in turn, to lower working alliances. This prediction was informed by the literature showing that more severe experiences of discrimination was significantly and positively correlated with healthcare system distrust, and negatively correlated with treatment satisfaction and trust in providers (Armstrong et al., 2013; Benkert et al., 2006; Freeman et al., 2017). Similar to the literature and as hypothesized,

the present results found that greater racialized stress was indeed significantly associated with greater healthcare system distrust, which was associated with lower reported working alliances. Further, health system distrust was found to help to explain some of the negative impact of racialized stress on the working alliance.

Since this study was proposed – through the heart of the COVID-19 pandemic – social psychology has increasingly focused on racialized stress and healthcare system distrust as important forces within individuals' relationships with their providers. Parallel to the findings of this study, recent research across multiple minority groups has demonstrated significant associations between experiences of discrimination and more unfavorable attitudes toward seeking out mental healthcare (Stewart, 2022); more non-disclosure with their providers (Nong et al., 2022); and lower medication adherence (Pugh et al., 2021); all mediated by health care system distrust. These pieces of evidence further support the present result showing that distrust in the healthcare system is one of the important legacies of racialized stress, which can negatively impact a wide range of aspects of individuals' experiences in their medical/mental health care relationships, including their ability to feel supported in moments of worry and mistrust.

In addition to the effect of racialized stress on the working alliance being partly explained by healthcare system distrust, we hypothesized that this relationship would also depend on the level of therapist system justification in a given encounter. Specifically, we expected that those with more racialized stress and healthcare system distrust would have significantly stronger working alliances with the low system-justifying therapist, and those with less racialized stress and healthcare system distrust would have significantly stronger working alliances with the high system-justifying therapist.

This prediction was informed by the clinical literature on match, or "goodness of fit," between the patient and the therapist across several domains relevant to system justification. First, as noted, match between patients' and clients' sociopolitical values have been found to be strongly predictive of positive therapeutic outcomes, even beyond demographic match itself, and discrepancies in these values are related to lower therapist empathy and worse therapeutic outcomes (Redding & Cobb, 2023). Further, alliances have been found to benefit from patient-therapist agreement on whether the presenting problem is primarily internal (related to the patient's beliefs, feelings, behaviors) or primarily external (related to their circumstances, relationships, or resources) (e.g., Chowdhary et al, 2014). Mismatches in conceptualizing patients' difficulties – and specifically the mistake of viewing racialized stress as an individualistic problem – is a staple manifestation of system-justifying attitudes (Neville & Thompson, 1999). Finally, this expectation was shaped by the literature indicating that while greater transparency and power-sharing can be comforting for those with more mistrust, these same dynamics can activate a sense of risk for clients for whom mistrust was not initially salient (Das & Teng, 2001). The findings of this study were partly congruent and partly discrepant with the prediction that those with higher racialized stress and system distrust would report stronger alliances with the low system-justifying therapist, and vice versa for those with lower racialized stress and system distrust. Low therapist system justification did indeed significantly and positively impact alliances with participants with more racialized stress and healthcare system distrust. However, the flipside hypothesis - that high system justification would benefit those with lower racialized stress and healthcare system distrust - was not supported, as there was no significant effect of high system justification

on the stress/distrust/alliance relationship. In other words, low system justification does appear to impact the way healthcare system distrust participates in the relationship between racialized stress and working alliance, but high system justification does not exert any such influence, even for those with low racialized stress and system distrust.

It is notable that the highly system justifying therapist did not appear to garner the expected strong negative responses from participants with high racialized stress, nor the expected positive responses from those with low racialized stress. It is possible that even the simple acknowledgement of the patient's mistrust and the systemic context which might inform that mistrust (albeit while reassuring them that the system is "good") is a sort of system conscious intervention in itself. It is possible that the therapist who names the system for the purposes of justifying it (a sort of quasi-system-consciousness involved in identifying the system in any form) may ultimately provide *too much* system-consciousness for those with low racialized stress, and *too little* system-consciousness for those with high racialized stress, contributing to its overall non-significant effect.

These findings suggest that, while some therapists feel doubtful or anxious toward the idea of bringing "the political" into therapy (Danzer et al, 2016), the political is already present, especially for those who have experienced more racial discrimination. This is to say, psychotherapy's position within its broader systemic contexts is a highly relevant piece of the therapeutic alliance for our more racially traumatized and distrustful patients, and addressing those systems directly is one possible route to effectively circumnavigating these difficulties. Overall, systemic concerns are shown here to be a key part of our racially-minoritized patients' negative expectations of mental health care, and systemic responses are emerging as well-positioned to be part of the solution.

Supporting this finding, public health research following the murder of George Floyd discovered that closeness to experiences of police brutality, personally or vicariously, decreased Black Americans' likelihood of seeking needed medical treatment. A considerable percentage of this effect (18%) was accountable to the resultant medical mistrust following experiences of police brutality (Alang et al, 2021). These patterns illustrate that individuals' ability to trust in and seek the help from the healthcare system is affected by their experiences in other systems (e.g., law enforcement). It behooves therapists to recognize that, just as interpersonal expectations are informed by past experience – even, at times, seemingly distal experience – systemic expectation can be informed by past experience with other systems as well. For this reason, increasing marginalized populations' felt safety in mental health treatment requires that clinicians acknowledge and be able to engage in conversation about racial and systemic dynamics.

Finally, we chose to evaluate system justification in context of a non-psychotherapy manifestation of cultural mistrust toward the healthcare system which is prevalent in this culture at the time this study was conducted, during and after the highest spikes of COVID-19 (Cokley et al, 2021). Vaccine hesitancy is also of particular relevance, not only because of its current significance through the COVID-19 pandemic but as an unavoidable domain of healthcare utilization; while not every individual will search for a psychotherapist, every adult must make decisions regarding whether they will accept a recommended vaccine. To this end, we explored whether vaccine hesitancy would be negatively associated with working alliances, and whether this relationship would be influenced by level of therapist system justification that the participant encounters. Just

as with racialized stress, it was expected that the negative effect of vaccine hesitancy on working alliances would become weaker when given a low system-justifying therapist.

Indeed, this study found that vaccine hesitancy was negatively associated with working alliance, and that therapist system justification did exert a significant influence on this interaction. Specifically, low system justification significantly decreased the negative effects on vaccine hesitancy on working alliance, high system justification had a positive but non-significant effect, and the "non-responding" therapist significantly increased the negative association. This suggests that low system-justifying interventions may mitigate some of the negative effects of vaccine hesitancy on working alliances, and non-responsiveness may aggravate alliance difficulties. That said, at the highest levels of vaccine hesitancy, the alliances differences between conditions become negligible. These results show the potential uses of low system-justifying interventions among providers in addressing patients' vaccine hesitancy; a notion supported by Flavio Azevedo and John Jost's (2021) recent finding that less trust in scientific experts is associated with lower system justification, even with other demographic and political variables controlled.

Clinical Implications

Overall, it is clear from the literature that therapists often feel anxious and ill-prepared to engage with the political nuances of therapeutic work; and, related to this anxiety and unpreparedness, may avoid such discussions or even see them as potentially threatening to the therapeutic relationship (Winter 2021). However, becoming equally apparent – particularly in social and clinical psychology research through and after March 2020, bringing an increased focus on racial justice and systemic brutality – is that systemic dynamics are important to many of our patients, and particularly those with

more severe racialized stress. Research is finding that patients often experience it as beneficial to the alliance when they are able to discuss political and systemic elements of the therapeutic relationship in an open, nonjudgmental way, even when there are ideological differences between them (Farrar & Hanley, 2023).

The present results highlight individuals' systemic worries and beliefs as a potentially very meaningful manifestation of their racialized stress in the therapeutic alliance, and therapists' ability to acknowledge the legitimacy of system mistrust as one potentially effective route of bridging those cultural gaps. This particular experiment did not find any alliance detriments related to addressing the system explicitly, even with individuals with lower reported racialized stress. This is to say, engaging in open and honest discussion of the political and systemic elements of our work stands to strongly benefit some alliances that may otherwise be fairly precarious, possibly with few overt downsides. However, in order to have these conversations openly and nondefensively, therapists must foster an awareness and fluency in the political aspects of their role.

The instinct to justify the mental healthcare system may help to explain some of therapists' instinct to altogether avoid these discussions, which may in fact be the most detrimental form of response. However, these topics may also help to pave a path for therapists to start moving toward a solution. Cultivating a non-justifying system consciousness can be one way for therapists to maintain and build alliances with racially minoritized clients, who are likely to present to treatment with higher levels of mistrust. Therapists' examination of their sociopolitical beliefs appears to be impactful to their alliance not only when stated explicitly, as in the primary study, but also as part of their general demeanor and without explicit expression, as in the process-outcome pilot study.

By both believing in mental health care enough to be part of it and being openly willing to acknowledge system weaknesses, clinicians can model a healthy ambivalence wherein space is created for both positive and negative elements of the mental healthcare system (Gawronski, 2012). This stance may help therapists respond constructively to ego, group, and macro-level system threats, including patients' cultural and healthcare mistrust, allowing dissonance to exist rather than avoiding or prematurely resolving it using system justification. Given that systemic concerns are a significant factor in racially-minoritized patients' negative expectations of mental health treatment, systemic-conscious responses can play a key role in improving these experiences and outcomes.

In sum, racialized stress, addressed thoughtfully and respectfully, may actively benefit the alliance, in spite of significant healthcare system distrust. Therapists' ability to allow space for the weaknesses of the mental healthcare system appears to help build trust, both in therapeutic dyads and between providers and vaccine-hesitant individuals. As such, this study finds clinicians' capacity to regulate their instinct to system-justify to be a promising element of effective alliance-building with racially minoritized patients.

Limitations

There were several notable limitations of this study which should be considered regarding its generalizability and applicability. First, as discussed in the general discussion section, there were potential disadvantages to the use of the Cultural Mistrust Inventory. In particular, based on participant feedback, it appeared that the fairly forceful phraseology of the CMI (e.g., "When a white teacher asks a Black student a question, it is usually to get information which can be used against him or her") may itself activate some mistrust regarding what precisely is being researched, which in turn may affect how

individuals respond. It is worth recognizing that the concepts of cultural mistrust and the CMI were developed in the 1960-70's, and that these early measures may speak to a time when explicit racial bias was more common. Further, some participant feedback suggested that the CMI's focus on individuals' experiences with specific White politicians or "White friends" was not necessarily how racially-minoritized people experience discrimination in the present day. To paraphrase one participant's feedback: "I trust my White friends, I just wouldn't want to see them as police officers." Just as many modern uses of the CMI choose to omit certain items due to outdated and/or bigoted language (e.g., "White people are the real Indian givers") with the recognition that this helps to maintain the CMI's integrity, the validity and longevity of the CMI may benefit from broader evaluations of cultural mistrust in the present day.

Another worthwhile criticism is of the experimental manipulation itself. The vignettes here were validated based on therapists' evaluation of what system justification may look like within the dyad. However, upon retrospective appraisal of the "high system justifying" condition, it may be that this therapist – who responds empathically to their client's cultural mistrust, acknowledges the potential difficulties of the treatment's context in the mental healthcare system, but states their belief that the system is worth engaging in – could represent an overly optimistic view of the average system-justifying clinician. Based on recent literature, it seems that the highly system-justifying therapist is likely more akin to the system-avoidant therapist, as described in Vignette 3 (the "non-responding" condition), who tends to view sociopolitical discussion a threat to the alliance and is unable to put words to system mistrust. Thus, it is possible that the "high

system justifying" condition here may be less highly system-justifying than initially conceptualized, which may have contributed to some of the non-significant results.

Additionally, the primary study recruited participants and collected data through Amazon's Mechanical Turk (MTurk), which has come under empirical fire for including more "bots" and inattentively responding members than previously recognized (Webb & Tangney, 2022). Some of these concerns were mitigated by using CloudResearch (previously "MTurk Prime") which has its own screening process ensuring that participants are describing themselves consistently across multiple surveys and have a demonstrated history of attentive, thorough responding. In addition to using the built-in data quality protection of CloudResearch, this study also utilized comparatively scrupulous data checking procedures similar to those described by Webb and Tangney (2022), including review of IP address, completion time, consistency across demographic items, qualitative write-in responses, three attention checks, and a randomized survey ID number. However, limitations related to the use of these platforms and risk of particularly well-constructed bots continue to pose challenges to the quality of online survey data.

Finally, and not unrelatedly, research has found that severity of experienced racism and subsequent distrust toward healthcare systems and providers are important predictors of those individuals' likelihood to withhold information from medical researchers, as well as their own medical providers (Nong et al, 2022). As noted, this research should be considered with the stipulation that those with the highest levels of racialized stress and systemic distrust have likely self-selected out, either due to MTurk-based data collection or through the various questions on racial and social dynamics presented (e.g., beliefs regarding race relations, psychiatric history, common conspiracy

theories, vaccinations). This is congruent with the somewhat lower-than-expected range of racialized stress reported among these participants. The exclusion of many of the most systemically traumatized and mistrustful individuals has critical implications for the quality and fullness of data accessible to social and clinical psychology research.

Future Directions

The present results establish a basis for several potential avenues of future research. As noted, one of the most fruitful directions for further investigation may involve analyzing the characterology of contemporary cultural mistrust through racially and socially diverse eyes, toward the development of a modernized Cultural Mistrust Inventory. Similarly, one of the primary limitations of this study was its reliance on therapists' self-reported sense of what high vs. low system justification would look like in the clinical encounter. To this end, exploring therapists' in-the-moment system-justifying responses – as well as the actual alliance consequences of those responses – from a rupture-repair perspective could add great richness to the cultural competency literature.

Another promising line of inquiry would be the thorough investigation of contributing factors, protective factors, and manifestations of mental healthcare system justification, toward the goal of building non-justifying system consciousness as part of clinical training. As observed in the process-outcome pilot study, trainee therapists who were themselves in therapy and those who were further along in their doctoral training were significantly less likely to system-justify. Given that lower system justification was found here to be a significant predictor of stronger alliances with racially minoritized patients, there could be great value in examining the possible mediating factors of these associations. For example, perhaps engaging in one's own psychotherapy and/or experiencing a diversity of treatment settings over the course of one's training diminishes

some of the naïve romanticism of the mental healthcare system, which more junior trainees might have the instinct to justify.

To this end, it may be tremendously enlightening to collect longitudinal data tracking student therapists' shifting levels of system justification, satisfaction with their own psychotherapists, recognition of weaknesses in the mental health system, and clinical effectiveness over the course of various clinical experiences. For such a study, our provisional hypothesis may be that disappointments with trainees' own therapists, supervisors, and broader mental healthcare structures would lower their levels of system justification, speculatively increasing their effectiveness with their minoritized patients. Along similar speculative lines, it is possible that trainee therapists who have had their own lived experiences of troubling aspects of the mental health care system (e.g., involuntary hospitalization or forced treatment) may hold a more nuanced, non-justifying views of the mental healthcare system, which may have positive implications for their multicultural competencies. In this vein, further analysis of the Mental Healthcare System Justification scale, as described in the vignette pilot study above, could add richness to such research on psychotherapists' system justification as well.

Future research applying these concepts to practice would also be enhanced by evaluating the most effective methods of delivering system-conscious interventions to help culturally mistrustful individuals derive more benefit from their healthcare systems. Discussion groups may be one favorable avenue for these interventions, particularly with patients for whom the closeness and hierarchy of individual treatment may be activating and emotionally fraught (see Appendix 5 for a trial discussion group therapy curriculum related to these topics). Finally, as suggested by the exploratory results, providers' ability

to respond to their patients' mistrust, and in particular to respond while resisting the urge to system-justify, appears to be a promising method toward building alliances with vaccine-hesitant individuals as well. Ongoing research in the medical, pharmaceutical, and public health fields may be advanced by considering non-system-justifying techniques while working to maintain clinical alliances in the face of vaccine hesitancy.

Conclusions

The present study contributed to the existing literature in four primary ways: first, it empirically connected the constructs of cultural mistrust and healthcare system distrust, using a larger sample and a broader range of racial-ethnic minority identities than previous research on these phenomena in psychotherapy. Second, it identified system justification as a crucial factor in therapists' difficulties with responding to their patients' racialized stress and system distrust. Specifically, it found that therapists' capacity to regulate the psychological instinct to advocate the effectiveness and fairness of their work can create more space for their patients to experience important feelings of mistrust. Third, this research begins to demonstrate the positive effects of *resisting* system-justification, adding to the considerable literature on the detriments of *engaging* in system justification. The pilot results bear further contributions to this point including, notably, the emergent evidence that therapists' system justifying beliefs can appreciably impact their alliances with both majority- and minority-group clients, even without the therapists explicitly sharing these beliefs in session. The similarities between the pilot and primary results also provide early indication of the potential for replicability of these patterns.

Finally, and perhaps most notably, this research suggests that making an effort to address systemic concerns, even when those efforts are not perfectly adherent with

cultural competence ideals, is far more effective than avoiding the topic altogether. It is vital as mental health professionals to ensure that our guilt, anxiety, and perfectionism do not preclude us from acknowledging structural concerns and putting words to the system.

Overall, this study helps to expand the current understanding of what it means to be a culturally competent clinician, to include the emotional work of managing our own anxiety and defensiveness about operating within systems that have failed many of those it professes to serve. While no individual clinician must (or can) remedy the violations of trust committed by the healthcare system at large, every therapist is responsible for working to become emotionally available to the consequences of those violations. In the words of the Talmud, "You are not expected to finish the work [of healing the world.] Nor are you ever free to abandon it."

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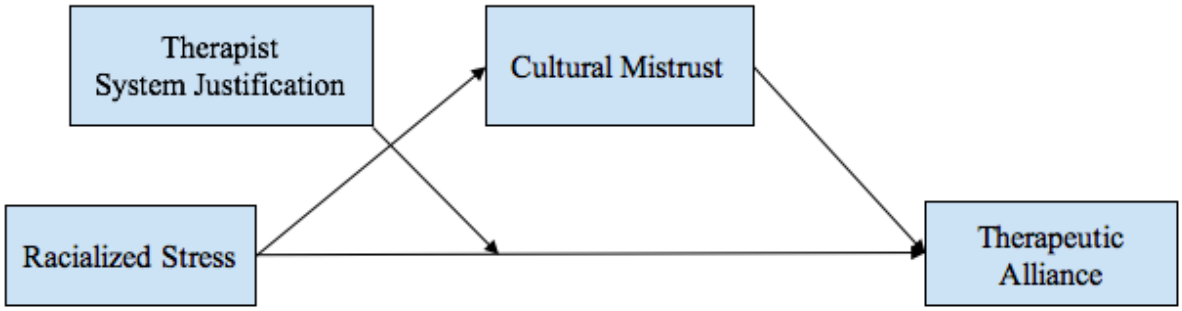
Appendix 1

Proposed Model



Appendix 2

The Mental Healthcare System Justification scale (MHSJ)

Indicate the degree to which you disagree or agree with each statement using the scale provided.

		Strongly Disagree	Moderately Disagree	Disagree	Slightly Disagree	Uncertain	Slightly Agree	Agree	Moderately Agree	Strongly Agree
01.	In general, the mental health care system is equitable for all patients.	❍	❍	❍	❍	❍	❍	❍	❍	❍
02.	In general, the mental health care system operates as it should.	❍	❍	❍	❍	❍	❍	❍	❍	❍
03.	The mental health care system needs to be restructured in important ways.	❍	❍	❍	❍	❍	❍	❍	❍	❍
04.	Everyone has equal access to quality mental health care.	❍	❍	❍	❍	❍	❍	❍	❍	❍
05.	If people work hard in their therapy, they almost always get what they want out of it.	❍	❍	❍	❍	❍	❍	❍	❍	❍
06.	Working hard in therapy always pays off.	❍	❍	❍	❍	❍	❍	❍	❍	❍
07.	Most people who do not see significant improvement in therapy should examine their own level of effort, rather than blaming their mental health care.	❍	❍	❍	❍	❍	❍	❍	❍	❍
08.	Disparities in therapy outcomes reflect biases and weaknesses in the mental health care system.	❍	❍	❍	❍	❍	❍	❍	❍	❍
09.	Therapy outcomes are legitimate reflections of the effort that patients put into their therapy.	❍	❍	❍	❍	❍	❍	❍	❍	❍
10.	Patients' level of effort in their therapy is responsible for the differences in their outcomes.	❍	❍	❍	❍	❍	❍	❍	❍	❍

Appendix 3

General Demographic Survey

1. What best represents your gender?

    - Female
    - Male
    - Non-binary
    - Transgender
    - Genderqueer
    - Prefer not to say
    - Another identity (please specify)

2. Which best represents your race/ethnicity?

    - Black/African American/African Caribbean
    - Arab/Mizrahi, Middle Eastern, or North African
    - Asian or Pacific Islander
    - Caucasian or White
    - Latino/a or Hispanic
    - Native American or Alaskan Native
    - Biracial or Multiracial
    - Other (please specify):

3. Which best represents your religion?

    - Buddhism
    - Hinduism
    - Sikhism
    - Judaism
    - Islam
    - Daoism
    - Christianity
    - Other (please specify):
    - No religion

4. Which best represents your sexual orientation?

    - Asexual
    - Bisexual
    - Gay or Lesbian
    - Heterosexual/Straight
    - Pansexual
    - Queer
    - Questioning
    - Other (please specify):
    - Prefer not to respond

5. In terms of **[social and cultural issues/economic issues/ overall political affiliation],** how liberal or conservative are you?

    - Extremely Liberal
    - Liberal
    - Slightly Liberal
    - Moderate
    - Slightly Conservative
    - Conservative
    - Extremely Conservative

6. What is your current marital status?

    - Single
    - Married
    - Separated
    - Divorced
    - Widowed
    - Other (please specify):

7. Have you ever attended counseling or psychotherapy?

    - Yes, only in the past
    - Yes, and currently attending
    - No

Appendix 4

Adapted Cultural Mistrust Inventory (Ward, 2002)

Below are some statements concerning beliefs, opinions, and attitudes about racial-ethnic minorities. Read each statement carefully and give your honest feelings about the attitudes expressed. Indicate the extent to which you agree by using the scale 1-7 below. There are no right or wrong answers, only what is right for you. If in doubt, choose the option which seems most nearly to express your present feelings about the statement. Please answer all items.

Scale: 1 – Strongly Disagree; 2 – Moderately Disagree; 3 – Slightly Disagree; 4 – Neutral; 5 – Slightly Agree; 6 – Moderately Agree; 7 – Strongly Agree

1. Whites are usually fair to all people regardless of race.
2. White teachers teach subjects so the lessons favor Whites.
3. White teachers are more likely to slant the subject matter to make racial- ethnic minorities look inferior.
4. White teachers deliberately ask racial- ethnic minority students questions which are difficult so they will fail.
5. There is no need for a person of a racial- ethnic minority to work hard to get ahead financially because Whites will take what they earn anyway.
6. Racial-ethnic minority citizens can rely on White lawyers to defend them to the best of their ability.
7. Racial-ethnic minority parents should teach their children not to trust White teachers.
8. White politicians will promise minorities a lot but deliver little.
9. White policemen will slant a story to make minorities appear guilty.
10. White politicians usually can be relied on to keep the promises they make to racial-ethnic minorities.
11. Minorities should be suspicious of a White person who tries to be friendly.
12. Whether or not you should trust a person is not based on their race.
13. Probably the biggest reason Whites want to be friendly with minorities is so they can take advantage of them.
14. A person of a racial-ethnic minority can usually trust their White co-workers.
15. If a White person is honest in dealing with minorities, it is because of fear of being caught.
16. A person of a racial-ethnic minority cannot trust a White judge to evaluate them fairly.
17. A person of a racial-ethnic minority can feel comfortable making a deal with a White person simply by a handshake.
18. Whites deliberately pass laws designed to block the progress of minorities.
19. There are some Whites who are trustworthy enough to have as close friends.
20. Racial-ethnic minorities should not have anything to do with Whites since they cannot be trusted.
21. It is best for minorities to be on their guard when among Whites.
22. White friends are least likely to break their promise.

23. Racial-ethnic minorities should be cautious about what they say in the presence of Whites since Whites will try to use it against them.
24. Whites can rarely be counted on to do what they say.
25. Whites are usually honest with minorities.
26. Whites are as trustworthy as members of any other ethnic group.
27. Whites will say one thing and do another.
28. White politicians will take advantage of racial-ethnic minorities every chance they get.
29. When a White teacher asks a minority student a question, it is usually to get information which can be used against them.
30. White policemen can be relied on to exert an effort to apprehend those who commit crimes against minorities.
31. Racial-ethnic minority students can talk to a White teacher in confidence without fear that the teacher will use it against them later.
32. Whites will usually keep their word.
33. White policemen usually do not try to trick racial-ethnic minorities into admitting they committed a crime which they didn't.
34. There is no need for minorities to be more cautious with White businessmen than with other minorities.
35. There are some White businessmen who are honest in business transactions with racial-ethnic minorities.
36. White store owners, salesmen, and other White businessmen tend to cheat minorities whenever they can.
37. Since Whites can't be trusted in business, the old saying "one in the hand is worth two in the bush" is a good policy to follow.
38. Whites who establish businesses in minority-dominated communities do so only so they can take advantage of those minorities.
39. Racial-ethnic minorities have often been deceived by White politicians.
40. White politicians are equally honest with Blacks and Whites.
41. Racial-ethnic minorities should not confide in Whites because they will use it against them.
42. person of a racial-ethnic minority can loan money to a White person and feel confident it will be repaid.
43. White businessmen usually will not try to cheat minorities.
44. White business executives will steal the ideas of their racial-ethnic minority employees.
45. A promise from a White person is about as good as a three dollar bill.
46. Racial-ethnic minorities should be suspicious of advice given by White politicians.
47. If a minority student tries, he will get the grade he deserves from a White teacher.

Appendix 5

Cultural Healthcare Mistrust-Focused Psychotherapy Group

Navigating the Healthcare System (12 Weeks) Bellevue Hospital Center – Outpatient Psychiatric Clinic	
GROUP FACILITATOR	Gerard Quinn, PharmD; Rachel Buxbaum, Psychology Intern
DATE & TIME	Starting from 3/2/2023 Every Thursday 3-4pm
LOCATION	Hybrid: in-person at the OPC, telehealth (Webex)
DESCRIPTION	This is an informational/discussion group open to adults of any gender who are being seen currently at the Bellevue OPC, who rely on regular medical and/or mental healthcare services but also worry about the system's trustworthiness or effectiveness. The group meets weekly and lasts a total of 12 weeks. The group focuses on providing information about healthcare system topics (e.g., systemic discrimination; specific treatments, medications, and vaccines; supplements and alternative medicines; and self-advocacy skills to maximize our safety and autonomy in healthcare encounters) and facilitates discussion and communal support-giving among participants. The group will be open to new participants, pending an individual screening. Max capacity is 10 participants for any given session.
OUTLINE	Week 1: Orientation Week 2-3: Current & Historical Discrimination in the Healthcare System --- i.e., Why We Mistrust Week 4-6: Thinking About Common Treatments and Interventions --- Worries about common medications; worries about immunization; worries about medical/mental healthcare interactions and documentation Week 7-8: Thinking About Supplements and Alternative Medicine --- Risks, Benefits, and Interaction Effects Week 9-12: Self-Advocacy in the Healthcare System --- Identifying trustworthy providers; asking questions and researching; maintaining contact with support systems
INCLUSION CRITERIA	• Current and consistent clinic attendance for at least 3 months with an individual provider at the OPC • Computer literacy and access to video chat • Completion of a 20-minute screening session