Published in final edited form as:

Child Youth Serv Rev. 2009 January ; 31(1): 161–168. doi:10.1016/j.chilgyouth.2008.07.008.

Satisfaction with Counseling among Black Males in Transition from the Foster Care System

Lionel D. Scott Jr.^{a,*}, Michelle R. Munson^b, and Tony White^c

^a School of Social Work, Georgia State University, United States

^b Mandel School of Applied Social Sciences, Case Western Reserve University, United States

^c District of Columbia Child and Family Services Agency, Washington, D.C., United States

Abstract

Using the Multidimensional Adolescent Satisfaction Scale (Garland, Saltzman, & Aarons, 2000), satisfaction with counseling and associated variables were examined among Black males (n = 47) transitioning from the foster care system. Potential associated variables assessed were foster care custody status, counseling status, diagnosis of major depression and disruptive behavior disorder based DSM-IV criteria, history of placement in congregate care settings, attitudes toward mental health services, stigma beliefs, and masculine norms. Results from simultaneous multiple regression analysis showed that attitudes toward mental health services contributed significantly to satisfaction with counseling. Specifically, Black males who expressed more positive attitudes toward mental health services in terms of confidence in mental health professionals and the therapeutic process reported greater satisfaction. Implications and future research directions are discussed.

Keywords

Black males; foster care; client satisfaction; counseling; attitudes toward mental health services

Despite the growing interest in consumer's level of satisfaction with services among public and private systems of mental health care, focus on the level of satisfaction with mental health services among children and youth has not matched the attention given to adult consumers (Garland, Haine, & Boxmeyer, 2007). Among young consumers of mental health services, studies clearly show that children and youth in foster care utilize significantly more services than their counterparts who are (a) recipients of SSI, AFDC, and other types of statewide Medicaid assistance (dosReis, Zito, Safer, & Soeken, 2001; Harman, Childs, & Kelleher, 2000), (b) living in poverty (Farmer et al., 2001), and (c) receiving services in other sectors of care such as the juvenile justice system (Hazen, Hough, Landsverk, & Wood, 2004). In this study, we focus on Black males who are transitioning from the foster care system. Specifically, their level of satisfaction with counseling and the variables associated with their satisfaction are examined.

*Correspondence may be addressed to Lionel D. Scott, Jr., Georgia State University, School of Social Work, P.O. Box 3995, Atlanta GA 30302; email: lscottjr@gsu.edu; Tel.: +1 404 413 1064; fax: +1 404 413 1075.

Publisher's Disclaimer: This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting proof before it is published in its final citable form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

Despite the disproportionate representation of Black children in the foster care system (Wulczyn & Lery, 2007), studies indicate that Black children and youth in public systems of care are less likely to receive outpatient mental health services than their White counterparts (e.g., Burns et al., 2004; Garland et al., 2005; McMillen et al., 2004). Evidence of gender differences in the receipt of outpatient mental health services among youth in public systems of care has been mixed. While a number of studies have shown no gender differences (e.g., Burns et al., 2004; Farmer et al., 2001; McMillen et al., 2004), others indicate that male youth are less likely to receive specialty mental health outpatient services than female youth (e.g., Hazen et al., 2004).

Concerning older youth who are transitioning from foster care, it is clear that they are at increased risk of a host of psychosocial problems in comparison to their counterparts who have not been in foster care. These include lower educational attainment, more chronic unemployment, more teenage pregnancies, and greater violence perpetration and criminal victimization (Courtney et al., 2005). Gender and race comparative analyses are not replete in the studies assessing psychosocial outcomes among transitioning foster youth. Nonetheless, there is some indication that males, in general, and ethnic minority males, in particular, may fare worse on a number of psychosocial indicators. For example, higher rates of recent alcohol abuse, substance dependence, and substance abuse based on DSM-IV diagnostic criteria was found by Courtney et al. (2005) for males than females who were formerly in foster care. In addition, McMillen & Tucker (1999) found that ethnic minority males exiting foster care were more ill-prepared academically, more likely to have histories of criminal involvement, and more likely to have no employment experiences. When considered with recent analyses of the general plight of young Black males as it relates to declining labor force participation and rising rates of incarceration (e.g., Mincy, 2006; National Urban League, 2007), there is cause to be concerned. As elucidated by Lee (1990), the academic, economic, personal, and social challenges confronted by Black males are cumulative and incur a greater emotional and physiological toll at each stage of development. For Black males with histories of receiving mental health services while in the care and custody of state authorities, their appraisal of services may have a significant influence on their future decisions about whether to seek needed services.

Correlates of Satisfaction with Mental Health Services

A number of published studies have examined correlates of satisfaction with mental health services among young consumers. In their study of a multi-ethnic sample of youth who had recently received mental health services, Garland, Aarons, Saltzman, and Kruse (2000) found that youth who expressed greater overall satisfaction were those who reported greater choice/motivation in seeking treatment, more positive expectations about treatment, received services at a specialty clinic for maltreated youth (vs. a school based clinic or a outpatient psychiatric clinic), and had been in treatment for more than one year (vs. < 6 months or 6 months to 1 year). Other variables under consideration such as treatment status and lifetime experience of restrictive care (i.e., inpatient or residential) were unrelated to satisfaction with mental health services. In a more recent study, Garland et al. (2007) found that greater satisfaction among youth receiving publicly funded mental health treatment was related to being Caucasian (vs. non-Caucasian), having clinicians with more years of experience, and reduction in parent-reported symptoms. Among a predominantly Black sample of youth who had received school-based mental health services, Nabors, Weist, Reynolds, Tashman, and Jackson (1999) found that those who received therapy from a licensed psychologist (vs. psychology trainee), and interestingly, those who perceived their therapist as less available reported greater satisfaction with services. In Barber et al.'s (2006) study, children and youth with self-reported conduct problems expressed less satisfaction with mental health services. Similarly, Garland, Aarons,

et al. (2000) found that more severe internalizing and externalizing symptoms were related to lower overall satisfaction with mental health services.

Studies of satisfaction with mental health services among various populations of Black males are not evident in the literature. Yet, the seminal and contemporary counseling literature that focuses on adolescent and young adult Black males, in general, suggests that effective service delivery to them is predicated on a number of factors that are culturally based (e.g., Davis, 1999; Johnson, in press; June & Gunnings, 1985, 1986; Rasheed & Rasheed, 1999). These include concerns about being stigmatized and the subscription to certain masculine norms. Among Black males, stigma is suggested to manifest itself in a very particularistic manner due to issues concerning masculinity. Wearing a mask to conceal vulnerabilities has become an art form among Black males, according to Majors and Billson (1992). "Cool pose," as it has been termed, connotes "behaviors, scripts, physical posturing, impression management, and carefully crafted performances that deliver a single, critical message: pride, strength, and control" (Majors & Billson, 1992, p. 4). Self-disclosure or the uncovering of personal vulnerabilities in the counseling process is an ultimate assault to cool pose (Franklin, 1992). Being "hypersensitive to a loss of control" and fearing the ramifications of the appearance of psychological difficulties contributes to a resistant stance to the idea of counseling or other types of mental health care (Rasheed & Rasheed, 1999, p. 50). From this vantage point, stigma concerns and the subscription to certain masculinity norms may be related to satisfaction with counseling among Black males.

The Present Study

Using the Multidimensional Adolescent Satisfaction Scale (MASS; Garland, Saltzman, & Aarons, 2000), a number of potential variables that might be associated with satisfaction with counseling were examined: foster care custody status, counseling status, diagnosis of major depression and disruptive behavior disorder based on DSM-IV criteria, history of placement in congregate care settings (i.e., group homes or residential treatment centers), attitudes toward mental health services, stigma beliefs, and masculine norms. Based on the available evidence, we made the following hypotheses: (a) Black males who meet DSM-IV diagnostic criteria for major depression and a disruptive behavior disorder (i.e., oppositional and/or conduct disorder) will report lower satisfaction with counseling; (b) those who express more positive attitudes toward mental health services will report greater satisfaction with counseling; and (c) counseling status and placement in congregate care settings will be unrelated to satisfaction with counseling. No hypotheses were made with regard to foster care custody status, stigma beliefs, and masculine norms given unavailable empirical evidence concerning their relationship to satisfaction.

Method

Participants

From an on-going longitudinal study of older foster care youths in the care and custody of the Missouri Children's Division (MCD), Black males were recruited to participate in a separate study that focused on their readiness to seek help for personal, behavioral, or emotional problems upon transitioning from the foster care system. The longitudinal study at baseline consisted of 406 older foster care youth (Mean Age = 16.99, $SD = .09$), 97 (23.9%) of whom were Black males. With regard to the service utilization histories of Black males as assessed by the Service Assessment for Children and Adolescents (SACA) at baseline in the larger longitudinal study, 40% reported having received outpatient help from a community mental health center or mental health professional, 26% had received inpatient psychiatric treatment, 86% had received residential treatment, 4% had received outpatient care from a partial

hospitalization or day treatment program, 2% had received outpatient care from an emergency room, and 6% had received outpatient care from a self-help group.

Seventy-four (76.3%) of the 97 Black males in the longitudinal study were successfully contacted and agreed to participate in this study. Participants were 18 ($n = 68$, 91.9%) and 19 ($n = 6$, 8.1%) years of age. The Foster Care Independence Act (FCIA) of 1999 expanded the eligibility for care, support, and services to older youth in foster care up to age 21 (Collins, 2004). Hence, the majority were still in the care and custody of MCD ($n = 44$, 59.5%). Based on DSM-IV diagnostic criteria (American Psychiatric Association, 1994) as assessed by the Diagnostic Interview Schedule (DIS) at baseline in the larger longitudinal study, close to half of the Black males in the present study ($n = 34$, 45.9%) met criteria for lifetime or past-year psychiatric disorders. The most prevalent disorders were oppositional disorder ($n = 21$, 28.4%) and conduct disorder ($n = 15$, 20.3%), followed by major depression ($n = 10$, 13.5%) and attention deficit/hyperactivity disorder ($n = 10$, 13.5%). Results of attrition analysis showed that the 74 Black male participants did not significantly differ on major study variables (e.g., age at entry into foster care, psychiatric history, etc.) from the 23 Black males in the larger longitudinal study who could not be located.

The 74 participants in the present study were queried as to their receipt of counseling. Twenty-seven percent ($n = 20$) were currently receiving counseling from a mental health professional, 36.5% ($n = 27$) had previously received counseling from a mental health professional, and 36.5% ($n = 27$) self-reported as never having received counseling from a mental health professional. Results of chi-square analysis revealed that the self-reported receipt of counseling was significantly related to diagnosis of a 12-month or lifetime psychiatric disorder based on DSM-IV criteria, $\chi^2(1, N = 74) = 9.63, p = .002$, with 82.4% of Black males who met criteria for a DSM-IV psychiatric disorder reporting having received counseling. The 27 Black males reporting no current or previous receipt of counseling were eliminated from further analyses, resulting in a final sample of 47. Among these 47 participants, 61.7% ($n = 29$) were still in MCD custody and 59.6% ($n = 28$) met criteria for having a lifetime or past-year psychiatric disorder.

Measures

Satisfaction with counseling—Satisfaction with counseling was measured by the Multidimensional Adolescent Satisfaction Scale (MASS; Garland, Saltzman, et al., 2000). The MASS is a 21-item scale that measures adolescent's satisfaction with outpatient mental health services. Participants were asked to indicate if they were currently or had ever received counseling from a mental health professional like a psychologist, psychiatrist, social worker, or family counselor. In the present study, the verb tense (past/present) of items used was based on participant's counseling status. Black males who had received counseling multiple times were asked to respond to items based on their last counseling experience. Four dimensions of service satisfaction are assessed by the MASS: (a) *counselor qualities* (9-items, e.g., "I like talking to my counselor"); (b) *meeting needs* (4-items, e.g., "I wish I had gotten more help with my problems at counseling"); (c) *effectiveness* (4-items, e.g., "Has counseling helped your problems get better?"); and (d) *counselor conflict* (4-items, e.g., "My counselor is too nosey"). Response options for questions regarding counselor qualities, meeting needs, and counselor conflict ranged from *strongly disagree* (1) to *strongly agree* (4). Response options to questions regarding effectiveness ranged from *yes, a lot* (1) to *no, not at all* (4). Several items were recoded so that higher mean scores indicated greater satisfaction with each dimension of counseling. In the MASS development study among a ethnically diverse sample of adolescents, the total 21-item scale and the four subscales obtained good internal reliability estimates (α): .91 (total scale), .91 (counselor qualities), .72 (meeting needs), .85 (effectiveness), and .74 (counselor conflict). In this study, one item from the counselor conflict subscale ("Has

counseling made things worse in your life?”) was deleted in that it significantly reduced the internal reliability estimate. In this study, the internal reliability estimates (α) for the MASS were .89 (total scale), .88 (counselor qualities), .72 (meeting needs), .85 (effectiveness), and .65 (counselor conflict).

Attitudes toward mental health services—Attitudes toward mental health services were measured by a modified version of the *Confidence in Mental Health Practitioner* subscale from the Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970). The ATSPPHS (Fischer & Turner) is a 29-item scale that assesses attitudes toward traditional mental health services across four factors: recognition of need, stigma tolerance, interpersonal openness, and confidence in mental health practitioner. Only the Confidence subscale (9-items) was administered due to the relevance of the items to the aims of our study. The essence of this subscale is the amount of faith that respondents have in mental health practitioners and the therapeutic process. Fischer & Turner (1970) reported an internal reliability estimate (α) of .74 for the Confidence subscale. In the present study, the Confidence subscale was modified in order to update terms that might be less familiar to participants. Specifically, *mental health professional* was substituted for *psychiatrist* and *psychologist*, and the words *emotional and mental problems* were substituted for *mental troubles* and *mental conflicts*. In addition, an out-of-date item was dropped (“A person with a serious emotional disturbance would probably feel most secure in a good mental hospital”) resulting in an 8-item scale. Items included: “Although there are clinics and agencies for people with emotional or mental problems, I would not have much faith in them;” and “If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief by speaking to a mental health professional.” Participants responded to items on a 5-point, Likert-type scale ranging from *strongly disagree* (0) to *strongly agree* (4). Several items were recoded so that higher mean scores indicated more positive attitudes toward mental health services. The internal reliability estimate (α) for the modified version of the ATSPPHS Confidence subscale was .70.

Stigma Beliefs—Stigma beliefs were measured by modified versions of the *devaluation-discrimination* and *secrecy* scales designed by Link and associates (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). The devaluation-discrimination scale is a 12-item scale that measures the extent to which respondents believe that a person who has received mental health treatment will be devalued and discriminated against by most people. The secrecy scale is a 5-item scale that measures coping orientations that persons with mental illness might use to deal with stigmatization. Link et al. (1989) reported internal reliability estimates (α) of .76 for the devaluation-discrimination scale and .71 for the secrecy scale. In the present study, the devaluation-discrimination and secrecy scales were modified in order to (a) update terms that might be less familiar to participants and (b) contextualize mental health problems and services in a more recognizable manner. Example modifications for the devaluation-discrimination scale included revising the original item, “Most people feel that entering a mental hospital is a sign of personal failure” to read, “Most people feel that getting help for serious mental health problems is a sign of weakness.” Example modifications for the secrecy scale included revising the original item, “If you have been treated for a serious mental illness, the best thing to do is keep it a secret” to read, “If you have been treated for a serious mental health problem, the best thing to do is keep it a secret.” Participants responded to items on a 5-point, Likert-type scale ranging from *strongly disagree* (1) to *strongly agree* (5), with higher mean scores indicating greater stigma beliefs. In the present study, a number of items from the devaluation-discrimination (4 items; e.g., “Most women would be reluctant to date a man who has been treated for serious mental health problems”) and secrecy (2 items; i.e., “A person who used to have a serious mental health problem will have to hide the fact that he or she has been hospitalized in the past”) scales were omitted to increase reliability estimates. The internal

reliability estimate (α) for the modified version of the devaluation-discrimination scale (8 items) was .70. The internal reliability estimate (α) for the modified version of the secrecy scale (3 items) was .73.

Masculinity Norms—Adherence to masculine norms was measured by the Conformity to Masculinity Norms Inventory (CMNI; Mahalik, Locke, et al., 2003). The CMNI is a 94-item scale that assesses 11 masculine norms: winning, emotional control, risk taking, violence, power over women, dominance, playboy, self-reliance, primacy of work, disdain for homosexuality, and pursuit of status. In the present study, only the emotional control (11 items) and self-reliance (6 items) subscales were administered given their relevance. The emotional control subscale assessed the degree to which participants restricted their expression of emotions (e.g., “I hate it when people ask me to talk about my feelings”). The self-reliance subscale assessed the degree to which participants were disinclined to ask for help (e.g., “It bothers me when I have to ask for help”). Participants responded to items on a 4-point, Likert-type scale ranging from *strongly disagree* (0) to *strongly agree* (3). Several items were recoded so that higher mean scores indicated greater adherence to masculine norms. Mahalik, Locke, et al. (2003) reported internal reliability estimates (α) of .91 for the emotional control subscale and .85 for the self-reliance subscale. In this study, the internal reliability estimates (α) were .86 for the emotional control subscale and .80 for the self-reliance subscale.

Procedures

Details of the procedures used in the longitudinal study are reported elsewhere (McMillen et al., 2004). For the present study, the names and contact information of Black males in the longitudinal study was provided to the first author who contacted them directly to solicit their participation. None of those successfully contacted refused to participate. Upon providing informed consent, all participants were interviewed by the first author at their place of residence ($n = 66$, 89.2%) or by telephone ($n = 8$, 10.8%). Participants interviewed by phone resided in locales that were a significant distance from the project site (> 100 miles). Items from the measures were read aloud to control for reading difficulties. Interviews were conducted from July 2003 to November 2004. All participants were paid \$20. The Washington University Institutional Review Board approved the procedures for this study.

Analysis

Data analysis occurred in the following steps. First, descriptive statistics were computed to provide a profile of the sample on the primary study variables. Second, we examined the relationships between satisfaction with counseling and the following variables: (a) background characteristics – custody status (still in foster vs. no longer in foster care), counseling status (active vs. inactive), DSM-IV diagnosis of major depression and disruptive behavior disorder (i.e., conduct disorder or oppositional defiant disorder) (yes vs. no), history of placement in congregate care settings (yes vs. no); (b) attitudes toward mental health services; (c) stigma beliefs – devaluation discrimination and secrecy; and (d) masculine norms – emotional control and self-reliance. Similar to the approach taken by Garland, Aarons, et al. (2000), for variables that were significantly related ($p \leq .05$) to overall satisfaction (i.e., total score), their relationships to MASS subscales were also examined. Simultaneous multiple regression analysis was then conducted with only those variables showing a moderate-to-significant bivariate relationship ($p \leq .10$) to examine their relative contribution to the prediction of overall satisfaction with counseling.

Results

Table 1 shows the means, standard deviations, skewness, and ranges of the study variables. Exploration of the distributional characteristics of the study variables indicated that none

deviated significantly from normality. Overall, based on the average score ($M = 2.66$ on a 4-point scale), Black males reported a moderate level of overall satisfaction with counseling. Notably, the average satisfaction score obtained in the present study is significantly lower than that obtained by Garland, Aarons, et al. (2000) in their multi-ethnic sample of youth who had received mental health services ($M = 3.12$), $t(46) = 6.28$, $p < .001$, and Garland et al. (2007) in their community-based sample of youth who had received outpatient mental health treatment ($M = 3.20$), $t(46) = 7.37$, $p < .001$.

Independent-samples t tests were conducted to examine the relationship of background characteristics to Black male's satisfaction with counseling (see Table 2). Results showed that custody status was significantly related to overall satisfaction, $t(45) = -2.70$, $p \leq .01$, with Black males who were still in foster care reporting significantly greater satisfaction with counseling services than those no longer in foster care. Custody status was also related to the subscales of counselor qualities, $t(45) = -2.15$, $p \leq .05$, and counselor conflict, $t(45) = -2.15$, $p \leq .05$, with those still in foster care reporting greater satisfaction with these dimensions of counseling. Counseling status was only moderately related to overall satisfaction, $t(45) = -1.70$, $p = .10$, with Black males who were actively receiving counseling services reporting higher satisfaction than those who were inactive. Neither diagnosis of major depression, $t(45) = -.85$, $p = .40$, diagnosis of disruptive behavior disorder $t(45) = -.23$, $p = .82$, or history of placement in a congregate care setting, $t(45) = .69$, $p = .49$, were related to overall satisfaction with counseling.

Results of correlational analysis showed that attitudes toward mental health services were significantly and positively correlated with overall satisfaction ($r = .42$, $p \leq .01$). In addition, attitudes toward mental health services were significantly and positively correlated with the subscales of counselor qualities and counseling effectiveness ($r = .31$, $p \leq .05$ and $r = .40$, $p \leq .01$, respectively). Overall satisfaction with counseling was negatively but not significantly correlated with the stigma beliefs of devaluation-discrimination ($r = -.13$, $p = .39$) and secrecy ($r = -.21$, $p = .16$). Similarly, overall satisfaction was negatively but not significantly correlated with the masculine norms of emotional control ($r = -.06$, $p = .69$) and self-reliance ($r = -.18$, $p = .26$).

Regression Analysis Predicting Satisfaction with Counseling

A simultaneous multiple regression analysis with custody status, counseling status, and attitudes toward mental health services as the independent variables and overall satisfaction as the dependent variable was conducted. A summary of beta coefficients and semipartial correlation coefficients are shown in Table 3. The total model explained 29% of the variance in overall satisfaction, adjusted $R^2 = .24$, $F(3, 43) = 5.83$, $p = .002$. The main effect of attitudes toward seeking professional help ($\beta = .38$, $Sr^2 = .14$, $p = .006$) were statistically significant. Specifically, young Black males who reported more positive attitudes toward mental health services were more satisfied with counseling. Custody status evolved as a moderate, significant predictor ($\beta = .27$, $Sr^2 = .06$, $p = .062$).

Discussion

Among a small sample of Black males transitioning from the foster care system, this study examined their satisfaction with counseling and variables associated with their satisfaction. Three notable findings will be discussed at length. First, we found that the overall satisfaction score for participants was significantly lower than that of youth in other studies that utilized the Multidimensional Adolescent Satisfaction Scale (MASS). Second, bivariate analyses showed that only one of the background characteristics assessed was significantly related to overall satisfaction with counseling: custody status. Last, attitudes toward mental health services evolved as the only significant predictor of satisfaction with counseling.

The question as to why participants in our study scored significantly lower in overall satisfaction is not easily answerable, but may be attributable to differences in contexts and sample characteristics. Participants in the studies conducted by Garland and associates (Garland, Aarons, et al., 2000; Garland et al., 2007) were recruited from varied, but specific service sites (e.g., school based health & social services center), were multi-ethnic, and were predominantly in the care and custody of their parent(s). Not unlike other young consumers, adolescent and young adult Black males are most often involved in counseling because some authoritative agent thinks they need it (Hobbs, 1985). It is probable that most participants in our study did not self-refer to counseling, hence contributing to lower overall satisfaction. Furthermore, many youth do not voluntarily enter foster care. Whatever problems or issues warranted their removal from the home of their parent(s), it is likely that many would not prefer to live in unfamiliar settings and surroundings. From this standpoint, participant's level of satisfaction with counseling may be a reflection of not only the circumstances giving rise to their receipt of mental health care, but the extent to which they are satisfied with their current state of affairs (e.g., placements or living situations). Finally, the extent to which gender and race influenced their level of satisfaction directly or indirectly is indeterminable in that transitioning youth who were female or from other ethnic groups were not sampled. Clearly, more systematic research is needed to determine the client- and system-level characteristics that may influence differential appraisals of mental health services among young consumers from various systems of care.

As hypothesized, placement in more restrictive settings (i.e., group home or residential treatment center) and counseling status were not significantly related to overall satisfaction with counseling. Our hypothesis that having a major depressive disorder and disruptive behavior disorder would be related to lower satisfaction with counseling was not supported. This inconsistency with the findings of Garland, Aarons, et al. (2000) is likely attributable to the divergent manner in which emotional and behavioral problems were measured. In our study, the presence of emotional and behavioral problems was based on whether lifetime or 12-month DSM-IV diagnostic criteria were met, rather than current severity of symptoms. Current psychiatric symptoms may have far greater influence on appraisals of mental health services.

Neither stigma beliefs nor masculine norms were significantly related to overall satisfaction with counseling. This might be attributable to a number of factors including low statistical power due to the small sample size as well as measurement and methodological issues. Measures of stigma that are more personalized towards participant's own service use might be more associated with counseling satisfaction (e.g., Vogel, Wade, & Haake, 2006). In addition, stigma and masculinity issues are likely more related to Black males' attitudes toward mental health services and their predisposition to seek counseling (Scott, Munson, McMillen, & Snowden, 2007).

With regard to custody status, Black males who were still in the care and custody of state authorities reported greater satisfaction with counseling than their counterparts who had exited foster care. Custody status was also significantly related to the subscales of counselor qualities and counselor conflict. Specifically, those still in foster care tended to be more satisfied with the qualities of their counselor and the nature of the interactions with their counselor. These dimensions of service satisfaction signify more about the relational aspects of counseling. Black males who had exited foster care, whether voluntarily or involuntarily may possess very unflattering opinions about the quality and nature of their relationships with individuals that provided a range of services to them while in the foster care system. Furthermore, their negative appraisal of counseling may be a product of greater stressors and problems in daily living that they are experiencing in comparison to those still in foster care. Those who have exited foster care generally have little or no access to the tangible forms of assistance afforded by the child welfare system. The quality of the counseling received may have very little to do with their

current appraisal. In a different vein, it is plausible that the qualities exhibited by mental health professionals and the level of conflict that arose during the course of counseling was a reflection of the level of hostility, resistance, and treatment adherence displayed by the Black males themselves. Those still in foster care may have viewed the system with less hostility and perhaps were more adherent to treatment plans than those no longer in foster care, hence not only explaining their more positive appraisals of counseling, but also their continuance in the care and custody of state authorities.

In our study, attitudes toward mental health services connoted confidence in mental health professionals and more favorable attitudes toward the therapeutic process. As hypothesized, Black males who expressed more positive attitudes toward mental health services tended to be more satisfied with counseling. The dimensions of service satisfaction that were related to attitudes toward mental health services were counselor qualities and counseling effectiveness. This is consistent with the findings of Garland, Aarons, et al. (2000). That Black males with more confidence in mental health professionals and more favorable attitudes toward the therapeutic process would view the professionals providing services to them more favorably and perceive greater benefits from counseling is commonsensical and may be indicative of a self-fulfilling prophecy.

In the regression analysis, attitudes toward mental health services were the only significant contributor to the prediction of satisfaction with counseling. In their study, Garland, Aarons, et al. (2000) found that attitudinal variables were the strongest independent correlates of satisfaction with mental health services. Whether favorable evaluations of counseling is simply a natural outgrowth of positive attitudes or whether positive attitudes produce client behaviors that contribute to favorable evaluations of counseling due to positive outcomes is a crucial question, but one we cannot answer given our cross-sectional study. Nonetheless, attitudes apart from motivational and control factors have been found to be a weak predictor of behaviors (Armitage & Conner, 2001). Furthermore, a positive attitude toward counseling may not motivate Black males to engage meaningfully in the therapeutic process if characteristics of the mental health system, providers, and/or treatment are found to be unsatisfactory. In other words, it is possible that some Black males can go into counseling with favorable attitudes toward mental health services and providers, yet have those attitudes soured by their service experience. Findings based on a nationally representative sample of adult Blacks and Whites suggest the plausibility of such a scenario. Specifically, Diala et al. (2000) found that the attitudes of Blacks toward mental health care was transformed from positive to negative after having utilized services, hence lowering their odds of utilizing services again in the future. Hence, the link between positive attitudes and greater satisfaction may not be automatic. It may, in fact, be conditional on the service experience itself. This question cannot be adequately addressed or answered by way of cross-sectional studies. Prospective, longitudinal studies are needed to disentangle the mental health service attitude and satisfaction relationship.

The findings from this study are limited. First, they are based on a small and non-representative sample of Black males transitioning from the State of Missouri foster care system. Hence, no generalizations beyond the study sample can be made. Second, a lack of statistical power due to the small sample size likely obscured other significant relationships that might have evolved. Third, the cross-sectional and correlational research design and the concurrent administration of all the measures does not allow for causal inferences to be made. Fourth, based on self-report, the findings are subject to problems of recall and social desirability. A fifth limitation is that a theoretical framework did not guide our study as exemplified by the preponderance of previous studies assessing client satisfaction (Garland et al., 2007). Sixth, important characteristics of the mental health professionals rendering services to participants such as counselor's race and gender were not assessed. Finally, this study did not account for a range of service use and attitudinal variables that are likely to be related to satisfaction with

counseling. Despite these limitations, our use of a well validated measure of satisfaction with mental health services among an understudied population is a valuable addition to the current literature and sets a good foundation for future research efforts.

The limitations of our study preclude assertions about factors that might be uniquely linked to satisfaction with counseling among Black males transitioning from foster care. Certain factors are likely to be influential regardless of the ethnic background of the youths or young adults. However, several factors presented as pertinent to counseling effectiveness with Black males are also likely to have a significant bearing on satisfaction with counseling. These include (a) trust and (b) the integration of culturally-relevant content.

The extent to which young consumers trust the mental health professionals providing counseling to them is likely to be important irrespective of ethnic background. Yet, issues of trust for Black males cannot be divorced from social and historical forces (Franklin, 1992). In many cases, the contact of Black males with formal or mainstream systems of care occurs under circumstances that do not engender trust. Gibbs (1988) asserted that young Black males are often mishandled, mislabeled, and mistreated by the educational, mental health, and social welfare systems. Often labeled as emotionally disturbed or learning disabled, they are disproportionately represented in special education (Losen & Orfield, 2002). In addition, they often receive more externalizing diagnoses (Minsky et al., 2006; Nguyen, Huang, Arganza, & Liao, 2007) which generally result in more restrictive and correctional placements. Histories of interacting with authority figures who are “accepting, non-manipulative, non-punitive, and yet strong” within various settings may be severely lacking (Paster, 1985, p. 413). Hence, many Black males are likely to simply view counselors as institutional agents that are there to do the biddings of the systems in which they work rather than as an ally or source of help. Their approach to the counseling relationship with a bit of skepticism or paranoia may in fact be healthy, according to Franklin (1992), until the counselor is proven trustworthy. Black male counselees who do not come to trust the professionals providing counseling to them will likely be dissatisfied with services. Moreover, no meaningful engagement is likely to occur resulting in negative therapeutic outcomes such as premature termination.

Although Hilliard (1985) referred to traditional approaches to counseling and psychotherapy as “ahistorical” and “acultural,” he asserted that taking a positive or negative stance concerning the retention of Black culture is not the most critical issue for counselors, but having an understanding of how race and culture shapes the world of many Black males is indeed critical (p. 72). Depending on the extent to which issues of race and culture were integrated into the course content of the academic programs in which mental health professionals have matriculated, many who are in settings where counseling services are provided to Black males may be terribly lacking in this area. Critical in such cases is a proactive approach to developing a knowledge base about the social and cultural dimensions of the lives of Black males. For example, the National Urban League issues a report entitled, *The State of Black America*, on an annual basis. The 2007 report focuses on the plight of Black males in American society. Other contemporary sources of vital information and perspectives include *Black Males Left Behind* (Mincy, 2006) and *Against the Wall Poor, Young, Black, and Male* (Anderson, 2008).

Lee (1990, 1992) has outlined a number of proactive counseling modules that can be used by counselors to explore feelings, thoughts, and behaviors pertaining to Black male life. As it relates to elements of contemporary black and hip-hop culture, counselors might systematically or periodically review hip-hop magazines for profiles and stories that can be used to broach salient social, cultural, and mental health issues. These magazines are readily accessible in supermarkets and bookstores. For example, the July 2008 issue of *The Source*, a magazine that is self-described as “the bible of hip-hop music, culture, & politics,” profiles the rapper, The Game, with the following caption on the cover, “suicide is not an option.” In the article, the

ups and downs of the rapper's peculiar life are discussed, with The Game stating the following at one point:

It's just my life. It's a rollercoaster. Some days it'll go up, some days it goes down. If people really knew when somebody was about to commit suicide or had a feeling that something was about to go down, then nobody would be committing suicide because somebody would save them. (Ford, 2008, p. 58)

A very salient profile of and interview with the then 25-year old rapper Joe Budden appeared in the January/February issue of *XXL*, another hip-hop magazine. Not unlike many foster care youth, Joe Budden experienced a number of challenges and traumas in his life. His dad was in and out of jail, his mother suffered from drug addiction, and a gun was put to his head by an older brother when he was 10-years old (Linden, 2006). In the article, Linden (2006) states the following:

It's telling that the hip-hop community will talk openly about stints in prison, but mention "counseling" or "therapy," and you get wary looks. While shrink jargon is entrenched in the national lexicon and a prescription for Paxil won't get you a second look from a pharmacist, the idea of a young Black man seeking psychological assistance – well, that's some White [*expletive*]. And as such, is enough to make some members of the Black and Latino community go "hmmm." (p. 108)

Yet, having suffered from clinical depression, Joe Budden stated, "When people hear 'therapy,' they think something must really be wrong. Black folks aren't wired toward help. But therapy saved my life" (Linden, 2006, p. 108).

Many elements of hip-hop and contemporary black culture that is associated with young Black males are considered problematic (Reese, 2004) and might be considered too incendiary or unsettling by many counselors. Nonetheless, a reservoir of material in the form of music, print and web-based media, and movies such as that presented above is available to explore the personal, social, and cultural dimensions of their lives as Black males and to engage them in the therapeutic process. Recent work indeed suggests that addressing relevant social and cultural issues in counseling may foster engagement in the therapeutic process among young Black males. In a study of adolescent Black males who received Multidimensional Family Therapy, Jackson-Gilfort, Liddle, Tejeda, and Dakof (2001) found that the discussion of Black male developmental issues and the social-contextual issues pertaining to their lives was positively related to engagement in subsequent counseling sessions. Liddle, Jackson-Gilfort, and Marvel (2006) offer further guidelines for how to use culturally-relevant content to engage young Black males in counseling. More applied research is needed to further determine the efficacy of culturally-based counseling approaches with this population.

There are several important directions that future research might pursue. That only 29% of the variance in satisfaction with counseling was explained in our study indicates that a number of other factors need to be considered in future research. General factors that are not necessarily germane to gender or race are important to consider. These include the site where counseling services were provided, the degree of choice/motivation, and beliefs about mental health, (e.g., Garland, Aarons, et al., 2000). Second, it is important for future research to examine the relationship of pre-service attitudes and perceived provider behavior to satisfaction with counseling (e.g., Freed, Ellen, Irwin, & Millstein, 1998). Third, it is imperative that studies consider cultural factors that are suggested to be critical to counseling engagement among Black males. This includes feelings of general and cultural mistrust of mental health providers and the extent to which social and cultural issues are incorporated into counseling. It is important that these myriad factors be incorporated in research models developed to examine determinants of young consumer's satisfaction with mental health services (e.g., Garland et al, 2007).

In conclusion, the receipt of counseling and other mental health services is common among foster care populations. Sixty-three percent of our overall sample of Black males was active or formerly active counselees. Though having more positive attitudes toward mental health services was related to greater satisfaction with counseling, we cannot be sure about the true nature of this relationship. Whatever attitudes Black males bring to counseling, it is imperative that counselors and other mental health professionals utilize a range of general practice skills, activate a cultivated knowledge of the social and cultural dimensions of Black male existence, and implement strategies that are culturally-based. The road to satisfactory counseling experiences may depend on it.

Acknowledgments

Author's Note: This research was supported by a grant from the National Institute of Mental Health (5R03MH067124-02). Its content is the sole responsibility of the authors and does not represent the views or policies of the funding agency or the governmental entities in which the authors are affiliated. We are grateful to the young men who participated in this research project and thank anonymous reviewers for their valuable feedback and recommendations.

References

- Anderson, E. *Against the wall: Poor, young, Black, and male*. Philadelphia: University of Pennsylvania Press; 2008.
- Armitage CJ, Conner M. Efficacy of the theory of planned behaviour: A meta-analytic review. *British Journal of Social Psychology* 2001;40:471–499. [PubMed: 11795063]
- Barber AJ, Tischler VA, Healy E. Consumer satisfaction and child behavior problems in child and adolescent mental health services. *Journal of Child Health Care* 2006;10:9–21. [PubMed: 16464930]
- Burns BJ, Phillips SD, Wagner HR, Barth RP, Kolko DJ, Campbell Y, et al. Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child & Adolescent Psychiatry* 2004;43:960–970. [PubMed: 15266190]
- Collins ME. Enhancing services to youths leaving foster care: Analysis of recent legislation and its potential impact. *Children and Youth Services Review* 2004;26:1051–1065.
- Courtney, ME.; Dworsky, A.; Ruth, G.; Keller, T.; Havlicek, J.; Bost, N. *Midwest evaluation of the adult functioning of former foster youth: Outcomes at age 19*. Chicago: Chapin Hall for Children; 2005.
- Davis, LE., editor. *Working with African American males: A guide to practice*. Thousand Oaks: Sage Publications; 1999.
- Diala C, Muntaner C, Walrath C, Nickerson KJ, LaVeist TA, Leaf PJ. Racial differences in attitudes toward professional mental health care and in the use of services. *American Journal of Orthopsychiatry* 2000;70:455–464. [PubMed: 11086524]
- dosReis S, Zito JM, Safer DJ, Soeken KL. Mental health services for youths in foster care and disabled youths. *American Journal of Public Health* 2001;91:1094–1099. [PubMed: 11441737]
- Farmer EMZ, Burns BJ, Chapman MV, Phillips SD, Angold A, Costello EJ. Use of mental health services by youth in contact with social services. *Social Service Review* 2001;75:605–624.
- Fischer EH, Turner JI. Orientations to seeking professional help: Development and research utility of an attitude scale. *Journal of Consulting & Clinical Psychology* 1970;35:79–90. [PubMed: 5487612]
- Ford R. Mind blowing. *The Source* 2008 July;223:54–59.
- Franklin AJ. Therapy with African American men. *Families in Society: The Journal of Contemporary Human Services* 1992;73:350–355.
- Freed LH, Ellen JM, Irwin CE, Millstein SG. Determinants of adolescents' satisfaction with health care providers and intentions to keep follow-up appointments. *Journal of Adolescent Health* 1998;22:475–479. [PubMed: 9627818]
- Garland AF, Aarons GA, Saltzman MD, Kruse MI. Correlates of adolescents' satisfaction with mental health services. *Mental Health Services Research* 2000;2(3):127–139. [PubMed: 11256722]
- Garland AF, Haine RA, Boxmeyer CL. Determinates of youth and parent satisfaction in usual care psychotherapy. *Evaluation and Program Planning* 2007;30:45–54. [PubMed: 17689312]

- Garland AF, Lau AS, Yeh M, McCabe KM, Hough RL, Landsverk JA. Racial and ethnic differences in utilization of mental health services among high-risk youths. *American Journal of Psychiatry* 2005;162:1336–1343. [PubMed: 15994717]
- Garland AF, Saltzman MD, Aarons GA. Adolescent satisfaction with mental health services: Development of a multidimensional scale. *Evaluation and Program Planning* 2000;23:165–175.
- Gibbs, JT. Young Black males in America: Endangered, embittered, and embattled. In: Gibbs, JT., editor. *Young, black, and male in America: An endangered species*. New York: Auburn House; 1988. p. 1–36.
- Harman JS, Childs GE, Kelleher KJ. Mental health care utilization and expenditures by children in foster care. *Archives of Pediatrics and Adolescent Medicine* 2000;154:1114–1117. [PubMed: 11074852]
- Hazen AL, Hough RL, Landsverk JA, Wood PA. Use of mental health services by youths in public sectors of care. *Mental Health Services Research* 2004;6(4):213–226. [PubMed: 15588032]
- Hilliard AG III. A framework for focused counseling on the African-American man. *Journal of Non-White Concerns* 1985;13:72–78.
- Hobbs SR. Issues in psychotherapy with Black male adolescents in the inner city: A Black clinician's perspective. *Journal of Non-White Concerns* 1985;13:79–87.
- Jackson-Gilfort A, Liddle HA, Tejeda MJ, Dakof GA. Facilitating engagement of African American male adolescents in family therapy: A cultural theme process study. *Journal of Black Psychology* 2001;27:321–340.
- Johnson, WE, Jr. Social work and social welfare responses to African American males: What have we seen with our own eyes?. New York: Oxford University Press; in press
- June, LN.; Gunnings, TS., editors. *Journal of Non-White Concerns in Personnel and Guidance*. Vol. 13. 1985. The Black male: Critical counseling, developmental, and therapeutic issues: Part I [Special issue].
- June, LN.; Gunnings, TS., editors. *Journal of Multicultural Counseling and Development*. Vol. 14. 1986. The Black male: Critical counseling, developmental, and therapeutic issues: Part III [Special issue].
- Lee, CC. Black male development: Counseling the “native son”. In: Moore, D.; Leafgren, F., editors. *Problem solving strategies and interventions for men in conflict*. 1990. p. 125–137.
- Lee, CC. *Empowering young Black males*. Ann Arbor: ERIC Counseling and Personnel Services Clearinghouse; 1992.
- Liddle HA, Jackson-Gilfort &, Marvel FA. An empirically supported and culturally specific engagement and intervention strategy for African American adolescent males. *American Journal of Orthopsychiatry* 2006;2:215–225. [PubMed: 16719641]
- Linden A. 2006 January/February;XXL(101):104–106. 108–110. All good.
- Link BG, Cullen FT, Struening E, Shrout PE, Dohrenwend BP. A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review* 1989;54:400–423.
- Losen, DJ.; Orfield, G. *Racial inequity in special education*. Cambridge: Harvard Educational Publishing Group; 2002.
- Mahalik JR, Locke BD, Ludlow LH, Diemer MA, Scott RPJ, Gottfried M, et al. Development of the Conformity to Masculine Norms Inventory. *Psychology of Men & Masculinity* 2003;4:3–25.
- Majors, R.; Billson, JM. *Cool pose: The dilemmas of Black manhood in America*. New York: Touchstone; 1992.
- McMillen JC, Scott LD, Zima BT, Ollie MT, Munson MR, Spitznagel E. Use of mental health services among older youths in foster care. *Psychiatric Services* 2004;52(2):189–195.
- McMillen JC, Tucker J. The status of older adolescents at exit from out-of-home care. *Child Welfare* 1999;78(3):339–362. [PubMed: 10335595]
- Mincy, R., editor. *Black males left behind*. Washington, DC: The Urban Institute Press; 2006.
- Minsky S, Petti T, Gara M, Vega W, Lu W, Kiely G. Ethnicity and clinical psychiatric diagnosis in childhood. *Administration and Policy in Mental Health & Mental Health Services Research* 2006;33:558–567. [PubMed: 16786422]
- Nabors LA, Weist MD, Reynolds MW, Tashman NA, Jackson CY. Adolescent satisfaction with school-based mental health services. *Journal of Child and Family Studies* 1999;8:229–236.

- National Urban League. The state of Black America 2007: Portrait of the Black male. New York: Author; 2007.
- Nguyen L, Huang LN, Arganza GF, Liao Q. The influence of race and ethnicity on psychiatric diagnoses and clinical characteristics of children and adolescents in children's services. *Cultural Diversity and Ethnic Minority Psychology* 2007;13:18. [PubMed: 17227173]
- Paster VS. Adapting psychotherapy for the depressed, unacculturated, acting-out, Black male adolescent. *Psychotherapy* 1985;22(2S):408–417.
- Rasheed, JM.; Rasheed, MN. Social work practice with African American men: The invisible presence. Thousand Oaks: Sage Publications, Inc; 1999.
- Reese, R. American paradox: Young Black men. Durham: Carolina Academic Press; 2004.
- Scott LD Jr, Munson MR, McMillen JC, Snowden LR. Predisposition to seek mental health care among black males transitioning from foster care. *Children and Youth Services Review* 2007;29:870–882. [PubMed: 17710190]
- Vogel DL, Wade NG, Haake S. Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology* 2006;53:325–337.
- Wulczyn; Lery. Racial disparity in foster care admissions. Chicago: Chapin Hall Center for Children; 2007.

Table 1

Means, Standard Deviations, Skewness, and Ranges for Primary Study Variables (n = 47)

<i>Variable</i>	<i>M</i>	<i>SD</i>	<i>Skewness</i>	<i>Obtained Range</i>	<i>Possible Range</i>
Satisfaction with Counseling					
Total Satisfaction Score	2.66	.50	-.35	1.21–3.79	1.00–4.00
Counselor Qualities	2.79	.59	-.66	1.00–4.00	1.00–4.00
Meeting Needs	2.53	.64	-.02	1.00–4.00	1.00–4.00
Effectiveness	2.58	.97	-.15	1.00–4.00	1.00–4.00
Counselor Conflict	2.74	.64	-.31	1.00–4.00	1.00–4.00
Attitudes Toward Mental Health Services	2.32	.76	-.52	.13–4.00	.00–4.00
Stigma Beliefs					
Devaluation-Discrimination	2.78	.78	.40	1.25–4.50	1.00–5.00
Secrecy	2.39	1.06	.75	1.00–5.00	1.00–5.00
Masculine Norms					
Emotional Control	1.23	.48	-.26	.18–2.05	.00–.300
Self-Reliance	1.15	.57	-.28	.00–2.50	.00–3.00

Table 2
Group Differences for Overall Satisfaction with Counseling and Subscale Dimensions

	Overall Satisfaction Mean (SD)	Satisfaction Subscale Dimensions			Counselor Conflict Mean (SD)
		Counselor Qualities Mean (SD)	Meeting Needs Mean (SD)	Effectiveness Mean (SD)	
Custody Status					
Still in custody (<i>n</i> = 18)	2.81 (.45)	2.93 (.50)	2.65 (.54)	2.75 (.95)	2.90 (.50)
Out of custody (<i>n</i> = 29)	2.43 (.50)	2.57 (.67)	2.33 (.76)	2.30 (.96)	2.50 (.64)
Custody Status Differences (<i>t</i>)	2.70**	2.15*	1.65	1.55	2.15*
Counseling Status					
Active (<i>n</i> = 20)	2.80 (.46)				
Inactive (<i>n</i> = 27)	2.56 (.51)				
Counseling Status Differences (<i>t</i>)	1.70 ⁺				
Major Depression (MD)					
Yes (<i>n</i> = 9)	2.79 (.50)				
No (<i>n</i> = 38)	2.63 (.50)				
MD Differences (<i>t</i>)	.85				
Disruptive Behavior Disorder (DBD)					
Yes (<i>n</i> = 21)	2.61 (.51)				
No (<i>n</i> = 26)	2.70 (.50)				
DBD Differences (<i>t</i>)	.60				
Congregate Care Placement (CCP)					
Yes (<i>n</i> = 40)	2.64 (.51)				
No (<i>n</i> = 7)	2.78 (.44)				
CCP Differences (<i>t</i>)	.69				

⁺ $p \leq .10$.

* $p \leq .05$.

** $p \leq .01$.

Table 3

Regression Analysis Predicting of Satisfaction with Counseling

Variable	β	t	Sr ²	Total R ²
				.29
Custody Status (In State Custody = 1)	.27	1.92	.06	
Counseling Status (Active = 1)	.17	1.17	.02	
Attitudes Toward Mental Health Services	.38	2.91**	.14	

*
 $p \leq .05$.

**
 $p \leq .01$.