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Mental Health Awareness Among Parents in an Urban High School

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Mental Health Awareness Among Parents in an Urban High School

Nicole Taylor

The College at Brockport, State University of New York

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Abstract

Mental health literacy has been positively correlated with levels of service utilization and negatively correlated with levels of stigmatizing attitudes. The research is sparse in measuring parents' levels of mental health knowledge and even less research exists measuring parents' ability to locate resources in their community. The current study focused on parents in an urban high school in Western, New York. In this study, six participants completed a survey assessing their ability to identify the symptoms of mental illness and locate resources in the community. The results showed that participants were able to correctly identify four common mental illnesses. The results also suggested that parents would encourage their children to seek professional help and that most knew of resources in the community that can provide that help. Participants felt less confident in their ability to access community agencies for information and support.

Mental Health Awareness Among Parents in an Urban High School

The symptoms of mental illness typically arise during childhood and adolescence (Kessler et al., 2007). Despite 1 in 5 children between the ages of 9-17 having a diagnosable mental illness, only 20% of these children receive mental health services (DHHS, 1999; DHHS 2000). Factors preventing children from receiving help include socioeconomic status, parental mental health knowledge, and levels of stigma (Mendenhall, 2012). The American School Counseling Association stated that counselors have a responsibility to collaborate with stakeholders to ensure that families are aware of mental health issues and have access to mental health care (ASCA, 2009). Virtually no research exists that sets to establish a baseline level of understanding in a population of parents of high school students.

The purpose of this study is to attempt to establish a baseline understanding of the research questions *what do parents know about mental illness* and *how effective would parents be able to access help for their loved ones if they were experiencing the symptoms of mental illness.* Research suggests that cultural factors play a significant role in development of stigmatizing attitudes and views on mental illness. This study sought to examine parental responses specifically from an urban school district. The results of this study will be provided to Student and Family Support Services within the school for possible incorporation into future parent events.

The primary research questions are: What do parents know about mental illness and how effectively can parents access help for their loved ones if their loved ones were experiencing the symptoms of mental illness. This study examines these questions using a correlational quantitative non-experimental design. Several themes were explored throughout the research, including the impact of psychoeducational programs on levels of mental health literacy, the effect of stigma on mental health literacy, the need for increasing mental health first aid

knowledge, and the impact of both stigma and mental health literacy on levels of service utilization.

This study assumes that all returned surveys were completed by parents of the high school targeted. It is technically possible that the survey was received by the student or other member of the household and was completed and returned. This study also assumes that parents answered truthfully. This study was limited in the amount of surveys returned. Caution should be used when applying the results of this study to the sample population. Another limit of this study was the content of the survey. As indicated in the literature, mental illness is more stigmatized in African-American, Latino, and Asian-American populations. Furthermore research indicates that African-American and Asian-American families are less likely to family issues with strangers (Abdullah & Brown, 2011).

For the purpose of this study, the term *mental health literacy* is defined as knowledge of mental illness. The term *student* refers to any person enrolled in the high school utilized for the sample population. *Stigma* is defined as a stereotype surrounding an attribute that is discrediting. *Parental stigma* is defined as stigma held by the parent. *Self-stigma* is defined as stigma held by an individual about a personal attribute that the individual possesses.

In sum, this study aimed to identify a baseline level of understanding of urban high school students' parents of mental illness and their ability to access help. Understanding the knowledge gaps would be helpful in providing the school with informational needs of parents surrounding mental illness in an attempt to assure that all families have access to mental health care. The low response rate prevents meaningful interpretation of the results as they cannot be confidently applied to the population from which the sample was derived.

Review of the Literature

The American School Counseling Association (ASCA) states that school counselors have a responsibility to promote mental health awareness. Furthermore, their official position on student mental health states that school counselors will “advocate and collaborate with school and community stakeholders to ensure that students and their families have access to mental health service” (p.50). Mental health issues impact people of all ages, but the symptoms often show up in childhood or adolescence (Kessler et al., 2007). According to the literature, many people struggle to recognize mental illness in others and those that do are unaware of where to turn for help (Jorm, et al., 1997; Mendenhall, 2012). Adults often do not know how to provide help children with mental health symptoms, and thus give advice that may be unhelpful (Jorm, Wright, & Morgan, 2007; Kelly, et al., 2011). Only a fraction of children, experiencing mental health difficulties, utilize services (DHHS, 2000), and often only for a limited time (Burnett-Ziegler & Lyons, 2010).

Mental health symptoms often emerge during the ages in which youth are still living at home with their parents (NIMH, 2005). Although the research is lacking in studies that examine the mental health educational programming for parents, the research does suggest that individuals, who have a better understanding of mental health issues, are able to provide more effective help to those in need (Barrio & Yamada, 2010; Kelly et al., 2011; Mendenhall, 2010). Children living in poverty have been found to be at greater risk of developing mental illness (Farahmand, Grant, Polo & Duffy, 2011). Young people living in urban areas experience discrimination, poverty, and failing schools, which create feelings of powerlessness (Feldman, 2008), increasing their risk of developing mental illness. Programs targeting schools that serve underrepresented urban populations could mitigate the risk of developing these individuals developing a mental illness.

Community-based interventions are still needed to help dispel myths of mental illness and decrease stigmatizing attitudes (Elkington et al., 2010). Studies show increasing mental health knowledge reduces stigma (Fritz, 2007; Jorm, Kitchener, Fischer, & Cvetkovski, 2010; Lopez et al., 2007, Pinto Foltz, Logsdon, & Myers, 2011, Wang & Lai, 2008; Yau, Pun, & Tang, 2011). Interventions aimed at increasing this knowledge are necessary in combating childhood mental illness. Children are often unable to initiate treatment without the assistance of a caregiver. Even if the child is willing to enter treatment, parental views can impact whether they ultimately receive services. If stigmatizing views held by parents can be changed by increased education and awareness, it could have a positive impact on children's likelihood of receiving services.

Rates of mental illness vary by gender, race, socioeconomic status. The majority of the research shows that Caucasians have higher rates of mental illness than their African-American and Latino counterparts (NIMH, 2008; SAMHSA, 2010). Some of the research, however, indicates that Latino females have the highest rates of mental illness (McLaughlin, Costello, Leblanc, Sampson, & Kessler, 2012) and other research indicates that African-Americans have higher rates of mental illness (DHHS, 1999). The research is consistent in finding that Asian-Americans have lower rates of diagnosed mental illness than Caucasian, Latino, or African-American individuals. Self-reported levels of discrimination have been linked to a higher risk of mental illness (Gee, Ryan, Laflamme, & Holt, 2006; Williams, Yan, & Jackson, 1997). Although there may be discrepancies in the prevalence of mental illness among different racial groups, groups experiencing larger amounts of discrimination are at a higher risk of developing mental illness.

Mental Health Literacy

Jorm et al. (1997) defined mental health literacy as the "knowledge and beliefs about mental disorders which aid in their recognition, management, or prevention" (p. 182). Research revealed that levels of mental health literacy were negatively correlated with stigmatizing attitudes (Chandra & Minkovitz, 2006; Wang & Lai, 2008) and positively correlated with increased service utilization (Amone-P'Olak et al., 2010; Masuda, Anderson, & Edmonds, 2012; Mendenhall, 2012). Research was conducted on levels of mental health literacy in both the general population and within specific cultures (Lazaratou, Anagnostopoulos, Alevizos, Haviara, & Ploumpidis, 2007; Lopez et al., 2009). Power (2010) suggested that evidence-based promotion of mental health information would increase both public understanding and acceptance of mental health disorders.

A few studies that examined the effect of different programs aimed at increasing mental health literacy (Barrio & Yamada, 2010; Dietrich, Mergl, Freudenberg, Althaus, & Hegerl, 2010; Lopez et al., 2009) were found. The first study investigated the effectiveness of a media-based public awareness campaign on depression (Dietrich, et al., 2010). Radio, television, and print media were used to disseminate information about depression and how to obtain help. Three telephone surveys (pre-campaign, and 10 and 22 months post-campaign) revealed that the campaign increased public awareness about depression, but any effects related to decreasing prejudices or increasing knowledge of treatment options were short-lived. Media alone was not effective for long-lasting mental health literacy. Two other studies (Barrio & Yamada, 2010; Lopez et al., 2009) examined the impact of programs targeting mental health literacy in Latino populations. The first (Lopez et al., 2009) examined the use of PowerPoint, audio clips, video clips, and paintings on increasing knowledge of psychosis. After the intervention, participants possessed an increased knowledge of psychosis, had more realistic beliefs about the self-efficacy

of individuals experiencing psychosis, had more positive attitudes about psychosis, and were able to identify more effective methods for providing help. The second study (Barrio & Yamada, 2010) included 26 dyads of clients and caregivers who participated in a culturally competent, family-centered model, which increased mental health literacy, reframed views of individuals with mental illness, and improved assertiveness about seeking treatment. The three studies (Barrio & Yamada, 2010; Dietrich et al., 2010; Lopez et al., 2009) revealed, at least in the short term, mental health literacy interventions are effective in raising awareness about mental health symptoms. Related to increasing mental health literacy, a second target for ensuring youth have access to mental health services is to address stigma.

Stigma

Erving Goffman (1963) defined stigma as an "attribute that is deeply discrediting" (p. 3) and a "relationship between attribute and stereotype" (p. 4). Stigma related to mental illness is prevalent in our society and visible across all cultures (Hinshaw, 2005). The effects of stigma are plentiful in the literature, and evidence has shown that stigmatizing views impact individuals' willingness to seek mental health services (Komiya, Good, & Sherrod, 2000; Vogel, Wade, & Haake, 2006). Stigmatizing views held by families, cultures, communities, and societies impact how individuals with mental illness view themselves (Markowitz, Angell, & Greenburg, 2011; Moses, 2010).

The Surgeon General cited stigma as the most formidable obstacle to progress in the area of mental health. In his report, the Surgeon General identified that stigma leads to the discrimination of individuals suffering from mental illness and prevents these individuals from obtaining the help they need (DHHS, 1999). Studies show that stigma is negatively correlated with mental health literacy, or the ability to recognize, manage, and prevent mental illness (Fritz,

2007; Jorm et al., 1997; Lopez et al, 2009). Interventions aimed at increasing mental health knowledge ultimately decrease stigmatizing attitudes (Corrigan & Shapiro, 2004, Guttierez-Maldonado, Caqueo-Urizar, & Ferrer-Garcia, 2009). There is evidence to suggest that stigmatizing views are more prevalent in certain cultural groups, in particular, Latino, African-American, and Asian-American communities (Elkington et al., 2012; Garcia, Gilchrist, Vazquez, Leite, & Raymond, 2011; Hinshaw, 2005; Johnson, Mills, DeLeon, Hartzema, & Haddad, 2009; Kranke, Guada, Kranke, & Floersch, 2012; Rojas-Vilches, Negy, & Reig-Ferrar, 2011). Promoting culturally competent mental health awareness in these aforementioned communities could decrease stigmatizing views, thus increasing the likelihood that members would receive mental health treatment.

The impact of programs to reduce stigma. Research, albeit minimal, suggests that parental-held stigmatizing attitudes impact the parents' likelihood of obtaining professional help for their children when their children exhibit mental health symptoms (Burnett-Zeigler & Lyons, 2010; Fritz, 2007; Mendehall, 2012). The research suggests that interventions, to overcome this stigma, could prove to be effective in increasing parents' likelihood of seeking treatment for their children (Burnett-Zeigler & Lyons, 2010; Cohen, Calderon, Salinas, SenGupta, & Reiter, 2012; Fritz, 2007). Stigma was found to lead to parents' avoidance of addressing mental health issues of their children (Fritz, 2007). This avoidance leads to children lacking treatment that could dramatically reduce their symptoms. Fritz also suggested that programs targeting parental stigma could impact the future of children's mental health.

Kelly, et al. (2011) examined the effect of a mental health training course on stigmatizing attitudes in a sample of 246 Australian adults. Kelly et al. found that, after a 14-hour mental health first aid course, participants held less stigmatizing views about depression and

schizophrenia. Prior to the intervention, 35% of participants perceived individuals suffering from depression to be *dangerous*, 65% agreed that they were *unpredictable*, and 12% thought that individuals with depression could *snap out of it*. Immediately following the intervention, only 25% found this same group to be *dangerous*, 48% found them to be *unpredictable*, and only 6% held the view that individuals with depression could *snap out of it*. The results were even greater when participants were questioned about schizophrenia, with scores significantly improving on perceived *dangerousness* and *unpredictability*. Similar results were found in a study of 45 caregivers of individuals suffering from schizophrenia. Guttierez-Maldonado and Lewis (2009) conducted a controlled experiment in which caregivers were assigned either to a group, who received an intervention targeting knowledge of schizophrenia, or a usual-care group. Following the intervention, individuals in the experimental group showed more positive attitudes about schizophrenia and were able to view the disorder in a more flexible way. Similarly, Lopez et al. (2009) examined the effect of a 35-minute psychoeducational group to 63 community residents and 42 caregivers of individuals with psychosis in a Spanish-speaking community. Like the findings of the other studies (Guttierez & Maldonado, 2009; Kelly et al., 2011), Lopez et al. found that the intervention decreased negative attitudes about psychosis. Lastly, a study of 1,040 students, ages 12-19, were administered the 17-item public stigma scale for depression, and the 10-item self stigma of seeking help scale both prior to and after the implementation of a program aimed at decreasing stigma (Yau et al., 2011). Prior to the implementation of the program, participants possessed more negative views about mental illness, and that stigmatizing beliefs led to negative views on seeking treatment. Following the implementation of the program, students reported beliefs that were geared more toward social inclusion, respect and acceptance of individuals experiencing mental illness.

The studies (Guttierez & Maldonado, 2009; Kelly et al., 2011; Lopez et al., 2009; Yau et al., 2011) all shared a common theme of assessing attitudes about some form of mental illness prior to and after an intervention aimed decreasing stigma. Each of these studies was successful in getting participants to view the targeted mental illness in a way that promotes more respect for individuals suffering for these mental illnesses. Furthermore, researchers found that stigmatizing views were related to negative views about seeking treatment (Yau et al., 2011). In contrast to the aforementioned studies, one study examined the benefit of "In Our Own Voice" training, which focused on contact with individuals suffering from mental illness, on mental health literacy and stigmatizing attitudes (Pino-Foltz et al., 2011). Pino-Foltz et al. found that, although this intervention increased rates of mental health literacy, stigmatizing attitudes were not subsequently decreased. These results could suggest that the content of the intervention is weighty and increased mental health knowledge alone is not enough to decrease stigmatizing attitudes.

The effect of parental stigma on adolescent self-stigma. The available research on the origins of stigmatizing attitudes points strongly at individual, parental, cultural, and societal factors in the development of stigmatizing beliefs (Hinshaw, 2005). The research indicates that stigmatizing attitudes are formed early in development (Hinshaw, 2005) and that stigmatizing views held by parents, cultures, and societies often translate into self-stigma of individuals experiencing mental illness (Moses, 2010). Furthermore, it has been shown that higher levels of self-stigma translate into individuals being less likely to seek and accept help (Barney, Griffiths, & Jorm, 2006; Bathje & Pryor, 2011; Chandra & Minkovitz, 2007; Hinshaw, 2005; Komiya & Good, 2000; Vogel et al., 2006).

Stigma within the family. Moses (2010) and Markowitz et al. (2011) examined the impact of parental stigma on self-stigma in youth experiencing mental illness. In both studies, parents' negative views on mental illness were correlated with the likelihood of having a child who possessed self-stigmatizing views. Parents, who were more optimistic about their child's diagnosis, had children who reported a lower level of self-stigma (Moses, 2010). Parents of children with a mental health diagnosis, who reported concealing their child's diagnosis or, who held negative views about the amount of control their child had over their mental health symptoms, had a greater likelihood of having a child who possessed self-stigmatizing views. Children were accurately able to assess the stigmatizing views held by their parents (Markowitz et al., 2011). A correlation was discovered between parental self-stigmatizing views and symptoms, self-efficacy, and life satisfaction. Negative appraisals were found to facilitate sustained symptoms, reduce a sense of self-control, and lower feelings of empowerment and motivation. The researchers concluded that parental-held stigmatizing attitudes about their child's mental health diagnosis, whether salient or unexpressed, impacted the level of self-stigma experienced by the child and ultimately, willingness to accept mental health treatment (Moses, 2010). Furthermore, those who do accept treatment are not only impacted by clinical interventions, but also the views held by the family (Markowitz et al., 2011)

Stigma external to the family. Fritz (2007) identified that, in a study of 1,134 American parents, 30% of parents stated that they would not want their child to be friends with a child suffering form depression. Furthermore, 25% of parents would not want to live next door to a child suffering from depression. If children are using these cues to form their opinions of mental illness, then it is clear that targeting parental attitudes could be helpful in decreasing self-stigma in youth.

Cultural beliefs and their impact on stigmatizing attitudes. There is much evidence to suggest that culture plays a large role in the development of stigmatizing attitudes about mental illness. In particular, Latino, African-American, and Asian-American cultures tend to hold more stigmatizing beliefs than their white counterparts (Kranke et al., 2012; Rojas-Vilches et al., 2011). Individuals, who are part of these cultures, are also less likely to seek treatment due to stigma (Elkington et al., 2012)

African-American populations. In one study, 17 African-American youth, who were diagnosed with a mental illness, were interviewed about their perceptions of mental health help-seeking and psychiatric medication (Kranke et al., 2012). These youth provided researchers with information about the source of stigmatizing attitudes. The participants cited cultural beliefs within the African-American community as one of the primary reasons that they were reluctant to seek help or take psychiatric medication. In another study, 10 African-American women suffering from panic disorder participated in a focus group (Johnson et al., 2009). These women were asked several questions to assess how anxiety and mental health treatment were viewed among their families and in their communities. Participants reported being labeled as spiritually weak, that they commonly heard hurtful language used to describe mentally ill individuals, that there was a stigma about psychiatric medication, and that there were cultural barriers to communication in treatment. These two studies focused on a total of 27 individuals with a mental health diagnosis and are not representative of the African-American population as a whole, but the results suggested that culture plays a role in stigmatizing attitudes and that these attitudes are preventing people from obtaining help.

Research has shown that media messages play a large role in the generation of stigmatizing views (Elkington et al., 2012; Kranke et al., 2012). Messages related to depression

were examined in the three most popular African-American magazines: Ebony, Jet, and Essence (Clarke, 2010). Many of the themes discovered in these magazines pointed to a lack of cultural competence on behalf of treatment providers, African-Americans' continued vulnerability to racist social policies, and diagnosis of depression being a threat to black identity. These articles also discussed depression in terms of spirituality. Individuals suffering from mental illness were described as being "spiritually lacking" and many of the articles suggested that problems with depression could be handled within the church. Readership among these publications was not established and no studies were located that measured the impact of these media messages in individuals who were readers of these publications, however, the information is still valuable.

Latino Populations. Latino culture is highlighted by collectivism, interdependence, and cooperation (Abdullah & Brown, 2011). The personas of *marianismo* and *machismo* in Latino identity have been identified in the research (Abdullah & Brown, 2011). *Marianismo* is the concept that women handle suffering with dignity. *Machismo* is the concept that males remain strong and provide for their family. Diagnosis of mental illness can impact Latino identity by running contrary to these personas. If a woman seeks help for mental illness, she is no longer considered to be handling suffering with dignity and may face scorn from other members of the community. If a male is suffering from mental illness, he may be viewed as "weak" and unable to provide for his family.

The literature contained several studies that focused on the roots of stigmatizing attitudes in Latino culture. Stigmatizing beliefs were examined among 66 Puerto-Rican youth, 62 Cuban youth, and their parents (Rojas-Vilches et al., 2011). The researchers found that stigmatizing attitudes were positively correlated with the participants' level of enculturation. The more encultured individuals were toward Latino culture, the more likely they were to identify

individuals with mental illness as *dangerous*, to have poor personal and interpersonal skills, and to be *incurable*. In another study, 234 Latino urban and rural immigrants, mostly from Mexico, completed a questionnaire about mental illness (Garcia et al., 2011). The results showed that 35% of urban immigrants and 9% of rural participants equated seeing a mental health professional to being *crazy*. The number of urban immigrants that hold stigmatizing views on treatment has important implications for working with parents in urban school districts, many of which may be first generation Latino families. Many first generation immigrants from Latino families remain encultured toward their native culture and their views on mental illness are impacted (Rojas-Vilches et al., 2011).

Asian-American Populations. Asian-Americans often do not confide in people outside of their family and close friends due to stigma and mistrust in the mental health system (Li & Keshavan, 2010). Despite the large amount of heterogeneity found among Asian-Americans, the virtues of filial piety, or respect to the family, and collectivism are central to many Asian cultures (Ozer & McDonald, 2006). Asian cultural values have been positively correlated with an increase in stigmatizing attitudes (Miville and Constantine, 2007).

In a study of 201 college women of Asian decent, scores on the Stigma Scale for Receiving Psychological Help (SSRPH) and the Intentions to Seek Counseling Inventory (ISCI) were compared to the Asian Values Scale (ASV; Miville & Constantine, 2007). The ASV measures an individual's levels of traditional Asian cultural values such as filial piety and conformity to norms. The results of this study indicated that high scores on the ASV were positively correlated with higher scores on the SSRPH and negatively correlated with higher scores on the ISCI. There is evidence to suggest that self-stigma is more of a mediating factor in acceptance of professional help than social stigma (Iwasaki, 2005)

Loya, Reddy, and Hinshaw (2010) examined differences in stigmatizing attitudes between samples of 74 Caucasian college students and 54 South-Asian college students. The results showed that South-Asian college students held more personal stigma toward individuals suffering from mental illness than their Caucasian counterparts. The group comprised of South Asian students also demonstrated more negative attitudes toward seeking professional help. Interestingly, no difference was found in levels of perceived stigma, which supports Iwasaki's (2005) assertion that self-stigma has a larger role in the South Asians' willingness to obtain professional help.

Attempts to provide a possible explanation for the increase in stigmatizing attitudes were present in the research. The Asian value of conformity to norms is high in people of Asian decent. Mental illness is seen as unnatural and, thus, a deviation from norms in society (Abdullah & Brown, 2011). If mental illness conflicts with traditional Asian values, then it is not surprising that Asian cultures hold stigmatizing attitudes toward individuals who are experiencing mental illness.

Understanding the roots of stigmatizing attitudes is crucial in attacking stigma. The experience of individual and systematic racism by African-Americans has created a need to appear strong in the face of vulnerability (Clarke, 2010). Latino culture focuses on collectivism and equal contribution. It is important to appear strong and not be viewed as a "weak link" (Abdullah & Brown, 2011). Taking culture into consideration when developing new interventions to decrease stigma could have a large impact on their success.

Service utilization

Twenty-one percent of children aged 9-17 have a diagnosable mental illness that causes at least minimal impairment (DHHS, 1999). Of these children, only one in five receives mental health treatment (DHHS, 2000). The research shows that levels of mental health literacy, levels of stigma, and utilization of mental health services are all correlated (Clarke, 2010; Masuda et al., 2012; Mendenhall, 2012, Pescosolido et al., 2008; Vogel et al., 2006). Many factors influence service utilization, including socioeconomic status, mental health knowledge, culture, and location (Mendenhall, 2012). Exploring how these factors impact service utilization can aid in the development of programs that can combat these disparities.

Socioeconomic status. Children from low-income families have lower rates of service utilization than their higher-income counterparts. Children from low-income families also have higher rates of parental stress, parental depression, exposure to poverty, exposure to violence, and individual stress (Bringewatt & Gershoff, 2010). Members of this population are also accessing services for shorter periods of time (Burnett-Ziegler & Lyons). Families with low incomes have barriers that prevent them from seeking services, such as, lack of health insurance and lack of transportation (Mendenhall, 2012).

Mental health knowledge. Several studies have focused on links between low service utilization and mental health knowledge (Amone-P'Olak et al, 2010; Barrio & Yamada, 2010; Mendenhall, 2012). Many people are unable to correctly identify mental health symptoms in others, and people who are able may be unaware of available treatments or ways to obtain help (Jorm et al., 1997). If parents are unable to identify a disturbance in their child as a symptom of mental illness, then it is unlikely that they would utilize mental health services to help their child (Mendenhall, 2012).

A study of 2,149 youth examined the relationship of certain parental characteristics and service utilization (Amone-P'Olaket al., 2010). The researchers linked higher levels of maternal education with higher rates of mental health service utilization. The researchers speculated that mothers who had higher levels of education may have higher levels of mental health knowledge, which increases the likelihood that these mothers will access services for their child. The researchers, however, did not provide a direct correlation between mental health knowledge and service utilization. Low maternal education could have led to socioeconomic issues that impacted the rates of service utilization rather than knowledge of mental health issues.

A study of 165 children and their parents conducted by the National Institute of Mental Health, however, did find a correlation between parents' knowledge about mental illness and accessing mental health services for their child (Mendenhall, 2010). Another study of 24 parents of children with mental illness enrolled in the Children's Health Insurance Program (CHIP) in California (Cohen et al., 2012) also found a relationship between parents' willingness to seek help on behalf of their children and their perceptions about mental health and the need for mental health services. Parents cited the need for more mental health knowledge and information about how to navigate mental health resources in the community (Cohen et al., 2012).

Cultural factors. African-Americans, Latinos, and Asian-Americans have lower rates of mental health service utilization than their white counterparts (Loya et al. 2010; Merikangas et al., 2010). There are many cultural factors that prevent the utilization of services in these cultural groups. African-Americans may see treatment as a "white thing" and a threat to black identity (Clarke, 2010). One study showed that African-Americans were more likely to think that depression will resolve itself on its own (Pescosolido, 2008). Another study found that Latino and African-American cultures had higher rates of stigmatizing attitudes and that stigma is often

found in tandem with discrimination (Elkington et al., 2012). A third study explored the somatization of mental health symptoms its role as a barrier in detecting mental illness in Latino populations (Bauer, Chen, & Algeria, 2012). They found that Latino individuals are more likely than other ethnic groups to experience stress physically and that this difference can make it more difficult to detect mental illness.

Location. Several studies examined location as a factor impacting service utilization (Garcia et al., 2011; Mendenhall, 2012). Location was ranked as one of the top three reasons for low service-utilization, with urban children receiving more services than rural children (Mendenhall, 2012). Researchers suggested that rural children have less access to services in their communities. Urban areas also likely have a higher concentration of qualified mental health professionals. A study of urban versus rural immigrants, however, found that individuals in urban communities were significantly less likely to know available mental health resources for adolescents than their rural counterparts (Garcia et al., 2011).

Age and gender factors. In addition to the already mentioned factors that negatively impact service utilization, the literature identified age and gender as significant predictors of service. Older college students were more likely to seek mental health services (Masuda et al., 2012). On the other hand, in a study of 1,998 Australian adults, researchers found that younger adults (ages 18-25) viewed informal sources of help (parents, friends) equally as helpful as counseling (Farrer, Leach, Griffiths, Christiansen, & Jorm, 2008). As participants increased in age, their views about formal versus informal help shifted and they increasingly preferred counseling to informal social supports. The cause for these differences was not studied in the literature, but identifying factors that cause a shift in treatment preferences could shed light on why older adolescents are not seeking treatment.

Gender also plays a role in utilization of services. In a study of 8th graders, researchers found that females had a higher level of mental health knowledge and males had a higher level of stigmatizing attitudes (Chandra & Minkovitz, 2006). Predictably, the researchers also found that girls were more likely to seek help for mental health problems. In a study of 1,207 young Australians (ages 12-25), female respondents were more likely to identify depression from a vignette (Cotton, Wright, Harris, Jorm, & McGorry, 2006). Females were also more likely to encourage the use of mental health services to the individuals described in the vignettes. Males were more likely than females to identify that the person described in a depression vignette was suffering from mental illness, but were less likely to be able to identify the mental illness specifically as depression. Males were also more likely than females to endorse alcohol as an effective treatment for depression. A vignette describing schizophrenia was also used in this study, but the researchers were unable to identify any gender differences in identification or suggestions for help. Finally, in a study of 6,483 adolescents ages 13-18, researchers found that females had a much higher chance of being treated for mood or anxiety disorders (Merikangas et al., 2011). The research was lacking in any explanations for this difference, but using the results of the previously mentioned studies, one can speculate that females are more likely to receive treatment because they have more positive views about seeking help for mental health problems.

Mental Health First Aid

A number of studies have been conducted on the help-seeking intentions of adults when presented with an individual experiencing mental health symptoms. These studies have found that the public does not always know what is helpful when providing suggestions to individuals experiencing mental illness (Jorm, Morgan, & Wright, 2008; Yap & Jorm, 2012). Furthermore, the people providing help do not always feel confident doing providing this help (Jorm et al.,

2010, Kelly et al., 2011). Using the research, programs can be developed that provide parents with the ability to provide helpful interventions to children experiencing the symptoms of mental illness and increase the parents' confidence in doing so.

Knowledge of helpful interventions in youth and parents. Two studies attempted to examine the mental health first aid intentions of youth and their parents (Jorm et al., 2007; Yap & Jorm, 2012). In the first study, a random sample of 3,746 Australian youth and their parents were read vignettes during a telephone interview that described an individual with depression (Jorm et al., 2007). The purpose of the study was to assess differences in mental health first aid intentions. The results showed that young adults were less likely than their parents to recommend that the person described in the vignette seek help from a mental health professional. The study found that the majority (over 80%) of parents and youth perceived assessing the individual's risk of suicide to be harmful. These results are troubling because 17% of female high school students and 10% of male high school students have contemplated suicide within the past year (CDC, 2012). Additionally, one-third of parents stated that they would not suggest professional help for the person described in the vignette. In a follow-up study, 1,520 of the original participants, along with their parents, were interviewed via telephone to examine which interventions had been used following the initial study (Yap & Jorm, 2012). The researchers also examined whether mental health first aid intentions predicted actions and the impact of stigmatizing attitudes on these actions. Although the results showed that stigmatizing attitudes did not predict which mental health first aid actions were taken, but that these attitudes still had an impact.

Individuals in the second study (Yap & Jorm, 2012), who perceived that the vignettes described a person who was *weak, but not sick,* were more likely to endorse talking firmly to

them about *getting their act together*. Individuals who scored higher on an instrument measuring desired social distance were less likely to help make an appointment for a person suffering from mental illness. Yap and Jorm found that the stigmatizing attitudes held by participants influenced first aid actions more than other respondent characteristics. Although it would be beneficial, the researchers in the second study were not able to ascertain, which of the mental health first aid intentions identified in the first study (Jorm et al., 2007), were impacted by the stigmatizing attitudes examined in the second study (Yap & Jorm, 2012).

The results of these two studies suggest that parents are not prepared to provide appropriate mental health first aid to individuals exhibiting the signs of mental illness. Since the vignettes described a person that had no connection to the participants, it is difficult to determine what first aid intentions would be taken if the participants' child were to exhibit the same symptoms. Regardless, the results show both a need for further education surrounding appropriate mental health first aid actions when faced with an individual exhibiting mental health symptoms, as well as, a need for decreasing stigmatizing attitudes that contribute to these unhelpful first aid actions.

Interventions targeting mental health first aid knowledge. Several studies have demonstrated the efficacy of interventions aimed at increasing mental health first aid knowledge. The impact of a 14-hour youth mental health first aid course was examined in a random sample of 246 Australian adults (Kelly et al., 2011). Post-intervention, participants felt more confident providing help to individuals experiencing depression and psychosis, and first aid intentions were more effective. In another study, researchers conducted a controlled experiment in which participants were either presented with an e-learning mental health first aid training, were asked to read a the Mental Health First Aid manual, or were placed into a control group (Jorm et al.,

2011). The results showed that the training provided via e-learning increased knowledge of effective interventions for depression from 37% to 67% and for psychosis from 45% to 72%. After reading the Mental Health First Aid manual, participants increased their knowledge of effective interventions for depression from 40% to 65% and from 44% to 79%. The control group saw an increase as well, but the change was much smaller. Jorm et al. also found a significant increase in confidence in providing help among the groups that participated in the e-learning experience and that read the Mental Health First Aid manual. Similar results were also found with increases in help-seeking intentions after an intervention aimed at increasing mental health literacy (Lopez et al., 2009).

The results of these studies show that interventions that aim to increase mental health first aid knowledge are effective. The only study that examined retention of knowledge beyond the conclusion of the program was Kelly et al. (2012). In this study it was found that knowledge gained in the Youth Mental Health First Aid course extended to a 6 month post-test. The other studies mentioned did not measure change past the initial post-test, so it is difficult to speculate how long-lasting the effects of the training were. Nevertheless, these studies show promise that individuals with little experience with mental illness can learn effective mental health first aid treatments.

The school counselor's role

Interventions that target students' academic, career, and personal/social development benefits all children and adolescents (ASCA, 2005). Any intervention that provides parents with the tools to better help their child's personal/social development would benefit the child. The literature has provided evidence that suggests that parents need more knowledge of mental illness and mental health resources (Chandra & Minkovitz, 2006; Wang & Lai, 2008). This

information has been shown to decrease stigma and increase both mental health literacy and service utilization (Amone-P'Olak et al., 2010; Masuda et al., 2012; Mendenhall, 2012). Assessing for gaps in knowledge would, according to this principle, ultimately help students.

School counselors also have an obligation to assist other adults in being able to better meet the academic, career, and personal/social needs of students in an attempt to remove barriers to individual students' success (ASCA, 2005). ASCA (2005) stated that this should be done through advocacy and collaboration with adults who have a shared interest in the students' success. The school counselor's duty is to work not only with the child, but also to work with any adults who have a stake in the student's success. Applying this problem to mental health literacy of parents, assessments that identify gaps in knowledge allow for the school counselor to collaborate with parents in an attempt to best help their child achieve success.

Interventions that are intentionally designed and target specific needs are more effective than those that do not (ASCA, 2005). It is important to understand the needs prior to developing an intervention to combat a problem. Applying this principle to the problem, assessing parents is important in order best understand the gaps in knowledge. The literature provided a plethora of information about the needs of specific populations (Abdullah & Brown, 2012; Lazaratou et al., 2007; Lopez et al., 2009; Power, 2010), but none were representative of a population within an urban school district. In order to adhere to this principle, specific interventions would need to be developed based on the needs of the specific population.

Conclusion

A lack of accurate knowledge of mental illness is contributing to both stigma and lowered rates of service utilization (Barrio & Yamada, 2010; Chandra & Minkovitz, 2006; Fritz, 2007; Guttierez-Maldonado et al., 2009; Komiya et al., 2000; Vogel et al., 2006). Stigma is preventing

people from seeking help due to fear of discrimination and being labeled as *crazy* (Fritz, 2007; Vogel et al., 2006). The literature also provided evidence to support the role of culture in the development of stigmatizing attitudes and service utilization. (Abdullah & Brown, 2011; Clarke, 2010; Kranke et al., 2012).

The studies present in the literature suggested that stigma can be mitigated by raising mental health awareness and providing accurate information about mental illness (Fritz, 2007; Jorm et al., 2010; Lopez et al., 2009; Pino-Foltz et al., 2011; Wang & Lai, 2008). The literature also suggested that culture plays a role in the development of stigmatizing attitudes (Abdullah & Brown, 2011; Clarke, 2010; Kranke et al., 2012). Service utilization rates are often low in populations with limited resources. In order to ensure that all families have the same access to services, investigation into barriers should be an integral part of any intervention. There is evidence to suggest that providing information about mental illness would be helpful in decreasing stigma (Fritz, 2007; Jorm et al., 2010; Lopez et al., 2009; Pino-Foltz et al., 2011; Wang & Lai, 2008).

School counselors have a duty to promote mental health awareness and they have the ability to collaborate with various stakeholders serving children to accomplish this task (ASCA, 2009). Prior to intervention it is important the particular population targeted is considered. The literature demonstrated vast differences in knowledge and a need for interventions that tailored to the needs of the population being targeted. In addition to considering trends in the literature, it is also important to assess individuals for gaps in knowledge. The current available literature lacked studies that examined parents' knowledge of how to access specific resources. A more holistic look is needed at parents' familiarity with how to obtain help for their children when mental illness is suspected.

Research Questions

1. Can parents recognize signs of mental illness?

2. Are parents aware of appropriate resources for providing help to a child experiencing mental health issues?

Methods

The following research questions were addressed in this study: Can parents recognize the signs and symptoms of mental illness and are parents aware of appropriate resources for providing help to a child experiencing mental health issues. This study utilized a quantitative, non-experimental design in which participants completed a survey that contained 4 questions in which they had to identify a particular mental illness based on a list of symptoms followed by 18 likert-scale questions assessing their level of mental health literacy, and willingness and ability to access help for their child. The survey also contained demographic questions that inquired about the age, sex, and race of the participants.

Participants

The sampling procedure used by the researcher was purposive sampling. All parents of students attending a high school in an urban school district in Western New York were invited to participate in this study. The demographics of the high school are as follows: 69% African-American, 23% Hispanic/Latino, 3% Asian or Native Hawaiian, and 4% White (New York State School Report Card, 2012). Seventy-seven percent of the school is eligible for reduced-price lunch and 17% of students are limited in their English proficiency. In total, 318 parents were invited to participate in this study. Of the 318 invited, 4 surveys were returned by the post office as undeliverable, bringing the total of participants invited to 314. Of these 314 parents invited to participate in the study, 6 completed and returned their survey, representing a 2% response rate. Of the 6 participants, 5 were female and one participant chose not to answer. The mean age was two participants were African-American, one participant was Hispanic/Latino, two participants were Caucasian, and one participant chose not to answer.

Procedure

All parents of students attending an urban high school in upstate New York were mailed informed consent and a brief survey assessing their level of knowledge of mental illness. Communication was sent in Spanish for participants whom utilize Spanish as their primary language. Surveys were mailed via the school district's print shop and the researchers covered all printing and postage costs, including return postage. Completed surveys were returned to the school in a postage-paid pre-addressed envelope. Participation in the study was anonymous and there was no way to link the completed survey to the participant. Completed surveys were stored in a locked filing cabinet until the cessation of the study, after which they were destroyed.

Instruments

A survey was developed by researchers for use in this study. The survey contained twenty questions pertaining to knowledge of mental health issues and also contained three demographic questions; age, sex, and race. Questions 1-4 involved matching a list of common symptoms of depression, bipolar disorder, generalized anxiety disorder, or schizophrenia to their appropriate illness. Questions 5-20 are likert-scale questions with answers being *strongly disagree, disagree, agree, or strongly disagree*. Questions 1-4, 7, 9 and 10 surveyed participants on their knowledge of mental health symptoms. For analysis, the response of *strongly disagree* was given a score of 1, *disagree* a score of 2, *agree* a score of 3, and *strongly disagree* a score of 4. These questions were selected because the literature identified that lack of knowledge of mental illness and its symptoms were a significant factor in lack of mental health treatment (Garcia et al., 2011; Leavey, 2011; & Mendenhall, 2012). The literature also identified that stigma was decreased with greater knowledge of depression and schizophrenia (Kelly et al., 2011). Questions 5 and 6 surveyed participants on the prevalence of depression and anxiety

disorder. These questions were selected to because the literature identified that these two disorders are fairly common in youth with some cultures experiencing higher levels than others (DHHS, 1999; McLaughlin et al. 2012; NIMH, 2008; SAMSHA, 2010). Question 8 was used to assess whether participants had a family member with mental illness. This question was used to determine whether participants had previous knowledge of mental health issues. Question 11 assesses parent's willingness to seek help for their child from a qualified mental health professional. There is evidence to suggest that individual with a low level of mental health knowledge are not confident providing help to individuals experiencing mental illness (Kelly et al. 2011; Yap and Jorm, 2012). Question 12 assesses parental views on medication. Studies have suggested that there is a great deal of ignorance about medication, and that this ignorance leads to children lacking access to medication that could potentially help them (Lazaratou et al., 2007). Questions 13-20 assess parents' ability to access resources at the school and in the community that can support them in providing help to a child with mental illness. The literature suggested that people do not know where to turn to access services for an individual with mental illness (Garcia et al., 2011). Cohen et al. (2012) found that a lack of ability to navigate the mental health system was the largest barrier to children receiving care.

The demographic questions were added because the literature identified that culture plays a large role in the way that mental illness is perceived (Abdullah & Brown, 2011, Burnett-Zeigler & Lyons, 2010; Elkington et al., 2007; Johnson et al. 2009; Kranke et al. 2012; Pescosolido et al., 2008) Gender differences were also found to exist with females being more likely to seek treatment for mental illness (Chandra & Minkovitz, 2006).

Results

The data was analyzed using IBM SPSS 2.0. The first four questions focused on participants' ability to match a list of mental health symptoms with its corresponding mental illness. Participants were given a score of 1 if they answered the question correctly and 0 if they answered incorrectly. Of the 6 participants who returned their survey, 4 (66.66%) participants were able to correctly identify depression, 5 (83.33%) participants were able to correctly identify generalized anxiety disorder, 4 (66.66%) participants were able to correctly identify bipolar disorder, and 4 (66.66%) participants were able to correctly identify schizophrenia. Table 1 shows the correct and incorrect responses to questions 1-4. The results can be seen below in Table 1.

Table 1

Reponses to matching symptoms to mental illness

Mental Illness	Correct Responses	Percentage
1. Depression	4	66.66%
2. Generalized Anxiety Disorder	5	83.33%
3. Bipolar Disorder	4	66.66%
4. Schizophrenia	4	66.66%

Descriptive Statistics

The following 18 questions utilized a likert scale to identify participants' level of agreeability with a statement. Likert scale items were scored as follows: items marked *strongly disagree* were assigned a score of 1, items marked *disagree* were assigned a score of 2, items marked *agree* were assigned a score of 3, and items marked *strongly agree* were assigned a score of 4. Table 1 identifies the means and standard deviations for all items 5-20. The highest mean

score was in response to the question *I would know where to turn for help if my child was experiencing the symptoms of mental illness* (*M* = 3.833, *SD* = 0.408). The lowest mean score was in response to the question *mental illness runs in my family* (*M* = 2.000, *SD* = 0.632). Means and standard deviations to questions 5 - 20 can be seen in Table 2.

Table 2

Responses to questions assessing mental health knowledge and ability to obtain help

Question	*m*	*sd*
5. Depression is common among youth.	3.333	0.516
6. Generalized Anxiety Disorder is common among youth.	2.666	0.516
7. I know the difference between stress and Generalized Anxiety Disorder.	3.166	0.408
8. Mental illness runs in my family.	2.000	0.632
9. I would be able to recognize the signs of mental illness in my child.	3.000	0.894
10. I know the warning signs of suicide	2.833	0.983
11. If my child were showing signs of mental illness, I would encourage them to speak to a counselor.	3.666	0.516
12. If my child had a mental illness, I would encourage them to take medication.	3.000	0.894
13. I would know where to turn for help if my child were showing signs of mental illness.	3.833	0.408
14. I am familiar with the location of a psychiatric emergency department within the city of Rochester	3.500	0.836
15. I am familiar with Lifeline.	2.666	1.038
16. I am familiar with resources within the school to help my child if they were experiencing the symptoms of mental illness.	2.800	0.836
17. I would know how to access a mental health provider in the community if my child was experiencing the symptoms of mental illness.	3.333	0.816
18. I am familiar with community agencies that provide information about mental illness.	2.333	1.032
19. I am familiar with community agencies that provide support to families that are coping with a family member experiencing mental illness.	2.600	0.894
20. I know of other means of accessing information about mental illness.	2.800	0.477

Inferential Statistics

This study did not have enough participants to be considered a power sample ($n = 6$). Inferential results should be interpreted cautiously as this study was not a good representation of the sample population.

All participants who chose to answer the demographic questions responded as female. One participant chose not to answer. All participants were in the age range of 31-39. A one-way ANOVA was performed to examine the relationship between race and responses to the likert scale items. The results of the ANOVA showed no significant effect.

A bivariate correlation was utilized to determine correlations between likert scale questions. Several questions were significantly correlated. Responses to *if my child were showing signs of mental illness, I would encourage them to see a counselor* was positively correlated with *I am familiar with Lifeline* ($r = 0.875$, $p = .022$). The responses to *I am familiar with community agencies that provide support for families coping with mental illness in their family* was positively correlated with *I am familiar with community agencies that provide information about mental illness* ($r = 1.00$, $p = .000$). Responses to *if I had a family member with mental illness, I would encourage them to take medication* was positively correlated with *depression is common among youth* ($r = 1.00$, $p = .000$).

The question mental illness runs in my family was inserted to determine if responses were affected by having prior knowledge of helping a loved one with mental illness. A linear multiple regression was performed and found no significant effect was found.

Discussion

Individuals who suffer from mental illness typically begin showing symptoms in childhood or adolescence (Kessler et al., 2007). The American School Counseling Association stated that school counselors have a responsibility to both promote mental health awareness and to collaborate with stakeholders to ensure that families have access to mental health care (ASCA, 2009). Research has suggested that lower levels of mental health literacy are positively correlated with higher levels of stigma. Furthermore, the research also suggests that levels of mental health stigma are negatively correlated with service utilization.

The purpose of this study was to ascertain parents' knowledge about specific mental illnesses and to identify how effectively they could access help for their children if they were showing signs of mental illness. The research is lacking in studies that target parents of high school students and the data could be useful in identifying parental informational needs.

The survey used in this study was developed by the researcher and sought to identify how well the participants could match the symptoms of mental illness with the corresponding illness and their level of agreeability with statements focused on mental health knowledge and their ability to access help. The results should be interpreted cautiously, as few people responded to the survey and the sample may not be representative of the school population.

Mental health knowledge. The initial 4 questions provided a list of symptoms and asked participants to identify the mental illness that the symptoms were describing. The results showed that the majority of people participating in the study were able to identify the symptoms of the mental illnesses in question. When presented with symptoms that described depression, 66.66% of participants responded correctly. The of correct responses increased to 83.33% when participants were presented with a list of symptoms that described generalized anxiety disorder.

When presented with symptoms of bipolar disorder and schizophrenia, 66.66% of participants answered correctly. It is important to note that in 5 out of 6 cases, participants either answered all questions correctly or all questions incorrectly. This suggests that the parents that do know about mental illness are familiar with a variety of mental illnesses. Each mental illness was matched with one set of symptoms, so it is possible that parents were able to guess correctly based on elimination rather than knowing all of the mental illnesses in question. In addition, the first set of symptoms described depression and the second set of symptoms described generalized anxiety disorder. These illnesses are more common than the latter two illnesses, bipolar disorder and schizophrenia. Guessing correctly on the first two questions would lead to a higher probability of the second two questions being answered correctly, even if the participant was relying on chance. It is also possible that parents used internet and print resources to obtain information surrounding mental illness during completion of the survey. Parents were asked to take this survey anonymously and in the privacy of their home, so researchers were unable to monitor responses and assure that these responses were a reflection of the parents' actual mental health knowledge.

The following two questions ascertained parents' level of agreeability with concerning the prevalence of depression and generalized anxiety disorder. Parent responses to *depression is common among youth* suggested that they strongly agreed with the statement. Parents were less agreeable to the statement *generalized anxiety disorder is common among youth*. The differences likely reflect that differences in prevalence in the two disorders. The prevalence of generalized anxiety disorder in children ages 13-18 is 1%, while the prevalence of depression is 11.2% in the same age group (Merikangas et al., 2010). Answers to the following question, *I know the difference between stress and generalized anxiety disorder*, showed that parents agree

that they would be able to differentiate between the two. Participants indicated that they agreed that they would be able to recognize the signs of mental illness in their child. Parents were less agreeable with the statement *I know the warning signs of suicide*. Although responses trended toward *agree,* it is important to note that 17.4% of high school females and 10.5% of high school males have considered suicide (CDC, 2012).

The statement *mental illness runs in my family* was added to examine the effects of previous experience dealing with mental illness in the family on mental health knowledge. A multiple linear regression was performed and found that this question had no effect on responses to other questions suggesting that previous experience with mental illness did not necessarily lead to higher levels of mental health knowledge. In addition, results of a one-way ANOVA suggested that demographic characteristics played no role in responses to any of the items. Again, it is important to consider the sample size when interpreting the results of this study. A response rate of 2% is not sufficient to rely on the results of multiple regression and ANOVA analyses.

Ability to access mental health resources. The last 8 items on the survey assessed parents' ability to access help for their children if their children were suffering from mental illness. Parents were agreeable to the statements *if my child were showing signs of mental illness, I would encourage them to speak to a counselor* and *if my child had a mental illness,* and *I would encourage them to take medication.* Responses to the latter statement are not congruent with past research. In a study assessing the attitudes of parents attending a first-time mental health appointment for their children, 71% stated that they were against medication in any circumstance (Lazartou et al., 2007). Parents agreed strongly that they would know where to turn for help if their child were experiencing mental illness. They indicated that they agreed that

they knew how to access a mental health provider in the community, but disagreed to the statement that they knew how to access resources within the school. Parents may be less aware of the resources available within the school, which is valuable information for school counselors to know. Parents appeared to know how to access help from a psychiatric emergency department, but were less familiar with Lifeline. Parents agreed the least to the statements that ascertained their ability to seek out information about mental illness. Thus, while parents could act on suspicions of mental illness, they are less aware of how to access information. Studies have suggested that knowledge of mental illness decreases stigmatizing attitudes (Lopez et al., 2009) and that parental stigma impacts the personal stigma held by the individual suffering from mental illness (Moses, 2010). Stigma has also been linked to lower levels of service utilization (Komiya et al., 2000; Vogel et al., 2006). Previous experience with a family member with mental illness and demographic characteristics were also found to have no impact on parents' responses.

Limitations

There were several limitations to this study. The initial mailing was not completed until mid-March and results were analyzed in mid-April. Time did not permit a second mailing after a low initial response to the first mailing. Because of the low response (n = 6), it is difficult to generalize the results of this study to the sample population. The high school used for the sample population has a large percentage of English language learners. Sixteen of the 318 parents invited to participate required a Nepali translator. The survey was unable to be translated into Nepali, so those individuals would have had a more difficult time responding the items on the survey.

In addition to some of the design limitations, there was a sensitive nature to the study. Of the 318 parents invited to participate in this study, 69% were African-American and 23% were Latino. Stigmatizing views and family beliefs could have impacted response rates. These populations have been shown to have higher levels of stigmatizing attitudes when compared with Caucasian populations (Elkington et al., 2012). Studies have suggested that African-American individuals were more likely to keep mental health symptoms to themselves due to family and cultural beliefs (Kranke et al., 2012). Studies have also shown an element of mental illness being perceived as spiritual weakness in African-American populations (Johnson et al., 2009). Studies have also found that enculturation toward Latino culture leads to higher levels of mental health stigma and lower levels of mental health literacy (Rojas-Vilches et al., 2011).

Recommendations for Future Research

The purpose of this study was to ascertain how much parents know about mental illness and how effectively they can access help. There existed no studies that attempted to carry this out in urban high school populations. Much of the research on mental health literacy focused on the impact of specific interventions on levels of mental health literacy (Barrio & Yamada, 2010; Guttierez-Maldonado et al., 2009; Lopez et al., 2009). Studies showing the impact of a school-based intervention focused on parents would be beneficial.

This study was also lacking in examining parental stigma and it's direct impact on parents' ability to seek help for their children in this particular population. Stigmatizing attitudes were not directly measured in this study and no previous research has targeted parents of high school students.

Conclusion

Four main conclusions can be made about the six participants in this study. The first is that the majority of parents were knowledgeable of the symptoms of mental illness. Most participants were able to correctly match symptoms of mental illness with their corresponding illness. The research shows that symptoms typically occur at a time in which children are still living at home with their parents (Kessler, 2007), and therefore parent knowledge about mental illness is paramount. Parents agreed that they were able to differentiate between stress and generalized anxiety disorder and they agreed with the prevalence of depression and generalized anxiety disorder. Lack of knowledge of mental health disorders is a contributing factor in the development of stigmatizing attitudes (Gutierrez-Maldonado et al., 2009; Lopez et al., 2009; Moses, 2010); thus, their knowledge about the difference between depression and anxiety may be helpful. Being able to recognize mental illness also increases the likelihood that the children suffering from the symptoms of mental illness will receive help (Mendenhall, 2010).

Second, while parents appear to be knowledgeable of mental illness, they are less knowledgeable of suicide and crisis resources. Parents were less likely to agree that they were familiar with Lifeline or that they understood the warning signs of suicide. Given the rates of suicidal ideation among high school students, it is important that parents be provided with the knowledge to deal with suicidal behavior. As a school counselor, it is important to collaborate with stakeholders and advocate for the needs of students (ASCA, 2009).

Third, while parents indicated that they agreed to statements about accessing mental health providers in the community, they agreed less with the statements related to locating resources within the school.

As a school counselor, it is necessary to promote services not only to students, but to all stakeholders in the child's education (ASCA, 2009). If parents are unaware of services offered within the school, they are unlikely to turn to the school for help. The last main finding is that parents may be unaware of where to turn for support and information. School counselors have an obligation to be knowledgeable about mental illness, but to also empower parents to be able to obtain that knowledge on their own.

In conclusion, the results of this study are limited due to a low sample size, but show that parents would benefit from outreach from the school in the form of mental health information about resources and support. As school counselors, it is important to forge collaborative relationships with parents and provide parents with the tools to help their children succeed.

References

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review*, *31*(6), 934–948. doi:10.1016/j.cpr.2011.05.003

American School Counselor Association (2005). ASCA National Model: A framework for school counseling programs. (2nd ed.). Alexandria VA: Author. ISBN: 1929289022

American School Counselor Association. (2009). The professional school counselor and student mental health. *ASCA Position Statements*, 50-51.

Amone-P'Olak, K., Ormel, J., Oldehinkel, A. J., Reijneveld, S. A., Verhulst, F. C., & Burger, H. (2010). Socioeconomic Position Predicts Specialty Mental Health Service Use Independent of Clinical Severity: The TRAILS Study. *Journal of the American Academy of Child & Adolescent Psychiatry*, *49*(7), 647–655. doi:10.1016/j.jaac.2010.03.007

Barney, L. J., Griffiths, K. M., Jorm, A. F., & Christensen, H. (2006). Stigma about depression and its impact on help-seeking intentions. *The Australian and New Zealand journal of psychiatry*, *40*(1), 51–54. doi:10.1111/j.1440-1614.2006.01741.x

Barrio, C., & Yamada, A.M. (2010). Culturally Based Intervention Development: The Case of Latino Families Dealing With Schizophrenia. *Research on Social Work Practice*, *20*(5), 483–492. doi:10.1177/1049731510361613

Bathje, G.J. & Pryor, J.B. (2011). The relationships of public and self-stigma to seeking mental health services. Journal of Mental Health Counseling, 33, 161-176

Bauer, A. M., Chen, C.-N., & Alegría, M. (2012). Associations of physical symptoms with perceived need for and use of mental health services among Latino and Asian Americans. *Social Science & Medicine*, *75*(6), 1128–1133. doi:10.1016/j.socscimed.2012.05.004

Bringewatt, E. H., & Gershoff, E. T. (2010). Falling through the cracks: Gaps and barriers in the mental health system for America's disadvantaged children. *Children and Youth Services Review*, *32*(10), 1291–1299. doi:10.1016/j.childyouth.2010.04.021

Burnett-Zeigler, I., & Lyons, J. (2010). Caregiver Factors Predicting Service Utilization Among Youth Participating in a School-based Mental Health Intervention. *Journal of Child & Family Studies*, *19*(5), 572–578. doi:10.1007/s10826-009-9331-58624.2010.01554.x

Center for Disease Control. 2012. National Suicide Statistics at a Glance. Retrieved December 12, 2012 from http://www.cdc.gov/violenceprevention/suicide/statistics/youth_risk.html

Chandra, A., & Minkovitz, C. S. (2006). Stigma starts early: Gender differences in teen willingness to use mental health services. *Journal of Adolescent Health*, *38*(6), 754.e1–7 54.e8. doi:10.1016/j.jadohealth.2005.08.011

Clarke, J. N. (2010). The portrayal of depression in the three most popular English-language Black-American magazines in the USA: Ebony, Essence, and Jet. *Ethnicity & Health*, *15*(5), 459–473. doi:10.1080/13557858.2010.488261

Cohen, E., Calderon, E., Salinas, G., SenGupta, S., & Reiter, M. (2012). Parents' Perspectives on Access to Child and Adolescent Mental Health Services. *Social Work in Mental Health*, *10*(4), 294–310. doi:10.1080/15332985.2012.672318

Corrigan, P. W., & Shapiro, J. R. (2010). Measuring the impact of programs that challenge the public stigma of mental illness. *Clinical Psychology Review*, *30*(8), 907–922. doi:10.1016/j.cpr.2010.06.004

Cotton, S. M., Wright, A., Harris, M. G., Jorm, A. F., & McGorry, P. D. (2006). Influence of gender on mental health literacy in young Australians. *Australian & New Zealand Journal of Psychiatry*, *40*(9), 790–796.

Department of Health and Human Services. (1999). Mental Health: A Report of the Surgeon General. Rockville, MD

Department of Health and Human Services. (2000) U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC

Dietrich, S., Mergl, R., Freudenberg, P., Althaus, D., & Hegerl, U. (2010). Impact of a campaign on the public's attitudes towards depression. *Health Education Research*, *25*(1), 135–150. doi:10.1093/her/cyp050

Elkington, K. S., Hackler, D., McKinnon, K., Borges, C., Wright, E. R., & Wainberg, M. L. (2012). Perceived Mental Illness Stigma Among Youth in Psychiatric Outpatient Treatment. *Journal of Adolescent Research*, *27*(2), 290–317. doi:10.1177/0743558411409931

Farahmand, F. K., Grant, K. E., Polo, A. J., & Duffy, S. N. (2011). School-Based Mental Health and Behavioral Programs for Low-Income, Urban Youth: A Systematic and Meta-Analytic Review. *Clinical Psychology: Science & Practice*, *18*(4), 372–390.

Farrer, L., Leach, L., Griffiths, K. M., Christensen, H., & Jorm, A. F. (2008). Age differences in mental health literacy. *BMC Public Health*, *8*, 125–132.

Feldman, N. (2008). Exercising power from the bottom-up: Co-creating conditions for development with youth at an urban high school. *Families in Society, 89(3),* 438-446

Fritz, G. K. (2007). Stigma and childhood mental illness: Can advocates turn the tide? *Brown University Child & Adolescent Behavior Letter*, *23*(11), 8–8.

García, C., Gilchrist, L., Vazquez, G., Leite, A., & Raymond, N. (2011). Urban and Rural Immigrant Latino Youths' and Adults' Knowledge and Beliefs about Mental Health

Resources. *Journal of Immigrant and Minority Health*, *13*(3), 500–509. doi:10.1007/s10903-010-9389-6

Gee, G. C., Ryan, A., Laflamme, D. J., & Holt, J. (2006). Self-Reported Discrimination and Mental Health Status Among African Descendants, Mexican Americans, and Other Latinos in the New Hampshire REACH 2010 Initiative: The Added Dimension of Immigration. *American Journal of Public Health*, *96*(10), 1821–1828.

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Simon and Schuster.

Gutiérrez-Maldonado, J., Caqueo-Urízar, A., & Ferrer-García, M. (2009). Effects of a psychoeducational intervention program on the attitudes and health perceptions of relatives of patients with schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, *44*(5), 343–348. doi:10.1007/s00127-008-0451-9

Hinshaw, S. P. (2005). The stigmatization of mental illness in children and parents: developmental issues, family concerns, and research needs. *Journal of Child Psychology and Psychiatry*, *46*(7), 714–734. doi:10.1111/j.1469-7610.2005.01456.x

Iwasaki, M. (2005). Mental Health and Counseling in Japan: A Path Toward Societal Transformation. *Journal of Mental Health Counseling*, *27*(2), 129–141.

Johnson, M., Mills, T. L., DeLeon, J. M., Hartzema, A. G., & Haddad, J. (2009). Lives in Isolation: Stories and Struggles of Low-income African American Women with Panic Disorder. *CNS Neuroscience & Therapeutics*, *15*(3), 210–219.

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). Mental health literacy: a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia*, *166*(4).

Retrieved from https://www.mja.com.au/journal/1997/166/4/mental-health-literacy-survey-publics-ability-recognise-mental-disorders-and

Jorm, A. F., Wright, A., & Morgan, A. J. (2007). Beliefs about appropriate first aid for young people with mental disorders: findings from an Australian national survey of youth and parents. *Early Intervention in Psychiatry*, *1*(1), 61–70.

Jorm, A. F., Kitchener, B. A., Fischer, J. A., & Cvetkovski, S. (2010). Mental health first aid training by e-learning: a randomized controlled trial. *Australian & New Zealand Journal of Psychiatry*, *44*(12), 1072–1081.

Kelly, C., Mithen, J., Fischer, J., Kitchener, B., Jorm, A., Lowe, A., & Scanlan, C. (2011). Youth mental health first aid: a description of the program and an initial evaluation. *International Journal of Mental Health Systems*, *5*(1), 4. doi:10.1186/1752-4458-5-4

Kessler, R. C., Amminger, G. P., Aguilar‐Gaxiola, S., Alonso, J., Lee, S., & Ustun, T. B. (2007). Age of onset of mental disorders: A review of recent literature. *Current opinion in psychiatry*, *20*(4), 359–364. doi:10.1097/YCO.0b013e32816ebc8c

Komiya, N., Good, G. E., & Sherrod, N. B. (2000). Emotional Openness as a Predictor of College Students’ Attitudes toward Seeking Psychological Help. *Journal of Counseling Psychology*, *47*(1), 138–43.

Kranke, D., Guada, J., Kranke, B., & Floersch, J. (2012). What Do African American Youth With a Mental Illness Think About Help-Seeking and Psychiatric Medication?: Origins of Stigmatizing Attitudes. *Social Work in Mental Health*, *10*(1), 53–71. doi:10.1080/15332985.2011.618076

Lazaratou, H., Anagnostopoulos, D., Alevizos, E., Haviara, F., & Ploumpidis, D. (2007). Parental attitudes and opinions on the use of psychotropic medication in mental disorders of childhood. *Annals of General Psychiatry*, *6*(1), 32. doi:10.1186/1744-859X-6-32

Leavy, J. E. (2011). When youth know about their mental illness before caregivers do: Youth identified duration of mental disorder (YIDUMD). *Psychosis, 3(1),* 86-89

Li, H., & Keshavan, M. (2010). Mental health of Asian American populations: Challenges and opportunities. *Asian Journal of Psychiatry*, *3*(4), 161–162. doi:10.1016/j.ajp.2010.11.001

López, S. R., Lara, M. del C., Kopelowicz, A., Solano, S., Foncerrada, H., & Aguilera, A. (2009). La CLAve to increase psychosis literacy of Spanish-speaking community residents and family caregivers. *Journal of consulting and clinical psychology*, *77*(4), 763–774. doi:10.1037/a0016031

Loya, F., Reddy, R., & Hinshaw, S. P. (2010). Mental Illness Stigma as a Mediator of Differences in Caucasian and South Asian College Students' Attitudes Toward Psychological Counseling. *Journal of Counseling Psychology*, *57*(4), 484–490.

Markowitz, F. E., Angell, B., & Greenberg, J. S. (2011). Stigma, Reflected Appraisals, and Recovery Outcomes in Mental Illness. *Social Psychology Quarterly*, *74*(2), 144–165. doi:10.1177/0190272511407620

Masuda, A., Anderson, P. L., & Edmonds, J. (2012). Help-Seeking Attitudes, Mental Health Stigma, and Self-Concealment Among African American College Students. *Journal of Black Studies*, *43*(7), 773–786. doi:10.1177/0021934712445806

McLaughlin, K. A., Costello, E. J., Leblanc, W., Sampson, N. A., & Kessler, R. C. (2012). Socioeconomic Status and Adolescent Mental Disorders. *American Journal of Public Health*, *102*(9), 1742–1750.

Mendenhall, A. (2012). Predictors of Service Utilization Among Youth Diagnosed with Mood Disorders. *Journal of Child & Family Studies*, *21*(4), 603–611. doi:10.1007/s10826-011-9512-x

Merikangas, K. R., He, J., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., et al. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Study - Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, *49*(10), 980-989.

Merikangas, K. R., He, J., Burstein, M., Swendsen, J., Avenevoli, S., Case, B., Georgiades, K., et al. (2011). Service Utilization for Lifetime Mental Disorders in U.S. Adolescents: Results of the National Comorbidity Survey–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, *50*(1), 32–45. doi:10.1016/j.jaac.2010.10.006

Miville, M. L., & Constantine, M. G. (2007). Cultural Values, Counseling Stigma, and Intentions to Seek Counseling Among Asian American College Women. *Counseling & Values*, *52*(1), 2–11.

Moses, T. (2010). Adolescent mental health consumers' self-stigma: associations with parents' and adolescents' illness perceptions and parental stigma. *Journal of Community Psychology*, *38*(6),

National Institute of Mental Health. (2005). Mental Illness Exacts Heavy Toll, Beginning in Youth. Retrieved from: http://www.nimh.nih.gov/science-news/2005/mental-illness-exacts-heavy-toll-beginning-in-youths.html.

National Institute of Mental Health. (2008). Prevalence of Mental Illness of US Adults by Age, Sex, and Race. Retrieved from: http://www.nimh.nih.gov/statistics/SMI_AASR.shtml

New York State School Report Card. (2012). Retrieved from: https://reportcards.nysed.gov/files/2011-12/RC-2012-261600010097.pdf

Ozer, E. J., & McDonald, K. L. (2006). Exposure to Violence and Mental Health Among Chinese American Urban Adolescents. *Journal of Adolescent Health*, *39*(1), 73–79. doi:10.1016/j.jadohealth.2005.09.015

Pescosolido, B. A., Jensen, P. S., Martin, J. K., Perry, B. L., Olafdottir, S., & Fettes, D. (2008). Public Knowledge and Assessment of Child Mental Health Problems: Findings From the National Stigma Study-Children. *Journal of the American Academy of Child & Adolescent Psychiatry*, *47*(3), 339–349. doi:10.1097/CHI.0b013e318160e3a0

Pinto-Foltz, M. D., Logsdon, M. C., & Myers, J. A. (2011). Feasibility, acceptability, and initial efficacy of a knowledge-contact program to reduce mental illness stigma and improve mental health literacy in adolescents. *Social Science & Medicine*, *72*(12), 2011–2019. doi:10.1016/j.socscimed.2011.04.006

Power, A. K. (2010). Transforming the Nation's Health: Next Steps in Mental Health Promotion. *American Journal of Public Health*, *100*(12), 2343–2346. doi:10.2105/AJPH.2010.192138

Rojas-Vilches, A. P., Negy, C., & Reig-Ferrer, A. (2011). Attitudes toward seeking therapy among Puerto Rican and Cuban American young adults and their parents, *International Journal of Clinical and Health Psychology*, *11*, 313–341.

Substance Abuse and Mental Health Service Administration. (2010). National Survey on Drug Use and Health. Retrieved from:http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/

U.S. Census Bureau. (2011). Child Poverty in the United States 2009 and 2010: Selected Race Groups and Hispanic Origin. Retrieved from: http://www.census.gov/prod/2011pubs/acsbr10-05.pdf

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the Self-Stigma Associated with Seeking Psychological Help. *Journal of Counseling Psychology*, *53*(3), 325–337.

Wang, J., & Lai, D. (2008). The relationship between mental health literacy, personal contacts and personal stigma against depression. *Journal of Affective Disorders*, *110*(1–2), 191–196. doi:10.1016/j.jad.2008.01.005

Williams, D. R., Yan, Y., & Jackson, J. S. (1997). Racial differences in physical and mental health. *Journal of Health Psychology. 2,* 335-351.

Yap, M. B. H., & Jorm, A. F. (2012). Young people's mental health first aid intentions and beliefs prospectively predict their actions: Findings from an Australian National Survey of Youth. *Psychiatry Research*, *196*(2–3), 315–319. doi:10.1016/j.psychres.2011.10.004

Yau, S. S. W., Pun, K. H. W., & Tang, J. P. S. (2011). Outcome Study of School Programmes for Reducing Stigma and Promoting Mental Health. *Journal of Youth Studies (10297847)*, *14*(1), 30–40

APPENDIX A

Tim O. Mains
Director of Internal Operations
Division of School Operations
Rochester City School District
131 West Broad Street, room 2W-287
Rochester, New York 14614

February 28, 2013

Nicole Taylor

RE: Approval for Proposal

Dear Ms. Taylor:

This letter serves as Rochester City School District preliminary approval your proposal and survey, *Parental Perceptions of Mental Illness*, in satisfaction of your advanced degree in Counselor Education at SUNY Brockport. Please feel free to share this letter with your university's Internal Review Board (IRB). Note we approve without modification your survey. Please note that if you make any changes they must be approved in advance.

With as many as approximately 100 research, survey and intervention requests per year, there are specific criteria that must be met to gain District approval for a proposal. The request must tangibly benefit students, their parents, staff, schools or departments. We look for alignment with the Superintendent's Goals. Along with meeting District goals, it must be supportable by the schools or departments impacted. We note the explicit approval by the Principal Carol Jones. We believe your proposed study has met these criteria and has earned the support of the District.

Please continue to work with us, as you have, as you move forward with your project. Once you have completed your work, please forward to us your final product. You may have an opportunity, in various District forums (including symposia) to present your findings. We wish you every success in your project.

Very truly yours,

Tim O. Mains,
Director of Internal School Operations

Cc: Aloma Cason
Carol Jones
Andrew MacGowan
Department of Internal School Operations Research/Survey Review Committee

APPENDIX B

The College at
BROCKPORT
STATE UNIVERSITY OF NEW YORK

Grants Development Director

Date: March 19, 2013

To: Nicole Taylor

From: Colleen Donaldson
Institutional Review Board Director

Re: IRB Project # 2012-126

Project Title: Parental Perceptions of Mental Illness

Your proposal, "Parental Perceptions of Mental Illness" has been approved as of 3/18/13 per the decision of the Rochester City School District's IRB.

You must use only the approved consent form or informational letter and any applicable surveys or interview questions that have been approved by the IRB in conducting your project. If you desire to make any changes in these documents or the procedures that were approved by the IRB you must obtain approval from the IRB prior to implementing any changes.

If you wish to continue this project beyond one year, federal guidelines require IRB approval before the project can be approved for an additional year. A reminder continuation letter will be send to you in eleven months with the specific information that you will need to submit for continued approval of your project. Please note also that if the project initially required a full meeting of the IRB (Category III proposal) for the first review, then continuation of the project after one year will again require full IRB review.

Please contact Colleen Donaldson, IRB Administrator, Office of Academic Affairs, at (585) 395-5118 or cdonalds@brockport.edu, **immediately** if:

- the project changes substantially,
- a subject is injured,
- the level of risk increases
- changes are needed in your consent document, survey or interview questions or other related materials.

Best wishes in conducting your research.

350 New Campus Drive • Brockport, New York 14420 • 585-395-2523 • Fax: 585-395-2006 • *www.brockport.edu*

APPENDIX C

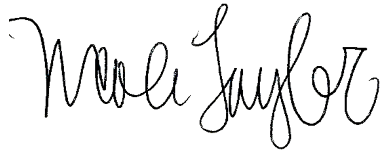
Dear Parent,

My name is Nicole Taylor, and I am a graduate student in the Counselor Education department at the College at Brockport, State University of New York. I am completing an internship in Student and Family Support Services at Franklin Education Campus. I am conducting a research study to complete the thesis requirement for my Master's degree in School Counseling.

The purpose of the study is to examine knowledge of mental illness in parents of high school students. The results of this study will be used to plan a mental health information night for parents sponsored by Student and Family Support Services. If you decide to participate, you will be asked to complete a brief survey assessing your knowledge of mental illness. The survey should take you around ten minutes to complete. Should you choose to participate in this research study, the following Statement of Informed Consent will explain your rights as a participant.

Thank you for considering this research study. I would be happy to answer any questions you may have regarding this survey. I can be reached by phone at [redacted] or via email at nmacd6879@gmail.com.

Kind regards,



Nicole Taylor
Student and Family Support Services Intern
Cell: [redacted]
nmacd6879@gmail.com

APPENDIX D

STATEMENT OF INFORMED CONSENT

The purpose of this research project is to examine parental perceptions of mental illness in youth populations. The data will be collected from answers to the attached survey. The data will be used to design a mental health education event for parents at Franklin Educational Campus. This research project is also being conducted in order for me to complete my master's thesis for the Department of Counseling at the College at Brockport, State University of New York.

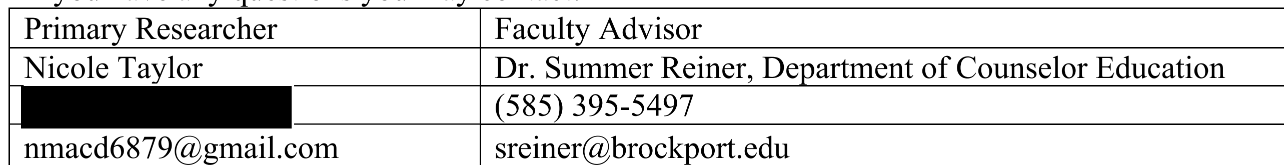
In order to participate in this study, your informed consent is required. You are being asked to make a decision whether or not to participate in the project. If you want to participate in the project, and agree with the statements below, then I have enclosed a paper survey with a postage-paid return envelope. You may change your mind at any time and leave the study without penalty, even after the study has begun.

I understand that:

1. My participation is voluntary and I have the right to refuse to answer any questions.
2. My confidentiality is protected. My name will not be written on the survey. There will be no way to connect me to my written survey. If any publication results from this research, I would not be identified by name.
3. There will be no anticipated personal risks or benefits because of my participation in this project.
4. My participation involves reading a survey of twenty-two questions, four matching questions, sixteen likert scale questions and two write-in questions. It is estimated that it will take 10 minutes to complete the survey.
5. A maximum of 350 people will take part in this study. The results will be used for the completion of a master's thesis by the primary researcher. The results will also be provided to Student and Family Support Services at Franklin Educational Campus to prepare a mental health information night for parents in the future.
6. Data will be kept in a locked filing cabinet by the investigator. Data and consent forms will be destroyed by shredding when the research has been accepted and approved.

I am 18 years of age or older. I have read and understand the above statements. All of my questions about participation in this study have been answered to my satisfaction. I agree to participate in the study realizing I may withdraw without penalty at any time during the survey process. Returning the survey indicates my consent to participate.

If you have any questions you may contact:



Primary Researcher	Faculty Advisor
Nicole Taylor	Dr. Summer Reiner, Department of Counselor Education
	(585) 395-5497
nmacd6879@gmail.com	sreiner@brockport.edu

APPENDIX E

Mental Illness Survey

After reading the symptoms, place an "x" in the box under the mental illness it is describing

	Symptoms	Common Mental Illnesses			
		Depression	**Generalized Anxiety**	**Bipolar**	**Schizophrenia**
1.	Feelings of excessive energy alternating with periods of feeling sad and empty, sleeping less than usual, unusual feelings of self-confidence, feeling irritable, poor judgment, racing thoughts.				
2.	Worrying a lot, feeling "on edge", nervousness, trouble sleeping, difficulty concentrating.				
3.	Hearing or seeing things that are not there, feeling that others are out to harm them, responding inappropriately to situations (ex. Laughing at something sad), disorganized speech.				
4.	Reduced interest in all or most activities, feelings of guilt or worthlessness, feeling hopeless, sleeping more or less than usual, feeling empty, change in appetite.				

Please place an [x] in the box that corresponds most closely with your answer
SD-Strongly Disagree, D-Disagree, A-Agree, SA-Strongly Agree

		SD	D	A	SA
5.	Depression is common among youth	☐	☐	☐	☐
6.	Generalized Anxiety Disorder is common among youth	☐	☐	☐	☐
7.	I know the difference between stress and generalized anxiety disorder	☐	☐	☐	☐
8.	Mental illness runs in my family.	☐	☐	☐	☐
9.	I would be able to recognize the symptoms of mental illness in my child.	☐	☐	☐	☐
10.	I know the warning signs of suicide.	☐	☐	☐	☐
11.	If my child were showing signs of mental illness, I would encourage them to see a counselor.	☐	☐	☐	☐
12.	If my child had a mental illness, I would encourage them to take medication.	☐	☐	☐	☐
13.	I would know where to turn for help if my child was experiencing the symptoms of mental illness	☐	☐	☐	☐
14.	I am familiar with the location of a psychiatric emergency departments within the city of Rochester	☐	☐	☐	☐
15.	I am familiar with Lifeline	☐	☐	☐	☐
16.	I am familiar with resources within the school to help my child if they were experiencing the symptoms of mental illness	☐	☐	☐	☐
17.	I would know how to access a mental health provider in the community if my child was experiencing the symptoms of mental illness	☐	☐	☐	☐

18.	I am familiar with community agencies that provide information about mental illness	☐	☐	☐	☐
19.	I am familiar with community agencies that provide support for families that are coping with a family member experiencing mental illness	☐	☐	☐	☐
20.	I know of other means to access information about mental illness	☐	☐	☐	☐

21. Is there anything else related to mental illness that you are unsure of that you would like to know more about?

____

____

____

____

22. Are there any comments you would like to add regarding any questions on this survey?

____

____

____

____

Demographic Questions (Optional)

Age: ______

Sex: ________________

Race/Ethnicity: ____