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Breaking Down the Wall: An Examination of Mental Health Service Utilization in
African American and Caucasian Parents

by

Idia O. Binitie

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts
Department of Psychology
College of Arts and Sciences
University of South Florida

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Keywords: children, barriers, attitudes, race, gender, psychopathology

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Thank you.

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Breaking Down the Wall: An Examination of Mental Health Service Utilization in
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Idia O. Binitie

ABSTRACT

This study investigated the influence of parents' gender, race, and psychopathology on barriers and attitudes to mental health utilization for themselves and for their children. It was hypothesized that mothers and Caucasian¹ parents would have more positive attitudes and would perceive fewer barriers to mental health services than fathers and African American² parents. A total of 194 African American and Caucasian parents were recruited from the community to participate in this study. Parents completed measures on barriers and attitudes toward treatment for themselves and their children, utilization of mental health services for themselves and their children, and their own current psychological symptoms. Results indicated that 36.3% and 19.4% of parents and children, respectively, had used mental health services during their lifetime. Parents perceived fewer barriers and had more positive attitudes toward seeking services for their children than for themselves. Race and gender differences were found in parental perceptions of barriers and attitudes toward treatment. Furthermore, barriers, attitudes, and psychopathology predicted parents' plan for future utilization of professionals for

¹ The terms Caucasian and White will be used interchangeably through out this paper.

² The terms African American and Black will be used interchangeably through out this paper.

mental health services. The clinical implications of this study and directions for future research were discussed.

Background

It is well established that mental health services are underutilized in our society. The issues related to the underutilization of mental health services have plagued researchers and clinicians for years. The report of the Surgeon General (U.S. Department of Health and Human Service, 1999) stated that 15 percent of the U.S. adult population use mental health services each year. This number is relatively small compared to the individuals who actually need mental health services. Research conducted by two nationwide epidemiological studies suggest that 50-60 percent of adults who would benefit from mental health services do not receive these services (Kessler, et al., 2001; Regier, et al., 1993).

This disparity between the number of individuals who need services and those who actually use mental health services is a dilemma referred to as the “service gap” (Cramer, 1999; Stefl & Prospero, 1985). This dilemma is not limited to adults given that mental health services are also underutilized by children (Horwitz, et al., 2001; Kuhl, Jarkon-Horlick & Morrissey, 1997). The Surgeon General’s report stated that 70 percent of children and adolescents who need mental health services do not receive any services at all and about 75-80 percent fail to receive specialty services (U.S. Department of Health and Human Services, 1999). Therefore, it is clear that utilization of mental health services is much lower than desired in both adults and children.

It is possible that these low rates of mental health service utilization in children are influenced heavily by their parents. Rates of attrition in children's mental health services have been associated with parental resistance to treatment of their children (Novick, Benson, & Renbar, 1981). In most cases, before children can receive mental health services, parental consent must be sought for the child's treatment. There are also other ways that parents influence their children's decisions to seek mental health services in addition to issues of consent. These issues include: the barriers influencing the parents' capability to seek mental services for themselves and for their children, parents' attitudes toward mental health services for themselves and their children, and parents' psychopathology. In addition, parents' cultural characteristics such as race/ethnicity³, socioeconomic status (SES), and gender could also have an influence on seeking treatment. These issues that influence the utilization of mental health services have been examined in Andersen and Newman's sociobehavioral model of Societal and Individual Determinants (1973).

Theories and Models

Andersen and Newman's model of Societal and Individual Determinants of Health Service Utilization (1973) is relevant in understanding how individuals use services, and provides a method of investigating the influence of different factors on individuals' utilization of health services. Although this model focuses on individuals' utilization of mental health services, it is relevant to assessing the parental factors related to seeking mental health services for their children. The framework of the model identifies three main components that influence health service utilization including:

³ Although race and ethnicity are often defined differently, in this study the terms will be used interchangeably.

Societal Determinants (technology and norms), Health Services System (resources and organizations), and Individual Determinants (predisposing characteristics, enabling resources and illness level). Both the Societal Determinants and Health Services System components directly influence the Individual Determinants component. The Individual Determinants component then has a direct influence on health service utilization. To assess the various parental factors influencing health service utilization for their children, the Individual Determinants component will be the focus of this current study. The Individual Determinants component includes: predisposing characteristics (demographic, social structure and beliefs), enabling resources (family and community) and illness level (perceived and evaluated; Figure 1).

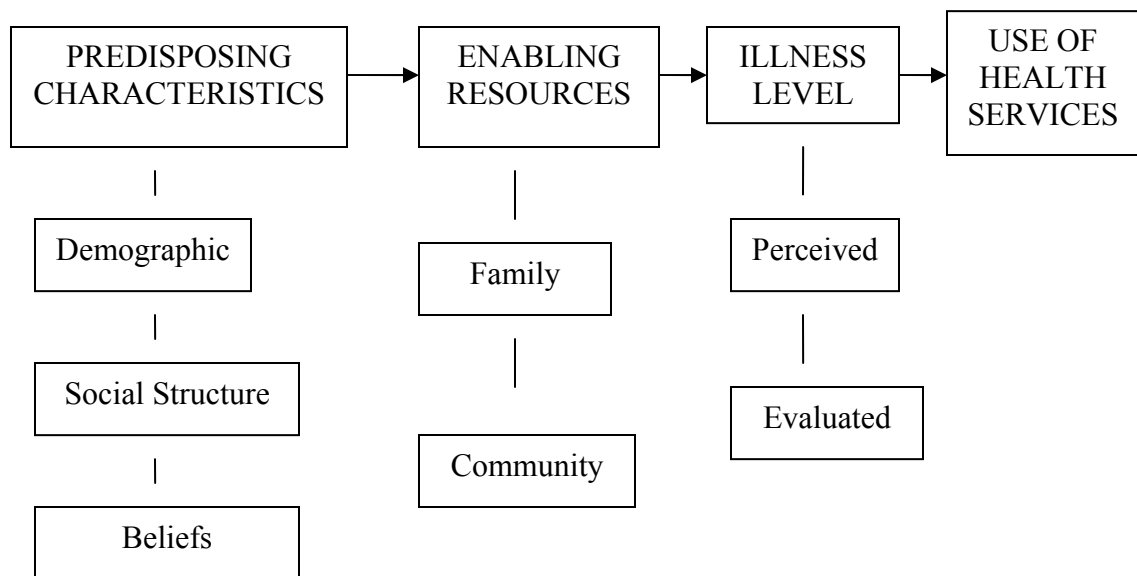


Figure 1
Andersen and Newman's model of Individual Determinants of Health Service Utilization

Predisposing characteristics can be described as the factors that predispose an individual to use mental health services. These factors have been grouped into three categories: demographic characteristics, aspects of social structure, and beliefs. Some examples of demographic characteristics that can be measured include, age, gender, marital status, and past illness. Some examples of social structure include education, race/ethnicity, occupation, family size, religion, and residential mobility. Finally, examples of beliefs include, values concerning health and illness, attitudes toward health services, and knowledge about disease. Enabling resources are described as the conditions that allow a family to act on a value or satisfy a need concerning health service use. Enabling resources have been grouped into two categories: family, and community resources. Some examples of family resources that can be measured include income, health insurance, and other source of third party payment. Community resources include, ratios of health personnel and facilities to population, price of health services, region of country, and urban-rural character of the community. The final influence on health service utilization, according to this model, is the illness/need level. This level can be described as the individual's or family's perception of their illness or evaluated illness. Illness level is grouped into two categories: perceived, and evaluated need levels. Some examples of perceived need include, disability, perceived symptoms, diagnoses, and general state. Examples of evaluated need are evaluated symptoms, and diagnoses. According to Andersen and Newman (1973), illness level is the most immediate cause of health service use.

Andersen has since revised this model (Andersen, 1995) to address other health care system issues, however, emphasis is still placed on the individual. The 1995 model

is now more heavily focused on the health care system and issues related to the medical sector specifically. The 1973 model is more relevant to this study and has been used in other recent studies of barriers to mental health (Hines-Martin, Malone, Kim, & Brown-Piper, 2003). Thus, the current study was based on the 1973 model.

Another theory that might appear relevant to this study is the Theory of Reasoned Action. Fishbein and Ajzen's theory of reasoned action (1975) suggests that an individual's behavior is based on his/her intention to act. They further propose that this intention is based on the subjective norms about the behavior and the individual's attitudes toward engaging in the behavior. An extension of this theory is the theory of planned behavior which includes the individual's perceived behavioral control as another aspect influencing his/her intention to act (Ajzen, 1985, 1991). Although this theory appears relevant to this particular study, it only addresses issues related to attitudes, social norms, and perceived behavioral control. This study, however, is focused on barriers and attitudes to utilization of mental health services. Furthermore, issues related to the influence of race/ethnicity, gender, and psychopathology are not discussed in Fishbein and Ajzen's models. Conversely, Andersen and Newman's 1973 model provides a more accurate and succinct method of investigating the variables relevant to this study that influence utilization of mental health services and so was the base model for this study.

Andersen and Newman's (1973) model, however, does not accurately explain the relationship between the variables and utilization of mental health service. It suggests that predisposing characteristics lead to enabling resources, which lead to illness level and finally lead to utilization of health services. It also implies a mediational model,

where each step has to be accomplished before utilization occurs. However, this is not the case because predisposing characteristics can lead to utilization without going through enabling resources (for example: how would aspects of social structure, like religion lead to aspects of family, like income). Therefore, this model has been revised to fit the current study's hypotheses, which are based on previous findings in the literature. The model has been reconstructed to show that each component (predisposing factors, enabling resources, and illness level) can lead to future utilization of mental health services. It also includes the influence of prior utilization on the various components and on future utilization (Figure 2).

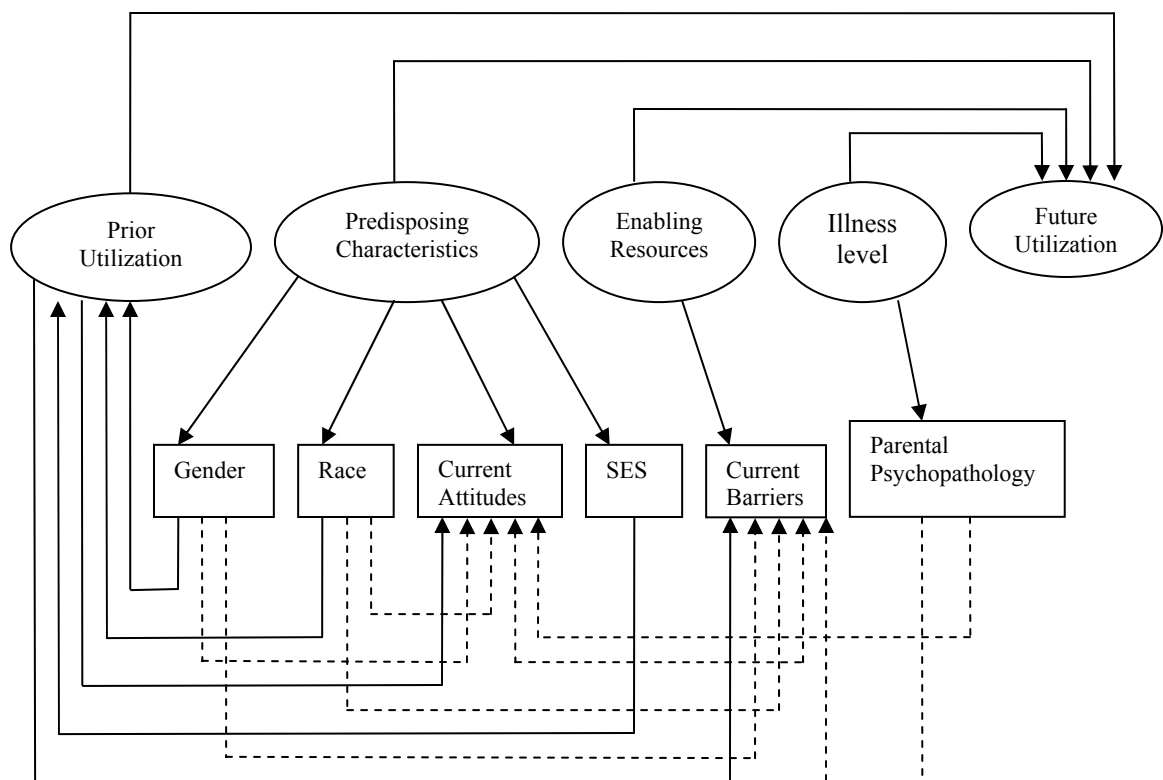


Figure 2
Adaptation of Andersen and Newman's Model for Specific Variables that will be Tested

The solid lines indicate the relationships between variables as posited in the original model, while the dashed lines indicate relationships that are being investigated in this study. Using this theoretical framework, this study investigated the influence of parents' and children's prior utilization of mental health services on current parental and child related barriers to mental health services use (enabling resources-family and community), and parental attitudes toward mental health services for themselves and their children (predisposing characteristic-beliefs). It also investigated the influence of gender (predisposing characteristic-demographic), race (predisposing characteristic-social structure), and parental psychopathology (illness level-evaluated) on barriers and attitudes. Finally, this study investigated the influence of parental and child-related attitudes toward mental health services (predisposing characteristics), SES (predisposing characteristics), parental and child-related barriers to mental health service utilization (enabling resources), and parental psychopathology (illness level) on future utilization of mental health services for parents and their children. Although child-related issues are not explicitly shown in the model, it is hypothesized that the child-related variables would be consistent with the model. The various components of this model and support for investigation of the components are discussed in detail below.

Barriers to Mental Health Service Utilization

There are numerous barriers to the use of mental health services for parents and children that influence all races and ethnicities. These barriers include: problems with cost, fragmentation of services, lack of availability of services, and societal stigma toward mental illness (U.S. Department of Health and Human Services, 1999). There are additional barriers that differentially influence racial and ethnic minorities including:

mistrust and fear of treatment, racism/discrimination, differences in language and communication and cultural barriers in general (Thompson, Bazile, & Akbar, 2004). It is also important to note that most of the barriers to mental health service utilization that influence all race and ethnicities tend to influence minorities more severely (Gary, 2005; Snowden & Yamada, 2005; U.S. Department of Health and Human Services, 2001). These findings appear to be due to the fact that a large proportion of racial and ethnic minorities are in lower socioeconomic classes and most of the barriers to mental health service utilization have a bigger or more detrimental effect on individuals of lower SES. For example, 30 percent of African American families but only 13 percent of Caucasian families with children under 18 have incomes below the poverty level (Statistical Abstract of the United States, 2003). Kazdin, Holland, Crowley and Breton (1997) identified socioeconomic disadvantage, difficult living circumstances, family stress and life events as predictors of dropping out of treatment among children and adolescents. It is also possible that even though barriers influence both children and their parents, there might be barriers that influence only parents' utilization of mental health services for themselves and barriers that influence only utilization of mental health services for children. However, there has been no study found that investigates how parents' barriers to utilization of mental health services might differ from children's barriers to utilization of mental health services.

Kessler and colleagues (2001) found that the most commonly reported reason by adults for failing to seek treatment and dropping out of treatment was their wanting to solve the problem on their own. They also noted that a major barrier to seeking treatment was the individual's belief that they did not have an emotional problem requiring

treatment. In a study of parents of preschool children, Pavluri, Luk, and McGee (1996) found that the most common parental barrier to seeking help for their children was the belief that the problems would get better by themselves or that the parents were strong enough to handle the preschoolers' problems on their own.

A study by Ringel and Sturm (2001) reported that 7% of families with a child claimed financial barriers as the reason for not receiving mental health care.

Unfortunately the researchers did not report the percentage for adult populations.

Stigma has also been identified as a major barrier to mental health service utilization in children (Kuhl, Jarkon-Horlick, & Morrissey, 1997) and adults (Stefl & Proseri, 1985). Both studies reported that fear of being stigmatized prevents adults and children from utilizing mental health services. Owens and colleagues (2002) found that about 35% of the parents in their study reported a barrier to mental health services and the most common perceived barrier was related to their perceptions of mental health services. These perceptions included, lack of confidence in those who recommended help, having negative experiences with professionals, stigma, thoughts that treatment would not help, child refusing to go, and not knowing who to trust. In a study of treatment retention, decreased quality of life and increased parental psychopathology predicted parental perception of barriers to treatment participation for their clinically referred children (Kazdin & Wassell, 2000). Hence, it appears that barriers to mental health services appear to influence initial utilization and treatment retention.

Various intervention programs have attempted to address these issues related to barriers to treatment utilization with little or no success. For example, Leaf, Bruce, and Tischler (1986) found that increasing only accessibility and availability of mental health

services was insufficient in promoting higher levels of utilization. Bickman, Heflinger, Northrup, Sonnichsen, and Schilling (1998) conducted an intervention program created to increase the parent's knowledge of mental health services, teach them skills needed to interact with mental health personnel, and enhance their mental health services self-efficacy. This intervention program did increase the parent's knowledge and self-efficacy but it did not increase treatment involvement, which was defined by how involved the parent/caregiver was in the child's treatment. These findings suggest that there are other variables influencing the under-utilization of mental health services in addition to barriers to treatment. One such variable is the individual's attitudes toward mental health services.

Attitudes toward Mental Health Services

Parents' attitudes appear to influence their willingness to seek mental health services for their children. Gustafson, McNamara, and Jensen (1994) found that parents were more likely to seek mental health treatment for their children when their children's behavioral disorder was severe and when the parents had positive attitudes toward seeking treatment as measured by a questionnaire. At the individual level, various studies have also found an association between attitudes toward treatment and help-seeking behaviors. Fischer and Turner (1970) showed that individuals' attitudes toward seeking mental health services have an influence on their decisions to seek mental health services. Other researchers also found that individuals' attitudes toward treatment predicted help-seeking behavior (Bayer, & Peay, 1997; Cramer, 1999). In contrast, Leaf, Bruce, and Tischler (1986) found that positive attitudes toward mental health services were only related to utilization in women and not men. They attributed this finding to the

fact that women identified the need for treatment at lower thresholds than men and were less likely to postpone treatment than men, once the need for treatment had been identified. Overall, it appears that parents' attitudes toward mental health service utilization play an important role in seeking mental health services for their children and for themselves. Although not previously investigated, it is also possible that parents' attitudes could be different when seeking mental health services for themselves and for their children. This possibility was further investigated in this study.

There are numerous issues that influence parents' attitudes toward seeking mental health services including: family attitudes toward mental health services (where family attitudes are positively related to parental attitudes), parents' gender (where women have more positive attitudes), race and socioeconomic status (where blacks and lower SES individuals have more negative attitudes) and previous utilization of mental health services (where prior use is positively associated with parental attitudes; Alvidrez, 1999; Kessler, et al., 2001; Leaf, Bruce, & Tischler, 1986; Leaf, Bruce, Tischler, & Holzer, 1987; Robbins & Greenley, 1983). Although not thoroughly investigated, barriers to treatment might also be influenced by attitudes toward mental health services or vice versa. Due to the lack of research in this area, this study will investigate this relationship further. Based on the background research on each individual topic (i.e., barriers to mental health services and attitudes towards mental health service utilization), it is sensible to propose that there might be an inverse relationship between the two variables.

As mentioned above, race has been found to influence parents' attitudes toward mental health services. Race is also associated with the utilization of mental health services.

Race/Ethnicity and Mental Health Utilization

The Surgeon General's report states that the prevalence of mental disorders for racial and ethnic minorities are equal to those for Whites, yet utilization of mental health services is extremely low for racial and ethnic minorities (U.S. Department of Health and Human Services, 2001). A study of an insured population found that Whites had 1.7 times greater odds of making a mental health visit than Blacks and Hispanics (Padgett, Patrick, Burns, & Schlesinger, 1994). This study also reported that Whites were estimated to make 2.64 more mental health visits during that year than Blacks and Hispanics (Padgett, Patrick, Burns, & Schlesinger, 1994). The Surgeon General's report describes several disparities that exist between racial and ethnic minorities and Whites that influence mental health service utilization including, minorities having less access to and availability of mental health services, they are less likely to receive needed mental health services, and they tend to receive poorer treatment (U.S. Department of Health and Human Service, 2001). Other researchers have also shown that under-utilization of mental health services in ethnic minorities is significantly influenced by higher levels of cultural mistrust between the clients and the providers of mental health services (McDermott, 2001; Nickerson, Helms, & Terrell, 1994; Thompson, Bazile, & Akbar, 2004). This pattern results in racial and ethnic minorities experiencing a greater disability burden from mental illness than whites because of the reduced and poor quality of care they receive.

Another issue related to race and the underutilization of mental health services is the use of alternate sources for the provision of mental health services. The utilization of the church for counseling is a characteristic that is highly associated with African

Americans (Boyd-Franklin & Lockwood, 1999; Neighbors, 1985). The National Survey of Black Mental Health found that of those African Americans who did seek help for mental health problems, only 9% of them used a psychologist, psychiatrist or community mental health facility, whereas the majority of them sought help from physicians, ministers, family and friends (Jackson, Neighbors, & Gurin, 1986). In a college population, Ayalon and Young (2005) found that Black students were more likely than White students to seek help from religious services. Neighbors (1985) also found that most African Americans seek mental health services from their minister, from their primary physician or from emergency room personnel. The opinions of family members and friends tend to be valued highly in the African American community, as individuals who were advised by family members and friends to seek mental health treatment sought out services over the course of time (Hines-Martin, Malone, Kim, & Brown-Piper, 2003). Alvidrez (1999) also found that having family/friends who had visited a mental health clinic was a marginally significant predictor of mental health service use in African Americans, Latina and European American women.

In addition to lower rates of utilization, drop out rates during treatment are also higher with ethnic minorities. Sue and Sue (1990) found that 50 percent of African American clients stop treatment after the first session compared with 30 percent of Caucasian clients. This pattern shows that not only are racial and ethnic minorities underutilizing mental health services but when they do use mental health services, they are not staying in treatment.

Socioeconomic Status and Mental Health Utilization

It seems almost impossible to discuss utilization issues related to race and ethnicity without mentioning socioeconomic status (SES) because a large proportion of racial and ethnic minorities are in lower socioeconomic classes. Approximately 30 percent of African American families with children under age 18 compared with 13 percent of Caucasian families have incomes below the poverty level (Statistical Abstract of the United States, 2003). It is also important to note that financial problems and even risk of poverty tend to be one of the burdens associated with raising children in single parent (usually single mother) households due to low wages, low education attainment, unfavorable economic conditions, and low rates and levels of child support (McLoyd, 1998). Yet 52.5 percent of African American children are being raised by single mothers compared with 15.5 percent of Caucasian children being raised by single mothers (Hofferth, Stueve, Pleck, Bianchi, & Sayer, 2002). Most of the issues related to under-utilization of mental health services have more detrimental effects on individuals of lower SES. An epidemiological study found that low socioeconomic status individuals perceived more barriers to using mental health services than higher SES individuals due to having fewer financial resources and the least educational attainment (Leaf, et al, 1987). Pumariega, Glover, Holzer, and Nguyen (1998) found that socioeconomic status had a positive impact while family composition had a negative impact on utilization of mental health services. Kazdin (1996) found that stress and socioeconomic disadvantage accounted for most of the racial and ethnic differences in dropout rates from treatment. Hence, race/ethnicity and socioeconomic status appear to have major influences on utilization of services due to the strong relationship between race/ethnicity and SES and

the influence of financial barriers on utilization of mental health services. Another factor influencing utilization of mental health services is gender.

Parental Gender and Mental Health Utilization

It is well known that parents have a tremendous genetic and environmental impact on the lives of their children. In comparison to mothers, however, less information is known about the father's role in predicting child outcome because the majority of studies that include parents tend to include only mothers rather than mothers and fathers (Johnson & Jacob, 2000; Phares & Compas, 1992). In a review of articles related to child and/or parental psychopathology, Phares and Compas found that out of 577 articles published over an eight year period, 1.4% of studies involved the father only, 48.0% involved mothers only, 26.2% involved fathers and mothers and analyzed them separately, and 24.4% either did not specify gender or did not analyze parents separately (Phares & Compas, 1992). A more recent review suggested that fathers continue to be ignored in studies of both developmental psychopathology and pediatric psychology (Phares, Lopez, Fields, Kamboukos, & Duhig, 2005). This pattern is a problem given that when mothers and fathers are studied, both appear to have tremendous influence on their children's lives (Lamb, 2004). To include only one parent is to ignore a large portion of the child's life.

It is well established that women tend to utilize mental health services more often than men (Mahalik, Good, & Englar-Carlson, 2003; Pescosolido & Boyer, 1999). A review of the literature suggests that this gender difference might be due to various reasons such as the possibility that there is a higher prevalence of symptoms and disorders in women, the greater likelihood of women to recognize, acknowledge and

report symptoms, or the gender biases in the measures and judgments of clinicians (Pescosolido & Boyer, 1999). It has been shown that girls and adolescent females tend to have more positive help-seeking attitudes (Cohen, 1999) and lower barriers to help-seeking (Kuhl, Jarkon-Horlick, & Morrissey, 1997) than their male counterparts. Other researchers have also shown that regardless of age, nationality, race/ethnicity or parental status, men tend to under-utilize mental health services (Addis & Mahalik, 2003; Duhig, Phares, & Birkeland, 2002). It seems that when men do seek services they are heavily influenced by others. Cusack, Deane, Wilson and Ciarrochi (2004) found that 96% of the male participants in their study reported that they were influenced by others to seek mental health services. Notably, 37% suggested that they would not have sought services without the influence of others. Unfortunately the researchers did not include women in their study.

The influence of parental gender on children's use of mental health services has not been investigated thoroughly. Since women utilize mental health services more often than men, it is reasonable to assume that mothers might be more inclined than fathers to seek mental health services for their children. There is also evidence that fathers are less inclined to participate in treatment than mothers (Carr, 1998; Duhig, et. al., 2002). Fals-Stewart, Fincham, and Kelley (2004) found that substance-abusing fathers were less willing than substance-abusing mothers to allow their children to receive treatment. It was noted in another review that men may often believe that problematic behavior is normal for children or that therapy is a waste of time (Phares, Fields, & Binitie, in press). These beliefs might also influence fathers when deciding to seek help for their children. This issue of parental gender and utilization of mental health services will be investigated

in the current study. Another issue that is related to utilization of mental health services for children and their parents is the issue of parental psychopathology.

Parental Psychopathology and Mental Health Utilization

Parental psychopathology can influence children differently. In a review of studies conducted over 10 years, Beardslee and colleagues found that in children with an affectively ill parent, there is a 40% chance that the child will experience a major depressive episode by age 20 (Beardslee, Versage, & Gladstone, 1998). This rate increases to 60% by age 25. In a study by Jaffee, Moffitt, Caspi, and Taylor (2003), results showed that higher levels of conduct problems were seen in children raised by antisocial fathers and lower levels were seen in children with an antisocial father who were not raised by their antisocial father (Jaffee et. al., 2003). These findings could be attributed to the fact that children who were raised by their mother and antisocial father had a double dosage of environmental and genetic risk factors. In a meta-analytic study, Connell and Goodman (2002) found that externalizing problems in children were related to psychopathology in both mothers and fathers to a comparable extent. On the other hand, internalizing behaviors were more closely related to psychopathology in mothers than in fathers. This difference, however, was small and was attributed to methodological differences in the various studies. When the effects of parental depression were explored, children were at increased risk for emotional/behavioral problems regardless of whether the mother or the father was experiencing depression (Kane & Garber, 2004). These findings establish that parental psychopathology has an influence on children's psychopathology.

Individuals' psychopathology has an influence on their own decisions to seek mental health services. In an overview of factors influencing mental health care utilization, Pescosolido and Boyer (1999) stated that the need for care was the best predictor of utilization, regardless of how "need" was defined. They described "need" as the level of psychological distress, number of psychiatric symptoms, limitations in mental health functioning, self reports of mental health, risk factors associated with mental health illness or an actual psychiatric diagnosis. Alvidrez (1999) found that having a self-reported drug problem was a significant predictor of seeking mental health treatment in African American, Latina and European American women. In this same study, having a probable alcohol disorder was also a predictor of mental health service use but was only marginally significant. However, as mentioned above, these results only refer to adult utilization of mental health services and not children's utilization.

Just as individuals' psychopathology has been shown to influence help-seeking behaviors, children's psychopathology has also been shown to influence parents' decisions on seeking mental health services for their children. An epidemiological study conducted by Leaf and colleagues (1996) found that youth with psychiatric disorders and poor functioning were 6.8 times more likely to have seen a mental health professional than youth with no psychiatric disorder and higher level of functioning. However, Kazdin, Holland, and Crowley (1997) found that both the child's psychopathology and the parents' psychopathology influence child treatment. They found that parental psychopathology (specifically, history of antisocial behavior), severity of the child's problem and child history of antisocial behavior significantly predicted dropping out of child-related treatment prematurely. Hence it appears that both parental and child

psychopathology influence children's use of mental health services. Most of the research on psychopathology and utilization of mental health services has been conducted on the influence of adult psychopathology on adult utilization (Alvidrez, 1999; Pescosolido & Boyer, 1999) and child psychopathology on child utilization (Leaf, et. al, 1996). Little is known about the specific influence of parental psychopathology on children's utilization of mental health services. This issue was investigated in the current study.

Overall, it appears that those individuals who are young, white, educated, middle-class, and female seek mental health services more often than individuals who are older, black, in minority status, have less than a high school education, and are in the working and lower classes (Gourash, 1978).

Hypotheses

The current study aimed to investigate the reasons behind underutilization of mental health services for children and their parents by exploring parents' race, gender, socioeconomic status, parents' psychopathology, and parent and child-related barriers, and attitudes to treatment. Although barriers to treatment tend to influence all individuals' decisions on seeking mental health services, the majority of these barriers are more pronounced in ethnic minorities due to their minority status and the history of professionals' treatment of ethnic minorities (Guthrie, 1998). This study specifically investigated the differences and similarities in attitudes and barriers to treatment in African American and Caucasian parents. Parents were the population of choice because not only do their attitudes and barriers to treatment influence their own use of services, but they usually seek mental health services for their children and as such their own perceived child-related attitudes and child-related barriers would probably influence their decisions on seeking mental health services for their children.

The specific aims and hypotheses of this study were as follows:

- 1) **To investigate the relationship between parents' and their children's previous utilization of mental health services and current parental and child-related attitudes toward mental health services.** Based on previous research (Fischer & Turner, 1970; Gustafson, McNamara, & Jensen, 1994), it is hypothesized that both parental and child

utilization will have positive relationships with parental and child-related attitudes toward mental health services, respectively.

2) **To investigate the relationships between parents' and their children's previous utilization of mental health services, and current perceived barriers to mental health service utilization for parents and for child-related therapy.** Based on previous research (U.S. Department of Health and Human Services, 1999), it is hypothesized that both parental and child utilization will have inverse relationships with parents' perceived barriers to their own and their child's treatment, respectively.

3) **To investigate the relationship between current perceived barriers to mental health service utilization in parents and children, and current perceived attitudes toward mental health services for parents and children.** Based on previous research (Alvidrez, 1999; Kessler, et al., 2001; Leaf, Bruce, Tischler, & Holzer, 1987), it is hypothesized that there will be an inverse relationship between both parental and child-related perceived barriers to treatment and parental and child-related attitudes toward mental health services, respectively.

4) **To investigate the relationship between parents' current barriers to treatment and parents' perceptions of current barriers to their children's treatment.** Based on previous research (Kuhl, Jarkon-Horlick, & Morrissey, 1997; Pavluri, Luk, & McGee, 1996; Stefl & Prospero, 1985), it is hypothesized that there will be a positive relationship between parents' reports of their own barriers to treatment and their reports of barriers to child-related treatment.

5) **To investigate the relationship between parents' current attitudes toward treatment and parents' perceptions of current attitudes toward their children's**

treatment. Based on previous research (Fischer & Turner, 1970; Gustafson, McNamara, & Jensen, 1994), it is hypothesized that there will be a positive relationship between parents' reports of their own attitudes toward mental health services and their reports of their attitudes toward child-related treatment.

6) To investigate the differences in current parental attitudes and parents' report of current child-related attitudes toward mental health service utilization in African American and Caucasian mothers and fathers. Based on previous research (Alvidrez, 1999; Cohen, 1999; Kessler, et al., 2001), it is hypothesized that mothers and Caucasian parents will have more positive attitudes toward mental health services for themselves and their children than fathers and African American parents, respectively.

7) To investigate the influence of parents' own current perceived barriers and parents' current perception of barriers to mental health service utilization for their children on African American and Caucasian mothers and fathers. Based on previous research (Kuhl, Jarkon-Horlick, & Morrissey, 1997; Thompson, Bazile, & Akbar, 2004), it is hypothesized that mothers and Caucasian parents will perceive fewer barriers to mental health service utilization for themselves and their children than fathers and African American parents, respectively.

8) To investigate the influence of current parental and child-related attitudes toward mental health services, current parental and child-related barriers to treatment, and parental psychopathology on future utilization of mental health services for parents and their children. Based on previous research (Gustafson, McNamara, & Jensen, 1994; Kazdin, Holland, & Crowley, 1997), it is hypothesized that higher parental and child-related attitudes, lower parental and child-related barriers, and

higher levels of parental psychopathology will predict higher plans for future utilization of mental health services for parents and their children.

Method

Participants

A total of 210⁴ parents were recruited to participate in this study. The sample comprised of parents of various racial/ethnic groups, including 47.6% African American, 44.8% Caucasian, 3.3% Asian, 3.3% Hispanic, .5% Native American/Alaskan, and .5% who reported their race as “Other”. No parents were denied participation in the study, however, only the African American and Caucasian participants were used in the analyses, as this was the focus of this study. Thus the final sample used in the analyses was 194 parents; 51.5% African American and 48.5% Caucasian.

Parents ranged in age from 20 to 62 years of age, with a mean age of 37.71 years (SD = 8.19). The sample consisted of approximately equal numbers of fathers (49.5%) and mothers (50.5%), and majority of the parents, 70.5%, were married, 12.4% were single without a partner, 7.8% were divorced, 5.2% were single with a partner, and 4.1% were separated. The percentage of married participants in this study is fairly high. The national average of married individuals in the United States is 51.7% (Statistical Abstract of the United States, 2003). However, participants were required to have monthly face-to-face contact with their child and since more married individuals (especially married fathers) tend to have more contact with their children, this might explain the high rates of married parents in this study.

⁴ There were 211 questionnaires returned, but one participant was left out of all the analyses because he only completed 36% of the questionnaires.

Parents had an average of 2.31 children (SD = 1.17). Fathers had a mean of 16.29 years (SD = 3.26) of education and mothers had a mean of 15.46 years (SD = 2.48) of education. A total of 10.8% of parents were receiving some kind of public assistance and based on Hollingshead criteria for socioeconomic status(Hollingshead, 1975), the social strata for the average participating parent represented medium businesses, minor professionals, and technical jobs (M = 48.98; SD = 10.06).

A majority of parents had physical health care insurance for themselves (92.7%) and their children (97.4%). When asked about mental health care insurance there was some variability in responses. A total of 69.1% of parents had insurance for themselves, 16.8% did not, and 14.1% did not know if their insurance covered mental health needs. Similarly, 69.3% of parents had insurance coverage for their children, 12.7% did not, and 18.0% did not know if their insurance covered mental health care needs for their children.

Based on a power analysis with power set at .80, alpha set at .05, and expecting a medium effect size, 45 participants per group were required to adequately test the hypotheses via multiple regressions and analyses of covariance (ANCOVAs). Since the focus of this study was to examine similarities and differences between African American and Caucasian mothers and fathers, a minimum of 180 parents (45 per group) was necessary to test for a medium effect size. The demographic information for parents by gender and race/ethnicity is presented below (see Table 1). Similarities and differences in these groups are discussed in the Results section.

Table1
Demographic Variables for Parents by Race and Gender

Variable	Statistic	African American Fathers (n = 50)	Caucasian Fathers (n = 46)	African American Mothers (n = 50)	Caucasian Mothers (n = 48)
Age	Mean	38.54	39.26	35.75	37.33
	SD	7.92	8.10	8.56	7.97
Socioeconomic Status	Mean	49.58	52.52	45.53	48.34
	SD	11.15	9.17	9.89	9.20
Years of Education	Mean	15.40	17.22	14.96	15.96
	SD	2.98	3.31	2.15	2.70
Number of Children	Mean	2.28	2.37	2.40	2.19
	SD	1.42	1.12	1.11	1.02

Note. SD = Standard deviation

Measures

Demographics questionnaire. The demographics questionnaire included questions about basic background information on each parent's marital status, age, ethnicity/race, gender, occupation, yearly income, years of education completed (for self and spouse/partner), and number of individuals in the household (Appendix B). The mothers and fathers who participated in this study were not necessarily dyads; therefore demographic data on both the parent and his/her spouse/partner were collected from the parent who completed the questionnaires. Socioeconomic Status (SES) was measured based on the four-factor index of socioeconomic status (Hollingshead, 1975), which uses gender, marital status, education, and occupation to calculate the SES of the participants. These variables were included in the demographics questionnaire.

Utilization of mental health services questionnaire. A questionnaire was given to parents, which inquired about their previous use of mental health services including: psychiatrists, psychologists, social workers, pastoral counseling, and primary care doctors

for mental health problems (Appendix C). Parents answered these questions for themselves, and their children. Parents were asked if they or any of their children needed mental health services and how likely they would be to seek treatment for themselves or their children from various professionals. Parents who had seen a professional for mental health services were asked about their referral reason, termination reason, number of sessions attended, and therapist's race and gender. They were also asked to rate how satisfied they were with the services they received on a scale from 1-10. This questionnaire was based on a utilization measure developed by Healy (1997). Previous and future utilization of all five professionals (psychiatrists, psychologists, social workers, pastoral counselor, and primary care doctor) for mental health services were used in the final analyses. However, post hoc analyses were conducted using other variables including, satisfaction with mental health services, quantity of mental health services used, future utilization of a pastor for mental health services, and future utilization of mental health professionals (i.e. psychiatrists, psychologists, and social workers) for mental health services.

Attitudes toward seeking professional psychological help. The shortened version of Fischer and Turner's original 1970 scale-Attitudes toward Seeking Professional Psychological Help (ATSPPH)-was used in this study to assess parents' attitudes toward seeking treatment for themselves and their children. This new measure (Appendix D), which was developed by Fischer and Farina (1995) is a 10-item unidimensional version of the old scale that had 29 items. The new scale correlates .87 with the old scale and has an internal consistency of .84 (Cronbach's alpha). The new scale also has a test-retest reliability of .80 (Cronbach's alpha; Fischer & Farina, 1995). The questionnaire asks

participants about their attitudes toward seeking psychological help by responding to each statement in a likert-type format consisting of the following answer choices: strongly disagree, disagree, agree and strongly agree (response choices were changed from “partly” to “strongly” to allow for clarity in the responses). The items can be totaled from 0-30, but mean scores were used for the analyses to control for missing items, with means ranging from 0-3. Higher scores indicate a pro-help seeking direction (i.e., more positive attitudes toward seeking help). Parents were asked to report on their attitudes toward seeking mental health services for themselves and their attitudes towards seeking services for their children on two separate questionnaires. The phrasing of the original questionnaire was modified slightly for the second questionnaire, in order to focus on parental perceived child-related attitudes towards seeking mental health services (Appendix E). In the current sample, internal consistency (Cronbach’s alpha) was strong for both the parent ($\alpha = .83$) and the child-related ($\alpha = .88$) measures.

Barriers to treatment utilization. This measure inquires about possible barriers to seeking treatment that parents might face for themselves and their children. The questionnaire was developed by Healy (1997) based on the work of Lorion and Parron (1987) and based on Parron’s (1982) findings that four main factors contribute to underutilization of mental health services in minorities⁵. The four factors are: Accessibility, Availability, Acceptability and Accountability (Parron, 1982). The Accessibility factor can be described as barriers due to cost issues. The Availability factor can be described as having too few choices where services can be obtained. The

⁵ The Barriers to Treatment Participation Scale (Kazdin, Holland, Crowley, & Breton, 1997) was not used in this study because it measures barriers that occur once in treatment, the focus of this study was to measure barriers to accessing treatment.

Acceptability factor can be described as barriers that influence the unique needs, values and beliefs of those seeking services. Finally, the Accountability factor describes the accountability of services to those who are being served. Since Healy's 1997 questionnaire was developed to be used only with African American participants, some of the questions were changed slightly to generalize to all races for the purposes of this study (for example: Item 18, "The therapist will not be black, so cannot be trusted" was changed to "The therapist will not be the same race as me, so cannot be trusted").

Finally, six additional items were included based on a recent study by Kessler and colleagues (2001). Item 4 ("my mental health insurance would not cover this type of treatment") was added to the Accessibility factor, Item 16 ("I went to a mental health professional in the past but it did not help") was added to the Acceptability factor and Items 22-25 ("I would think my problem would get better by itself", "I would be concerned about what others might think of me", "I would want to solve the problem on my own", and "I would be scared about being put in the hospital against my will") were added to a new category labeled as "Other". Parents' perceived barriers to treatment for themselves and for their children were measured using a likert-type response format consisting of the following answer choices: strongly disagree, disagree, agree and strongly agree (response choices were changed from "somewhat" to "strongly" to correspond with ATSPPH response choices). Parents were asked to report on the barriers that might arise when seeking services for themselves (Appendix F) and to report on the barriers that might arise when seeking services for their children (Appendix G). The measure for parents' barriers to services was modified to create the questionnaire for child-related barriers to services. An additional open ended item was included in both

measures asking participants to describe any other barriers to treatment that they might perceive. The mean scores of parents' perceived barriers for themselves and child-related treatment were used in the analyses, with mean scores ranging from 0-3. The open ended questions were not included in the analyses and were only included in the questionnaires for informative purposes. In the current sample, internal consistency (Cronbach's alpha) was strong for the parent ($\alpha = .94$)⁶ and child-related ($\alpha = .94$)⁶ barriers measures.

Brief symptom inventory (BSI). This questionnaire is a measure of current psychological symptom status with well-established reliability and validity (Derogatis, 1993). It is a 53 item self-report questionnaire for psychiatric, medical, and non-patient populations (Cundick, 2004). The BSI can be used with individuals age 13 and above and requires at least a sixth grade education. Participants are asked how much they have been distressed by various symptoms during the last seven days (Appendix H). Responses are given in a likert-type format, ranging from 0-4 with 0 being "not at all" and 4 "being extremely" distressed by symptoms. There are nine primary symptom dimensions including: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. There are also three global indices including: Global Severity Index (GSI), Positive Symptom Total (PST), and Positive Symptom Distress Index (PSDI). The GSI indicates the individual's current level of distress and is calculated by adding all the items and dividing by the total number of responses (Derogatis, 1993). The PST is the total number of positive responses that were endorsed by the individual. The PSDI is derived by adding all the items and dividing by the PST. For the purposes of this study, the Global Severity

⁶ Internal consistency reliability was run without items 15 and 16, which were optional items.

Index (GSI) will be used because it is designed to help quantify an individual's level of overall psychological symptoms. It is relevant because the goal of this study is to determine if psychopathology in general has an effect on future utilization. Higher numbers on this index represent more distress.

The BSI has acceptable internal consistency reliabilities from .71 on the Psychoticism dimension to .83 on the Obsessive-Compulsive dimension (Cundick, 2004). The test-retest reliability for the three global indices are above .80 and range from .68 on the Somatization dimension to .91 on the Phobic Anxiety dimension. Specifically, the test-retest reliability for the Global Severity index (GSI) is .90 (Peterson, 2004). The BSI also has good concurrent validity with the MMPI (Peterson, 2004). In the current sample, internal consistency (Cronbach's alpha) was strong for the BSI ($\alpha = .97$).

Procedure

Parents were recruited to participate in the study through the use of flyers, advertisements, and direct invitation (snow-balling and direct approach). Flyers were displayed on notice boards at schools including: elementary schools, daycare facilities, and throughout the University of South Florida (USF). Flyers were also displayed at children's hospitals, grocery stores, community centers, libraries, laundromats, and apartment complexes. Recruiting minorities in research is a difficult task and recruiting low SES minorities is even more taxing (Miranda, 1996). However, including only low SES individuals is misrepresentative of the Caucasian populations since a large majority fall in a higher SES bracket. On the other hand, including only high SES individuals is misrepresentative of the African American population, where a large proportion of individuals fall in a lower SES bracket. Hence extra effort was made to recruit a wide

variety of individuals from varying SES ranges by placing flyers in well-off, moderate, and impoverished areas.

Advertisements were placed in the Sentinel (a magazine geared toward the African American community) and on several listserves that targeted both African American and Caucasian parents. Parents were also approached directly at various places including grocery stores, and hair salons, and asked to participate in the study. The snow-ball method was used where parents who participated in the study and non-parents who were approached to participate in the study were asked to invite other parents to participate. Leaders of various organizations (churches, daycare facilities, and parent groups) were also approached and the parents at these organizations were invited by the researcher or the leader of the organization to participate in the study.

Effort was made to recruit biological, step, and/or adoptive parents who had a child between ages 2-17 and who had at least monthly face to face contact with their child. The age range was selected to ensure that parents would still have an active role in the child's life and the lower age limit was chosen because empirically supported treatments usually begin at age two (Barkley, 1997). Parents did not have to be dyads. This decision was important in order to ensure that a large proportion of African American families would not be excluded, because 52.5% of African American children are being raised by single mothers (Hofferth, Stueve, Pleck, Bianchi, & Sayer, 2002).

Since this study was based on a community sample and because participants were just asked to complete questionnaires, data collection took place largely through the mail. Although no order effects were expected, questionnaires were presented in randomized order so that possible biases due to order effects were minimized. However, in order not

to confuse participants, questionnaires for parent and child-related information were randomized as a block. When interested participants called or sent an inquiry via email, the requirements of the study were reiterated and they were asked to provide their mailing address. The questionnaires along with a cover letter explaining the study (Appendix A), a business reply envelope, and a business reply postcard for their contact information (if they wanted to be included in the drawing) were mailed to them. Participants who were approached directly had the option of completing the questionnaires immediately or mailing them back. If they chose to complete the questionnaires immediately, and filled out the business reply postcard with their contact information, it was immediately separated from their questionnaires to protect their privacy. Questionnaires took approximately 20 minutes to complete.

A total of 541 surveys were distributed and a total of 211 were returned. Thus, there was a 39% participation rate. This number is consistent with other survey research in the community with adults (Kropf & Blair, 2005; Shumway, Unick, McConnell, Catalano, & Forster, 2004). After the participant target number was reached (45 parents from each gender and racial group to be analyzed), the data were entered into SPSS and the various analyses were run. Once the study is complete (results have been defended), participants who filled out the business reply postcards will be entered into a drawing with a chance of winning one of six prizes which will be sent to the winners by mail. The prizes include: one \$100 monetary prize, two \$50 monetary prizes, and three \$30 gift certificates for Walmart, Target, and Publix. A referral list of mental health facilities (Appendix I) will also be sent at that time to all participants who provided contact information, in case they wish to seek mental health treatment for themselves or for their

children. Those parents who requested the results of the study will also be sent a brief synopsis of the results.

Results

Descriptives

To ensure that active parents were recruited to participate in this study, effort was made to invite those parents who had a child between ages 2-17 and had monthly face to face contact with the child. However, 17% of those parents whose children had used services ($N = 6$) reported utilization information on children who were older than 17. Nevertheless, because they still had monthly face to face contact with their children and thus appeared to still have an active role in their children's lives, they were included in the analyses. A total of 1.5% of the parents ($N = 3$) who participated in the study had contact with their children but not face to face contact on a monthly basis. None of these parents, however, had children who had used mental health services and so they were still included in the study.

Of the 194 parents included in the total sample, 36.3% had used mental health services for themselves in the past. These parents ranged in age from 24-56 years ($M = 37.94$, $SD = 8.22$), 69.6% were female and 30.4% were male, and 68.1% were Caucasian and 31.9% were African American. A total of 19.4% of the children mentioned in the total sample had used mental health services in the past. These children ranged in age from 5-23 years ($M = 12.60$, $SD = 4.75$) and were 71.0% male and 29.0% female. Furthermore, 67.6% of their parents had also used mental health services in the past.

The scores on the Attitudes toward Seeking Professional Psychological Help measure (ATSPPH) have a potential range from 0-3, with higher scores indicating a pro-help seeking direction. This sample had scores ranging from .50 - 2.90 ($M = 1.73$, $SD = .47$) for parent attitudes and .10 - 3.00 ($M = 1.97$, $SD = .49$) for child-related attitudes. The parent attitudes scores are consistent with the normative sample ($M = 1.75$, $SD = .60$) which were generally normally distributed but slightly positively skewed (Fischer & Farina, 1995). Unfortunately, there is no comparison sample for child-related attitudes.

The scores for the Barriers to Treatment Utilization range from 0-3, with higher scores indicating more perceived barriers to treatment utilization. The current sample had scores ranging from .00 - 1.89 ($M = .98$, $SD = .46$) for parent barriers and .00 - 1.91 ($M = .91$, $SD = .43$) for child-related barriers. No comparison information to a normative sample is available. The three most frequently endorsed parent barriers to seeking services were, “I would want to solve the problem on my own”, “Mental health services are not in my budget”, and “I would be scared about being put into a hospital against my will” (44.8%, 41.5%, and 32.0%, respectively). The three most frequently endorsed child-related barriers to seeking services were, “I would be scared about my child being put into a hospital against my will”, “I would want to solve my child’s problem on my own”, and “Mental health services are not in my budget for my child” (34.1%, 33.4%, and 27.9%, respectively).

On the Brief Symptom Inventory (BSI), those individuals who had 13 or more missing items were excluded from the analyses, as was suggested in the manual (Derogatis, 1993). The Global Severity Index (GSI) scores for parents’ overall level of psychopathology were calculated by summing all the items and dividing by the total

number of responses. This was done to correct for missing data (Derogatis, 1993). The scores for the GSI are represented by T scores and were normed for various male and female populations including inpatient, outpatient, and non-patient populations. The norms for the non-patient population will be used for this sample. The fathers in the current sample had GSI scores ranging from .00 - 1.83 ($M = .34$, $SD = .45$), representing an average T-score of 57, based on the manual (Derogatis, 1993). The mothers in the current sample, however, had GSI scores ranging from .00 - 2.27 ($M = .44$, $SD = .51$), representing an average T-score of 56.5, based on the manual (Derogatis, 1993). This indicates that on average neither fathers nor mothers were experiencing significant levels of psychopathology. The nine primary symptom dimensions of the BSI were calculated by summing the total items for each dimension and dividing by the total number of responses in that dimension. The nine primary symptom dimensions were only used in post-hoc analyses.

Analyses of Variance (ANOVAs) were conducted to determine if the groups (African American fathers, African American mothers, Caucasian fathers, and Caucasian mothers) were significantly different from each other on any of the major demographic variables (socioeconomic status, age, and number of children) and symptom severity (GSI scores). For the socioeconomic status (SES) variable, there was a significant main effect for gender, $F(1, 169) = 7.54$, $p < .01$, where fathers showed significantly higher SES ($M = 51.05$) than mothers ($M = 46.94$). There was no main effect for race/ethnicity and the interaction effect was not significant. Given the confounded nature of SES and race/ethnicity nationwide (McLoyd, 1998), it is notable that this sample did not differ significantly on SES across racial/ethnic groups.

For the age variable, there was a significant main effect for gender, $F(1, 188) = 4.03, p < .05$, where fathers were significantly older ($M = 38.90$) than mothers ($M = 36.54$). The main effect for race/ethnicity was not significant nor was the interaction effect for age. There was no significant effect for number of children or GSI scores. Since socioeconomic status was already planned to be statistically controlled in the analyses, the gender difference in SES was controlled. Although age was not controlled statistically for the analyses, post hoc analyses were completed with age controlled. When age was statistically controlled, the results of the analyses were the same, so it appeared that the difference in age did not influence the results either. Therefore, the analyses were run as proposed.

Hypothesis Testing

Correlations were used to determine the various relationships between previous utilization for parents, child utilization, parent barriers, parent attitudes, child-related barriers, and child-related attitudes (see Table 2). Consistent with Hypothesis 1, previous utilization of mental health services and parental attitudes toward mental health services were positively correlated ($r = .33$) while previous utilization and child-related attitudes were also positively correlated ($r = .28$).

Table 2
Parent and Child-related Intercorrelations between Utilization, Barriers, and Attitudes

Variable	P Utilization	P Attitudes	P Barriers	C Utilization	C Attitudes	C Barriers
P Utilization	-	.33***	-.21**	.32***	.27***	-.20**
P Attitudes	-	-	-.50***	.22**	.76***	-.54***
P Barriers	-	-	-	-.09	-.45***	.85***
C Utilization	-	-	-	-	.28***	-.18*
C Attitudes	-	-	-	-	-	-.55***
C Barriers	-	-	-	-	-	-

Note. P = Parent; C = Child-related.
* $p < .05$, ** $p < .01$, *** $p < .001$

Consistent with Hypothesis 2, previous utilization of mental health services and perceived parental barriers to mental health service utilization ($r = -.21$) was inversely correlated while previous utilization and perceived child-related barriers was also inversely correlated ($r = -.18$).

Pearson correlations were used to determine the relationships between parent and child-related barriers and attitudes (see Table 2). Consistent with Hypothesis 3, parent barriers and parent attitudes have a negative relationship ($r = -.50$) and child-related barriers and child-related attitudes also have a negative relationship ($r = -.55$).

Pearson correlations were also used to determine the relationships between parents' perceived barriers and child-related barriers to utilization, and parents' reported attitudes and child-related attitudes toward mental health utilization. Consistent with Hypothesis 4, there was a strong positive relationship between parents' barriers and child-related barriers ($r = .85$). Consistent with Hypothesis 5, there was also a strong positive relationship between parents' attitudes and child-related attitudes ($r = .76$). Due

to the strong relationships between these variables, further analyses were conducted. A paired samples T-test indicated that parents' barriers ($M = .98$, $SD = .46$) were significantly higher than child-related barriers ($M = .90$, $SD = .43$), $t(187) = 4.52$, $p < .001$. Another paired samples T-test indicated that parents had significantly less positive attitudes ($M = 1.74$, $SD = .48$) toward seeking mental health services for themselves than for their children ($M = 1.97$, $SD = .49$), $t(179) = -9.02$, $p < .001$. Thus, although there were strong correlations between the parent and child-related measures, the mean differences suggest different levels of perceived barriers and attitudes for parents' therapy than for child-related therapy.

Due to the strong relationship between SES and race, the influence of SES on the sample was controlled in all the relevant analyses in order to investigate the direct effect of race on the sample. This procedure was achieved by covarying out the influence of SES on the participants' scores. Note, however, that this procedure is sometimes seen as a methodological limitation because it does not actually remove the socioeconomic differences but rather only statistically controls for its influence on the sample.

In order to test Hypothesis 6, a two-way Analysis of Covariance (ANCOVA) was conducted between parent attitudes and the independent variables of race (African American and Caucasian) and gender (male and female), covarying for the influence of SES. The main effect for gender was significant, $F(1, 165) = 7.45$, $p < .01$, indicating that mothers ($M = 1.83$) had more positive attitudes toward seeking services than fathers ($M = 1.63$). The main effect for race was also significant, $F(1, 165) = 4.74$, $p < .05$, indicating that Caucasian parents ($M = 1.81$) had more positive attitudes toward seeking services for themselves than African American parents ($M = 1.65$). However, the

interaction effect was non-significant, $F(1, 165) = .39, p = .53$. In order to test the child-related portion of Hypothesis 6, a second two-way ANCOVA was conducted between child-related attitudes and parents' race and gender, covarying for the influence of SES. The main effect for gender was significant, $F(1, 162) = 6.19, p < .05$, showing that mothers ($M = 2.06$) had more positive attitudes toward seeking services for their children than fathers ($M = 1.88$). However, neither the main effect of race, $F(1, 162) = 1.95, p = .17$, nor the interaction effect, $F(1, 162) = .001, p = .97$ were significant. Thus, there was support for the parental portion of Hypothesis 6 but only partial support for the child-related portion of Hypothesis 6.

In order to test Hypothesis 7, a third two-way Analysis of Covariance (ANCOVA) was run between parent barriers and the two levels of race (African American and Caucasian) and gender (male and female), with the covariate of SES. The results indicated a significant main effect of race, $F(1, 164) = 10.28, p < .01$, such that African American parents ($M = 1.09$) reportedly perceived more barriers to utilization than Caucasian parents ($M = .89$). The main effect for gender was non-significant, $F(1, 164) = 1.52, p = .22$ and neither was the interaction effect, $F(1, 164) = .33, p = .56$. In order to test the child-related portion of Hypothesis 7, a fourth two-way ANCOVA was conducted between child-related barriers and race and gender, covarying for SES. These results also indicated a significant main effect for race, $F(1, 165) = 11.03, p < .01$, showing that African American parents ($M = 1.02$) perceived more child-related barriers to utilization than Caucasian parents ($M = .81$). However, neither the main effect for gender, $F(1, 165) = 2.07, p = .15$, nor the interaction effect, $F(1, 165) = .01, p = .92$ were

significant. Thus, there was partial support for both the parental and child-related portions of Hypothesis 7.

Note that when all of the variables were run with Analyses of Variance (i.e. without SES as a covariate), the results were almost identical. The only difference was for child-related attitudes, where the main effect of race, $F(1, 176) = 5.12, p < .05$ was significant, such that Caucasian parents ($M = 2.04$) had more positive attitudes toward mental health than African American parents ($M = 1.88$). Overall, the results with and without SES covaried were predominantly consistent with the hypotheses.

In order to test Hypothesis 8, a multiple regression analysis was performed to predict parents' future utilization of services from parent attitudes, parent barriers, and parent psychopathology. Due to the potential confound between race and SES, the influence of SES was controlled statistically and then the remaining variables were added to the model. This second model, with SES controlled, was significant, $F(4, 146) = 6.41, p < .001, R^2 = .15$, however the parental barrier variable was the only predictor accounting for a significant amount of variance in the model (see Table 3). These results suggested that the more barriers parents perceive toward treatment, the less likely they will be to seek mental health services for themselves in the future. Thus, there was partial support for the parental portion of Hypothesis 8.

Table 3
Multiple Regression Analysis for Parent Attitudes, Barriers, and Psychopathology Predicting Future Utilization in Parents

Variable	B	SE B	β
Socioeconomic Status	-.03	.10	-.02
Parent Attitudes	3.99	2.31	.16
Parent Barriers	-7.79	2.52	-.29**
Global Severity Index	3.92	2.12	.15

Note. $R^2 = .15$
** $p < .01$

As a test of the second part of Hypothesis 8, a second multiple regression analysis was conducted to predict child's future utilization of mental health services from child-related attitudes, child-related barriers, and parent psychopathology. The influence of SES was also taken out before the rest of the other variables were added to the model. This second model, with SES controlled, was significant, $F(4, 144) = 3.76, p < .01, R^2 = .10$, however the child-related barrier variable was the only predictor that accounted for a significant amount of variance in this model (see Table 4). These results suggested that the more barriers parent perceive toward child-related treatment, the less likely they will be to seek mental health services for their children in the future. Thus, there was also partial support for the child-related portion of Hypothesis 8.

Table 4
Multiple Regression Analysis for Child-related Attitudes, Child-related Barriers, and Parental Psychopathology Predicting Future Utilization in Children

Variable	B	SE B	β
Socioeconomic Status	-.04	.12	-.03
Child-related Attitudes	2.53	2.69	.09
Child-related Barriers	-7.62	3.07	-.25*
Global Severity Index	3.21	2.49	.11

Note. $R^2 = .10$

* $p < .05$

Overall, the majority of the proposed hypotheses were supported, but there were some unexpected null results. Therefore, more analyses were conducted to explore the variables in a more thorough manner.

Post Hoc Analyses

Several post hoc analyses were run to explore the relationships between the parent and child variables further. These results are presented in this section because they were not proposed with the original hypotheses.

Utilization variables with barriers and attitudes. Pearson correlations were conducted to determine the relationships between parental and child-related satisfaction with prior mental health services and parental and child-related barriers, respectively. Correlations were also used to determine the relationships between parental and child-related satisfaction and parental and child-related attitudes, respectively. Correlations can be seen in Table 5. There was a non-significant correlation between parents' satisfaction with their treatment and parents' satisfaction with their children's treatment ($p = .08$). Pearson correlations were also run to determine the relationships between quantity of

mental health services used by parents and children (i.e., number of sessions) and parental and child-related barriers, respectively. Correlations were also used to determine the relationships between quantity of mental health services used by parents and children and parental and child-related attitudes, respectively. These correlations can also be seen in Table 5. There was a strong positive correlation between quantity of services used by parents and quantity of services used by children $r(22) = .79, p < .001$.

Table 5
Correlations of Parent and Child-related Barriers and Attitudes with Satisfaction and Quantity of Utilization

Variable	Satisfaction with MHS	Quantity of MHS used
Parent Attitudes	.37**	.36**
Parent Barriers	-.06	-.32**
Child-Related Attitudes	.40*	.33
Child-Related Barriers	-.10	-.40*

Note. MHS = Mental Health Service.

* $p < .05$, ** $p < .01$

Utilization of pastors for mental health services. Because religious leaders have been posited as a resource for the African American community more so than other communities, analyses were conducted to explore this pattern. A two-way Analysis of Covariance (ANCOVA) was performed between future utilization of a pastor for mental health services and the independent variables of race (African American and Caucasian) and gender (male and female), covarying for the influence of SES. The main effect for race was significant, $F(1, 151) = 5.95, p < .05$, indicating that African American parents ($M = 5.01$) are more likely to seek mental health services for themselves from a pastor than are Caucasian parents ($M = 3.63$). However, neither the main effect for gender, $F(1,$

151) = .40, $p = .53$, nor the interaction effect, $F(1, 151) = .61, p = .44$ were significant. Another two-way ANCOVA was performed between future utilization of a pastor for child mental health services and race and gender, with SES as the covariate. Neither the main effect for gender, $F(1, 151) = .03, p = .86$, the main effect for race, $F(1, 151) = 2.50, p = .12$, nor the interaction effect, $F(1, 151) = .32, p = .58$ were significant. Thus, it appeared that African American parents are willing to seek mental health services from pastors more often than Caucasian parents when therapy is for themselves but not when therapy is being sought for their children.

Utilization of mental health professionals for mental health services. A multiple regression analysis was performed to predict parents' future utilization of mental health professionals (psychologists, psychiatrists, and social workers) from parent attitudes, parent barriers, and parent psychopathology. The influence of SES was taken out before the rest of the variables were added to the model. This second model, with SES controlled, was significant, $F(4, 146) = 18.02, p < .001, R^2 = .33$. In addition, all the variables including parent barriers, parent attitudes, and parent psychopathology were significant predictors and accounted for significant amounts of variance in the model (see Table 6). Thus, in contrast to the regression that tested Hypothesis 8, which used all five professionals (psychiatrists, psychologists, social workers, pastoral counselors, and primary care doctors) and which had modest results, the focus on only mental health professionals appears to be more relevant to parental barriers, attitudes, and psychopathology.

Table 6
 Multiple Regression Analysis for Parent Attitudes, Barriers, and Psychopathology Predicting Parents' Future Utilization of Mental Health Professionals

Variable	B	SE B	β
Socioeconomic Status	.05	.06	.07
Parent Attitudes	5.06	1.25	.32***
Parent Barriers	-4.97	1.36	-.30***
Global Severity Index	3.47	1.15	.21**

Note. $R^2 = .33$
 ** $p < .01$, *** $p < .001$

Another multiple regression was conducted to predict children's future utilization of mental health professionals from child-related attitudes, child-related barriers, and parent psychopathology. The influence of SES was also taken out before the rest of the variables were added to the model. This second model, with SES controlled, was significant, $F(4, 144) = 12.76, p < .001, R^2 = .26$. In addition, child-related attitudes and child-related barriers accounted for significant amounts of variance in the model (see Table 7). Thus, in contrast to the regressions that tested the child-related portion of Hypothesis 8, which used all five professionals (psychiatrists, psychologists, social workers, pastoral counselors, and primary care doctors), and which also had modest results, the focus on only mental health professionals appears to be more relevant to child-related barriers and child-related attitudes.

Table 7
Multiple Regression Analysis for Child-related Attitudes, Child-related Barriers, and Parental Psychopathology Predicting Children’s Future Utilization of Mental Health Professionals

Variable	B	SE B	β
Socioeconomic Status	.03	.06	.03
Child-related Attitudes	4.68	1.45	.29**
Child-related Barriers	-5.21	1.66	-.28**
Global Severity Index	1.63	1.35	.09

Note. $R^2 = .26$
** $p < .01$

Parental psychopathology subscales and future utilization. Although the Global Severity Index (GSI) of the BSI is a robust measure of psychological symptoms, there may be fine-grained details that can be ascertained by exploring the subscales on the BSI. Therefore, multiple regression analyses were conducted to determine if the subscales of the BSI, along with attitudes and barriers, would predict future utilization of mental health professionals for mental health services in parents and children. The influence of SES was taken out before the rest of the variables were added to the model. For parent future utilization, the second model, with SES controlled, was significant, $F(12, 138) = 6.29, p < .001, R^2 = .35$. However, parent attitudes and parent barriers were the only predictors accounting for significant amounts of variance in the model (see Table 8). For child future utilization, the second model, with SES controlled, was also significant, $F(12, 136) = 5.04, p < .001, R^2 = .31$. However, child-related attitudes, child-related barriers, and the Obsessive-Compulsive subscale were the only predictors that accounted for a significant amount of variance in the model (see Table 8). Thus, none of the BSI subscales significantly predicted parent utilization of mental health professionals from

themselves in the future, however, the higher parents scored on the Obsessive-Compulsive subscale, the more likely they would be to seek services from mental health professionals for their children in the future.

Table 8
Multiple Regression Analyses for Parent and Child-related Attitudes, Barriers, and Parental Psychopathology Subscales Predicting Future Utilization of Mental Health Professionals

Variable	Group	B	SE B	β
Socioeconomic Status	Parent	.05	.06	.07
	Child-related	.05	.07	.05
Attitudes	Parent	4.39	1.35	.28**
	Child-related	3.88	1.53	.24*
Parent Barriers	Parent	-5.03	1.40	-.30***
	Child-related	-4.86	1.68	-.26**
Somatization Subscale	Parent	1.82	1.71	.10
	Child-related	2.51	1.91	.13
Obsessive-Compulsive Subscale	Parent	1.38	1.28	.14
	Child-related	3.01	1.51	.28*
Interpersonal Sensitivity Subscale	Parent	1.06	1.32	.09
	Child-related	-.49	1.66	-.04
Depression Subscale	Parent	.88	1.53	.07
	Child-related	-.09	1.78	-.01
Anxiety Subscale	Parent	1.71	2.16	.12
	Child-related	1.13	2.65	.07
Hostility Subscale	Parent	-1.21	1.34	-.10
	Child-related	-1.32	1.55	-.10
Phobic Anxiety Subscale	Parent	-.62	2.29	-.03
	Child-related	1.61	2.79	.07
Paranoid Ideation Subscale	Parent	-1.57	1.53	-.13
	Child-related	-2.88	1.80	-.22
Psychoticism Subscale	Parent	-.15	2.25	-.01
	Child-related	-1.44	2.47	-.08

Note. Parent $R^2 = .35$; Child $R^2 = .31$.
* $p < .05$, ** $p < .01$, *** $p < .001$

Discussion

The aim of this study was to investigate the relationship between African American and Caucasian parental and child-related barriers and attitudes toward mental health services. The relationships between prior utilization and parent and child-related barriers and attitudes were also examined. In addition, this study explored the predictors of future utilization for parents and children among barriers, attitudes, and parental psychopathology. Overall, in terms of utilization of mental health services, more mothers had utilized services than fathers; however more boys had utilized services than girls. This pattern has been well established in the literature, where boys tend to receive services more often than girls before adolescence; and then females take over in adolescence and adulthood (Costello & Janiszewski, 1990; Pescosolido & Boyer, 1999). There were also racial differences in utilization such that Caucasians parents used more services than African Americans parents, another well established fact (U.S. Department of Health and Human Services, 2001). In addition, parents did not differ by race or gender in terms of current psychopathology, indicating another consistency with the literature (U.S. Department of Health and Human Services, 2001). Thus, in terms of utilization of mental health services and parental psychopathology, the current sample is similar to those described in the literature. The specific aims of this study were explored by eight hypotheses.

The analyses confirmed the first hypothesis which predicted a positive relationship between parent utilization and parent attitudes and also predicted a positive relationship between child utilization and child-related attitudes. The finding that parents with more positive attitudes toward seeking services for themselves and their children used services more in the past for themselves and their children is consistent with the literature. For example, Gustafson, McNamara, and Jensen (1994) found that parents were more likely to seek treatment for their children when they had positive attitudes toward seeking treatment. Other researchers have also shown that individuals' attitudes toward treatment predicted help-seeking behaviors (Bayer & Peay, 1997).

The second set of hypotheses, which predicted a negative relationship between parent utilization and parent barriers and also predicted a negative relationship between child utilization and child-related barriers, were also confirmed. The finding that parents who perceived fewer barriers to utilization for themselves and their children used more services in the past for themselves and their children is consistent with the literature (Owens et al., 2002; Snowden, 2001). However, the relationship between child-related barriers and child utilization was quite weak, thus it appears that other issues may be involved when parents are seeking services for their children and for themselves too.

The results confirmed the third hypothesis as well, which predicted a negative relationship between parental barriers and attitudes and also predicted a negative relationship between child-related barriers and attitudes. The finding that parents who perceived fewer barriers for themselves and their children had more positive attitudes toward mental health services for themselves and their children has not been previously examined specifically in the literature. No studies were found that investigated the

specific relationship between barriers and attitudes. However, based on the well established literature that fewer barriers are associated with higher utilization and positive attitudes are also associated with higher utilization, these results are consistent with the literature.

A unique aspect of this study involved asking parents to report on their barriers and attitudes for seeking treatment for themselves and their barriers and attitudes for seeking treatment for their children. The fourth hypothesis, which predicted a positive relationship between parents' barriers and child-related barriers to seeking services was confirmed. The finding that parents who perceived barriers to mental health treatment for themselves also perceived barriers for their children was further investigated and results indicated that parents perceived significantly more barriers for themselves than for their children. Thus, it appeared that parents were able to overcome certain barriers when seeking services for their children in contrast to themselves. In fact, the most frequently endorsed barrier for parents ("I would want to solve the problem on my own") was different from the most frequently endorsed barrier for child-related treatment ("I would be scared about my child being put into a hospital against my will").

The analyses also confirmed the fifth hypothesis. This hypothesis predicted a positive relationship between parents' attitudes and child-related attitudes toward seeking services. The finding that parents who had more positive attitudes toward seeking services for themselves also had more positive attitudes toward seeking services for their children was investigated further. The findings indicated that parents had significantly more positive attitudes toward seeking services for their children than for themselves. These results provide important information for developing programs geared toward

increasing utilization of mental health services. Researchers interested in developing such programs might want to target different issues for parent treatment versus child treatment because it appears that the barriers influencing parents' utilization differ from those influencing them when seeking services for their children (Bannon & McKay, 2005; Pavluri, Luk, & McGee, 1996). Furthermore, since parents have more positive attitudes toward seeking services for their children, they might be more open to programs focused on increasing service use in their children first before increasing their own use of mental health services.

The sixth hypothesis predicted that mothers and Caucasian parents would have more positive attitudes toward mental health services for themselves and their children than fathers and African American parents. This hypothesis was mostly supported, such that mothers and Caucasian parents had significantly more positive attitudes toward mental health services for themselves and mothers also had more positive attitudes toward services for their children. However, there were no racial differences in attitudes toward services for children. This finding that gender has such a strong impact on attitudes for parents and their children's mental health is consistent with the literature (Fisher & Turner, 1970; Mahalik, Good, & Englar-Carlson, 2003). Furthermore, the finding that African American parents have less positive attitudes toward services for themselves is also well established (Diala et al., 2000). However, the fact that African American parents were not significantly different from Caucasian parents in child-related attitudes was unexpected. Again, it is likely that parents regardless of race put aside their attitudes when considering service utilization for their children and try to do what is best for their children regardless of their own attitudes toward mental health. The fact that

gender differences were found in child-related attitudes to treatment, speaks to the strong effect of parents' gender on mental health service utilization. Thus it appears that fathers tend to have less favorable attitudes toward mental health services regardless of whether it is for themselves or their children while mothers are able to modify their attitudes when their children are concerned.

The seventh hypothesis predicted that mothers and Caucasian parents would perceive fewer barriers to mental health utilization for themselves and their children than fathers and African American parents. This hypothesis was partially confirmed, such that Caucasian parents perceived fewer barriers to utilization of mental health services for themselves and their children than African American parents. However, there were no gender differences in parents' perception of barriers for themselves or their children. The finding that African American parents perceived more barriers to mental health utilization has been found consistently (Snowden, 2001; Thompson, Bazile, & Akbar, 2004). Several ideas have been offered to explain this relationship. For example, Gary (2005) suggested that minorities are concerned about prejudice and discrimination and feel that they might suffer "double stigma" from being in a minority group and having a mental health illness. Thompson and colleagues found that their sample of African American participants believed that psychologists would be insensitive to the "African American experience" (Thompson, Bazile, & Akbar, 2004). It was interesting that African Americans perceived more barriers than Caucasians for themselves and for their children. Thus it seemed that the racial issues were so strong that they persevered even when utilization for their children was concerned. However, the finding of no gender differences in perception of barriers was unexpected. This finding indicates that although

men (fathers) use services less often than women (mothers), their underutilization is not due to perception of more barriers. This finding could be because men perceive similar barriers to services but other issues such as less positive attitudes toward mental health, might prevent them from using services as often as women do. Mahalik and colleagues found that masculinity was associated with less help-seeking and negative attitudes toward mental health because help seeking implies dependence and vulnerability (Mahalik, Good, & Englar-Carlson, 2003).

Finally, the eighth hypothesis predicted that higher parental and child-related attitudes, lower parental and child-related barriers, and higher levels of parental psychopathology would predict higher rates of future utilization of mental health services for parents and children as reported by parents. This hypothesis was partially supported, such that the variable of lower rates of parental barriers was the only significant predictor of future utilization in parents and the variable of lower rates of child-related barriers was the only significant predictor of future utilization in children, accounting for 15% and 10% of the variance, respectively. These results were surprising since attitudes have a moderate relationship with prior utilization and level of distress has been shown to be related to help seeking (Pescosolido, & Boyer, 1999). Parents in this study were asked about future utilization of mental health services from various individuals including mental health service professionals (psychologists, psychiatrists, and social workers/other mental health professionals), pastors, primary care doctors, and family/friends. Research has shown that individuals (especially African Americans) are often willing to seek mental health services from sources other than mental health professionals, such as pastors, physicians, family members, and friends (Boyd-Franklin & Lockwood, 1999).

Thus it is possible that because future utilization was compiled into one category across mental health professionals and professionals in other disciplines (i.e., primary care, and spirituality), the influence of attitudes and psychopathology were not seen.

Post hoc analyses were conducted and future utilization of mental health professionals (psychologists, psychiatrists, and social workers/other mental health professionals) for mental health services was explored. These results indicated that all the variables (parent barriers, parent attitudes, and parental psychopathology) were significant predictors of parental future utilization of mental health professionals (MHP) for services and accounted for 33% of the variance. The results also indicated that child-related barriers and child-related attitudes were significant predictors of future utilization of MHPs in children and accounted for 26% of the variance. Parental psychopathology, however, was not a significant predictor of child utilization of MHPs. This finding was probably due to the fact that child psychopathology rather than parental psychopathology might be influencing parents' decision to seek services for their children. In fact, Gustafson and colleagues found that child problem severity and parent attitude toward treatment were positively related to seeking treatment (Gustafson, McNamara, & Jensen, 1994).

Further post hoc analyses investigated how specific clusters of symptoms on the BSI would predict future utilization of MHPs in parents and children. The results indicated that for parent MHP utilization, only parent attitudes and barriers were significant predictors, accounting for 35% of the variance. However, for child MHP utilization, child-related barriers, child-related attitudes, and the Obsessive-Compulsive subscale were significant predictors, accounting for 31% of the variance. It is not clear

why the Obsessive-Compulsive subscale was significant for parents' report of child-related utilization but not for parental utilization. It is possible that parents with these symptoms are so highly distressed that they are more apt to get help for their children to help reduce the likelihood of them developing similar symptoms.

Further post hoc analyses that were conducted on future utilization of mental health services indicated that African Americans were more likely to seek mental health services for themselves from their pastor than were Caucasians. This pattern is a consistent finding in the literature (Ayalon, & Young, 2005; Boyd-Franklin, & Lockwood, 1999) and provides further confirmation that these underserved populations need to be reached through pastors and other well respected members of their community in order to increase service utilization. Interesting, African American parents were not more likely than Caucasian parents to seek services for their children in the future from a pastor. Thus it appeared that African American parents were more likely to seek services from a pastor for themselves but not for their children. This finding again speaks to the issue of differential parental attitudes and opinions when service utilization concerns their children versus themselves and provides implications for programs aimed at increasing utilization in parents and children. Perhaps parents feel that pastors would be better equipped to deal with adults' problems rather than children's problems. Further research is needed in this area.

The final set of post hoc analyses investigated the relationships between satisfaction with mental health services and quantity of services with parental and child-related barriers and attitudes toward mental health. The relationship between parental satisfaction and satisfaction with child-related services was non-significant; however, the

relationship between quantity of services parents used and quantity of services used by their children was strong. Thus it appeared that parents judged their services differently from their children's services but were willing to expose their children to more sessions, if they themselves were using more sessions. Furthermore, parental and child-related attitudes were significantly correlated with satisfaction whereas barriers were not. This finding is consistent with the literature where attitudes and expectations have been shown to be related to satisfaction (Garland, Aarons, Saltzman, & Kruse, 2000). On the other hand, parental attitudes and barriers were significantly correlated with quantity of services used by parents while only child-related barriers were significantly correlated with quantity of services used by children. The finding that parental attitudes and barriers are significantly correlated with quantity of services used by parents is logical because more positive attitudes and less perceived barriers would enable an individual to seek services more, if there is a need. However, the finding that only child-related barriers and not child-related attitudes are related to quantity of services used by children is surprising. It appears that parents again, put attitudes aside and expose their children to more sessions regardless of their own attitudes toward mental health but as has been now consistently shown barriers still mattered.

Theoretical Conceptualizations

The results of this study were generally consistent with the theoretical model that guided this study (Andersen & Newman, 1973). The finding that parental and child-related barriers were related to parental and child-related attitudes, respectively, was consistent with the theoretical model, which described a relationship between predisposing characteristics (attitudes) and enabling resources (barriers). In addition, the

finding that parental attitudes toward treatment were related to parental race and gender while child-related attitudes were related to parental gender was partially consistent with the theoretical model, which described a relationship between all the predisposing characteristics (attitudes, race, and gender). The finding that perceived parental and child-related barriers to treatment were related to race was also partially consistent with the theoretical model, which described a relationship between the predisposing characteristics (race and gender) and enabling resources (barriers).

Furthermore, the finding that parental barriers, parental attitudes, and parental psychopathology predicted parental future utilization of mental health professionals for mental health services was consistent with the theoretical model, which described the relationship between predisposing characteristics (attitudes), enabling resources (barriers), illness level (psychopathology), and future utilization. The finding that child-related barriers, and child-related attitudes predicted children's future utilization of mental health professionals for mental health services was partially consistent with the theoretical model which described the relationship between predisposing characteristics (attitudes), enabling resources (barriers), illness level (psychopathology) and future utilization.

Thus, although the results of this study were not consistent with all aspects of the theoretical model for child-related utilization, the model was almost completely consistent for parental utilization. Therefore, it is possible that this model, while appropriate for parent related variables, is not as applicable to variables related to child utilization of mental health services. Future research should investigate the generalizability of this model to child-related treatment.

Limitations and Future Research

There were several limitations to this study. First, parents were asked to report lifetime use of mental health services and might have exaggerated or underreported actual service use for themselves and their children. Research indicates that parents are fairly accurate in reporting whether their children used services or not but the rate of false reporting increases when parents are asked to report on specific service providers or specific settings (Bean et al., 2000). Another limitation is that parents were the only informants used in this study and thus it was not possible to confirm the information they reported especially on utilization of mental health services. Future studies should attempt to collect information from the child and/or spouse/significant other, if one is available. However, researchers should be cognizant of the fact that recruiting only parental dyads for such studies would limit generalizability because a large percentage of African American children are being raised by their single mothers. Future studies could also verify parents' reports of utilization by contacting their mental health providers; however, this option is more research intensive.

In terms of procedures, there are some limitations to the use of surveys by mail versus having parents fill out the questionnaires in the presence of the researcher because parents might not have answered questions truthfully or some fathers might have given the surveys to mothers to complete (Phares, 1995). However, conducting the surveys by mail provided a certain level of anonymity for the parents, which could have resulted in more truthful responses. Another limitation is related to the generalizability of this study. It is notable that SES did not differ across racial groups, therefore it is possible that this study did not sample a wide enough range of individuals from lower SES groups. Future

research should endeavor to collect data from all SES groups to enhance the generalizability of the results. A fifth limitation is that this study examined perceived barriers to treatment utilization as opposed to actual barriers to treatment utilization, thus there was no way to determine if these barriers actually existed or if parents just felt that they did. However, research has been established that perceived barriers are related to underutilization of services, so regardless of if these are true barriers or not, they are likely affecting utilization and thus need to be addressed. Another limitation of this study is the possible confound of collecting both the parent and child-related information at the same time; however, the fact that differences were found in parent and child-related variables indicates that the relationship is fairly robust.

Although a strength of this study was the assessment of parental psychopathology, future research should include a measure of child psychopathology. It has been shown in previous research that child psychopathology influences parents' decisions to seek mental health services for their children (Gustafson, McNamara, & Jensen, 1994), thus this variable is important to assess. The psychometric properties of the barriers to treatment utilization measure should be investigated in future studies and factor analyses can be used to group barriers. Findings from these types of studies might provide a method for program developers to target specific groups of barriers that might be influencing parent and child utilization. In addition, future researchers should develop help-seeking models that are geared to the investigation of underutilization of services in minorities (Snowden & Yamada, 2005). Future research should also focus on other ethnic minority groups and determine whether barriers and attitudes are similar across various ethnicities and thus determine if interventions should differ depending on ethnicity. Finally, researchers

should also provide cost-benefit analyses of how underutilization of mental health services by parents and children in need contribute to overutilization of resources in the long run. This information should help policy makers develop programs to increase awareness and utilization of mental health services, such as national screenings for mental health problems in school age children.

Conclusions and Clinical Significance

Overall, findings from this study can be instrumental in providing researchers with specific issues to target when developing programs to increase utilization of mental health services in parents and children. This study will inform researchers about the relationships between barriers to treatment and attitudes toward mental health services and how this relationship differs for child-related treatment and treatment for parents. This information can be used to create tailored intervention programs to improve attitudes, decrease perception of barriers, and increase utilization of mental health services in children and parents.

Fathers and ethnic minorities utilize services the least, so researchers and clinicians should work on increasing utilization in these populations when the services are needed. This goal can be achieved by creating preventive intervention programs. Programs should address increasing utilization in parents and increasing utilization in children separately and should be tailored to different ethnic groups. Researchers creating such programs should focus on the various stages of help seeking including recognizing the problem, deciding to seek help, and selecting where to get services (Cauce et al., 2002). Psychoeducation is an important part of dispelling some of the myths and negative attitudes about mental health services and to educating the public

about the benefits of mental health services. Research on parents' explanatory models of mental health indicate that African American parents often express less worry over certain behavior problems than Caucasians and have less mental-health-minded explanations for behavior problems in their children (Bussing, Gary, Mills, & Garvan, 2003).

Program developers should also target specific barriers to treatment utilization by reducing access barriers, being more flexible with mode of delivery of treatment, developing strategies to decrease premature drop-out from treatment, matching interventions to family's needs, and being culturally sensitive to clients (Phelps, Brown, & Power, 2002; Snell-Johns, Mendez, & Smith, 2004). Phares and colleagues described several strategies that can be used to engage fathers in treatment including, increasing family related training in graduate programs, inviting fathers to participate in treatment and intervening when they are hesitant, creating a father-friendly environment, and being flexible in the structure of each session (Phares, Fields, & Binitie, In press). Satisfaction with mental health services is important in engagement and continuation of treatment (Garland, Aarons, Saltzman, & Kruse, 2000). Thus clinicians should work closely with their clients to build good relationships and ensure that clients are satisfied with treatment every step of the way.

Special attention should also be paid to recruiting and retaining minorities in clinical outcome research, especially those of low SES. Developing treatments that are tailored to minority clients should improve treatment outcome and reduce premature drop-out from treatment. This can be done by reaching out to "key informants" in the community (such as pastors), providing adequate training to research assistants, and

being culturally sensitive to issues of ethnicity (Miranda, 1996; Thompson, Neighbors, Munday, & Jackson, 1996). As this paper has shown, there are several ways that researchers and clinicians can increase the utilization of mental health services, so let's get started.

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Appendices

Appendix A

Dear Sir/Madam,

I would like to invite you to participate in a study about mental health services. The purpose of this research project is to better understand how typical parents and their children use mental health services and the reasons why they use mental health services. You are being asked to respond to questions about you and your children's previous use of mental health services. You do not need to have received mental health services in order to participate in this study. You are also asked to complete a series of questionnaires about how you are currently feeling, your beliefs and some background information. The entire task should take about 15-20 minutes.

Your participation in this survey is completely voluntary. You are free to participate in the study or withdraw at any time without penalty. Your consent to participate is shown by your decision to complete the questionnaires. We will not need to contact your child. The potential benefits for participating in this study are raising your awareness about mental health services. There are no known risks for those who take part in this study.

All participants who provide their contact information, using the business-reply post cards, will be entered into a drawing for one of six prizes. All contact information provided will be kept separate from questionnaires which will be identified by subject code to protect your privacy. The prizes include: one \$100 cash prize, two \$50 cash prizes and three gift certificates from merchants in the surrounding community.

Your privacy and research records will be kept confidential to the extent of the law. Authorized research personnel, employees of the Department of Health and Human Services, and the USF Institutional Review Board, its staff and other individuals acting on behalf of USF may inspect the records from this research project. If you have any questions about your rights as a person who is taking part in a research study, you may contact the Division of Research Compliance of the University of South Florida at (813) 974-5638.

If you have any questions about this research study, please contact Idia Binitie, Department of Psychology, University of South Florida, 4202 E. Fowler Avenue., PCD 4118G, Tampa, FL 33620, 813-974-9222, ibinitie@mail.usf.edu. Thank you.

Sincerely,
Idia Binitie
Graduate Student

Appendix B

INSTRUCTIONS: Please respond to the following questions on background information about you and your family.

1. What is your gender?

- Male
 Female

2. How old are you? _____

3. What is your race/ethnicity?

- African American /Black
 American Indian /Alaskan Native
 Asian /Pacific Islander
 Caucasian
 Hispanic/Latino (a)
 Other (specify _____)

4. Are you:

- Married
 Single, living with partner
 Single, no partner
 Separated
 Divorced
 Widowed
 Other (specify _____)

5. How many people, including yourself, live in your home? _____

6. How many children (biological, stepchildren, adopted and other children) do you have? _____

7. List the ages and gender of your children:

8. How many of these children are currently living in your home? _____

Appendix B (Continued)

9. List the ages and gender of your children currently living in your home:

10. Do you see at least one of your children (ages 2 to 17) at least once per month?

___ Yes

___ No

11. Employment status:

Self

Employed as (list job): _____

Unemployed _____

Retired _____

Other _____

Your Spouse/Partner

Employed as (list job): _____

Unemployed _____

Retired _____

Other _____

12. Highest level of education completed (please circle response):

Self

Grade School Middle School High School College Graduate School
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22

Your Spouse/Partner

Grade School Middle School High School College Graduate School
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22

13. Total household income per year (optional): _____

(This information is confidential and will not be seen by anyone other than the research staff)

14. What type of public assistance do you receive (if any)?

___ Food Stamps

___ Welfare

___ Help with Housing

___ Temporary Assistance for Needy Families

___ Medicaid

___ Other, please describe: _____

___ None

15. Do you have insurance coverage for physical health care needs?

For Self:

___ Yes

___ No

For your Children:

___ Yes

___ No

Appendix B (Continued)

____ Don't know

____ Don't know

16. Do you have insurance that covers mental health needs?

For Self:

____ Yes

____ No

____ Don't know

For your Children:

____ Yes

____ No

____ Don't know

Appendix C

INSTRUCTIONS: Please respond to these questions below on background information about you and your children.

1. Have you ever seen any professional for **mental health services** (including: Psychologist, Psychiatrist, Social worker, Pastoral Counselor, or Primary care doctor)?

Yes
 No (**Skip to #9**)

2. How many separate times/sessions did you use any of these services for mental health purposes?

Psychologist
 Psychiatrist
 Social worker/other mental health professional
 Pastoral Counselor
 Primary care doctor

3. How many different professionals have you seen for mental health purposes (Please write the number seen by each category, i.e. 1, 2, 3 ...)?

Psychologist(s)
 Psychiatrist(s)
 Social worker(s)/other mental health professional(s)
 Pastoral Counselor(s)
 Primary care doctor(s)

4. Why did you seek mental health services (Check all that apply)?

Voluntary
 Required (by _____)
 Other (_____)

5. Why did you stop receiving mental health services (Check all that apply)?

Still in treatment
 Felt better/No longer needed

Appendix C (Continued)

- Dissatisfied with treatment
- No longer required (If involuntary)
- Money reasons
- Moved
- Other (_____)

6. What was the gender of your therapist (If more than one therapist, write the number seen by each category)?

- | | |
|--|--|
| <input type="checkbox"/> Male Psychologist(s) | <input type="checkbox"/> Female Psychologist(s) |
| <input type="checkbox"/> Male Psychiatrist(s) | <input type="checkbox"/> Female Psychiatrist(s) |
| <input type="checkbox"/> Male Social worker(s)/other | <input type="checkbox"/> Female Social worker(s)/other |
| <input type="checkbox"/> Male Pastor(s) | <input type="checkbox"/> Female Pastor(s) |
| <input type="checkbox"/> Male Primary care doctor(s) | <input type="checkbox"/> Female Primary care doctor(s) |

7. What was the race of your therapist (If more than one therapist, write the number seen by each category)?

- African American
- American Indian /Alaskan Native
- Asian /Pacific Islander
- Caucasian
- Hispanic/Latino/Latina

8. On a scale of 1-10 (with 1 being LEAST and 10 being MOST), **how satisfied** were you with the mental health services you received from each of the following?

- Psychologist
- Psychiatrist
- Social worker/other mental health professional
- Pastoral Counselor
- Primary care doctor

9. Do you think you currently need to see a professional for **mental health services** (including: Psychologist, Psychiatrist, Social worker, Pastoral Counselor, or Primary care doctor)?

- Yes
- No

Appendix C (Continued)

10. If you needed services, on a scale of 1-10 (with 1 being LEAST and 10 being MOST), **how likely** are you to see each of the following individuals for mental health services in the future?

- _____ Psychologist
- _____ Psychiatrist
- _____ Social worker/other mental health professional
- _____ Pastoral Counselor
- _____ Primary care doctor
- _____ Family/friends

11. Have any of your children ever seen any professional for mental health services (including: Psychologist, Psychiatrist, Social worker, Pastoral Counselor, or Primary care doctor)?

- _____ Yes
- _____ No (**Skip to #21**)

12. How many of your children have ever used mental health services?

Please respond to the items below for your child who has used the most mental health services in the past.

13. What is the age and gender of this child? _____

14. How many separate times/sessions did your child use any of these services for mental health purposes?

- _____ Psychologist
- _____ Psychiatrist
- _____ Social worker/other mental health professional
- _____ Pastoral Counselor
- _____ Primary care doctor

15. How many different professionals has your child seen for mental health purposes (Please write the number seen by each category)?

- _____ Psychologist(s)
- _____ Psychiatrist(s)
- _____ Social worker(s)/other mental health professional(s)
- _____ Pastoral Counselor(s)
- _____ Primary care doctor(s)

Appendix C (Continued)

16. Why did you seek mental health services for your child (Check all that apply)?

- Voluntary
- Required (by _____)
- Other (_____)

17. Why did your child stop receiving mental health services (Check all that apply)?

- Still in treatment
- Felt better/No longer needed
- Dissatisfied with treatment
- No longer required (If involuntary)
- Money reasons
- Moved
- Other (_____)

18. What was the gender of your child's therapist (If more than one therapist, write the number seen by each category)?

- | | |
|--|--|
| <input type="checkbox"/> Male Psychologist(s) | <input type="checkbox"/> Female Psychologist(s) |
| <input type="checkbox"/> Male Psychiatrist(s) | <input type="checkbox"/> Female Psychiatrist(s) |
| <input type="checkbox"/> Male Social worker(s)/other | <input type="checkbox"/> Female Social worker(s)/other |
| <input type="checkbox"/> Male Pastor(s) | <input type="checkbox"/> Female Pastor(s) |
| <input type="checkbox"/> Male Primary care doctor(s) | <input type="checkbox"/> Female Primary care doctor(s) |

19. What was the race of your child's therapist (If more than one therapist, write the number seen by each category)?

- African American
- American Indian /Alaskan Native
- Asian /Pacific Islander
- Caucasian
- Hispanic/Latino/Latina

20. On a scale of 1-10 (with 1 being LEAST and 10 being MOST), **how satisfied** were you with the mental health services that your child received from each of the following?

- Psychologist
- Psychiatrist
- Social worker/other mental health professional

Appendix C (Continued)

- Pastoral Counselor
- Primary care doctor

21. Do you think your child currently needs to see a professional for **mental health services** (including: Psychologist, Psychiatrist, Social worker, Pastoral Counselor, or Primary care doctor)?

- Yes
- No

22. If your child needed services, on a scale of 1-10 (with 1 being LEAST and 10 being MOST), **how likely** are you to seek mental health services for your child from each of the following individuals in the future?

- Psychologist
- Psychiatrist
- Social worker/other mental health professional
- Pastoral Counselor
- Primary care doctor
- Family/friends

Appendix D

INSTRUCTIONS: In this questionnaire, you will read statements about **your** attitudes towards seeking mental health services **for yourself**. Please circle a response to each statement according to how you currently feel.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	SD	D	A	SA
2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.	SD	D	A	SA
3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.	SD	D	A	SA
4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears <i>without</i> resorting to professional help.	SD	D	A	SA
5. I would want to get psychological help if I were worried or upset for a long period of time.	SD	D	A	SA
6. I might want to have psychological counseling in the future.	SD	D	A	SA
7. A person with an emotional problem is not likely to solve it alone; he or she <i>is</i> likely to solve it with professional help.	SD	D	A	SA
8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	SD	D	A	SA
9. A person should work out his or her own problems; getting psychological counseling would be a last resort.	SD	D	A	SA
10. Personal and emotional troubles, like many things, tend to work out by themselves.	SD	D	A	SA

Appendix E

INSTRUCTIONS: In this questionnaire, you will read statements about **your** attitudes towards seeking mental health services **for your children**. Please circle a response to each statement according to how you currently feel.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. If I believed my child was having a mental breakdown, my first inclination would be to get him/her professional attention.	SD	D	A	SA
2. The idea of my child talking about his/her problems with a psychologist strikes me as a poor way to get rid their emotional conflicts.	SD	D	A	SA
3. If my child were experiencing a serious emotional crisis at this point in their life, I would be confident that they could find relief in psychotherapy.	SD	D	A	SA
4. There is something admirable in the attitude of a person who is willing to let their child cope with his or her conflicts and fears <i>without</i> resorting to professional help.	SD	D	A	SA
5. I would want to get psychological help for my child if they were worried or upset for a long period of time.	SD	D	A	SA
6. I might want to have psychological counseling for my child in the future.	SD	D	A	SA
7. A child with an emotional problem is not likely to solve it alone; he or she <i>is</i> likely to solve it with professional help.	SD	D	A	SA
8. Considering the time and expense involved in psychotherapy, it would have doubtful value for my child.	SD	D	A	SA
9. A child should work out his or her own problems; getting psychological counseling would be a last resort.	SD	D	A	SA

Appendix E (Continued)

10. Personal and emotional troubles, like many things, tend to work out by themselves for my child.	SD	D	A	SA
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Appendix F

INSTRUCTIONS: Below are statements about various barriers or obstacles that prevent individuals from seeking mental health services **for themselves**. Please circle a response for each statement that best represents how **you** currently feel about seeking mental health services **for yourself**.

If you are not currently seeking mental health services for yourself, please respond to each statement as if you were seeking services for yourself.

Strongly Disagree
SD

Disagree
D

Agree
A

Strongly Agree
SA

	SELF			
	SD	D	A	SA
1. To get counseling or therapy for myself is too expensive.	SD	D	A	SA
2. I would have to travel too far to get these services.	SD	D	A	SA
3. Mental health services are not in my budget.	SD	D	A	SA
4. My health insurance would not cover this type of treatment.	SD	D	A	SA
5. I am not aware of any available services for myself.	SD	D	A	SA
6. There would not be an available therapist who shares my cultural background.	SD	D	A	SA
7. The hours that these services are available are not good for me.	SD	D	A	SA
8. It takes a lot of time to get an appointment to see a mental health professional.	SD	D	A	SA
9. The therapist would probably not deal with the issues I want to work on.	SD	D	A	SA
10. Whatever treatment a mental health professional could offer would probably not be of use to me.	SD	D	A	SA
11. If there were affordable and nearby services, I still doubt that I would use them.	SD	D	A	SA
12. I doubt that the quality of the services I would receive would be acceptable to me.	SD	D	A	SA

Appendix F (Continued)

13. Going to therapy would be like admitting I am a weak person.	SD	D	A	SA
14. I would not get the kind of help I want from a mental health professional.	SD	D	A	SA
15. I have talked to family members/friends who have had experiences with therapy, and this influenced me seeking therapy for myself (leave blank, if not applicable).	SD	D	A	SA
16. I went to a mental health professional in the past but it did not help (leave blank, if not applicable).	SD	D	A	SA
17. The therapist could not possibly understand my experience.	SD	D	A	SA
18. The therapist will not be the same race as me, so cannot be trusted.	SD	D	A	SA
19. I do not trust mental health professionals to help me.	SD	D	A	SA
20. The therapist would not really care about me, he/she is only in it for the money.	SD	D	A	SA
21. The therapist would probably not be trustworthy and would let others know my business.	SD	D	A	SA
22. I would think my problem would get better by itself.	SD	D	A	SA
23. I would be concerned about what others might think of me.	SD	D	A	SA
24. I would want to solve the problem on my own.	SD	D	A	SA
25. I would be scared about being put into a hospital against my will.	SD	D	A	SA
26. The therapist would treat me badly because of my race.	SD	D	A	SA
27. The therapist would treat me like a child because of my race.	SD	D	A	SA

Other Barriers

Please list other reasons (not listed above) that prevent you from seeking mental health services for yourself.

Appendix G

INSTRUCTIONS: Below are statements about various barriers or obstacles that prevent parents from seeking mental health services **for their children**. Please circle a response for each statement that best represents how **you** currently feel about seeking mental health services **for your child**.

If you are not currently seeking mental health services for your child/children, please respond to each statement as if you were seeking services. If you have more than one child, please respond for the child who might be most in need of services.

Strongly Disagree
SD

Disagree
D

Agree
A

Strongly Agree
SA

	CHILD/CHILDREN			
	SD	D	A	SA
1. To get counseling or therapy for my child is too expensive.	SD	D	A	SA
2. I would have to travel too far to get these services for my child.	SD	D	A	SA
3. Mental health services are not in my budget for my child.	SD	D	A	SA
4. My child's health insurance would not cover this type of treatment.	SD	D	A	SA
5. I am not aware of any available services for my child.	SD	D	A	SA
6. There would not be an available therapist who shares my child's cultural background.	SD	D	A	SA
7. The hours that these services are available are not good for my child.	SD	D	A	SA
8. It takes a lot of time to get an appointment for my child to see a mental health professional.	SD	D	A	SA
9. The therapist would probably not deal with the issues I want to work on for my child.	SD	D	A	SA
10. Whatever treatment a mental health professional could offer would probably not be of use to my child.	SD	D	A	SA
11. If there were affordable and nearby services, I still doubt that I would use them for my child.	SD	D	A	SA

Appendix G (Continued)

12. I doubt that the quality of the services I would receive would be acceptable for my child.	SD	D	A	SA
13. Going to therapy would be like admitting my child is a weak person.	SD	D	A	SA
14. I would not get the kind of help I want from a mental health professional for my child.	SD	D	A	SA
15. I have talked to family members/friends who have had experiences with therapy, and this influenced me seeking therapy for my child (leave blank, if not applicable).	SD	D	A	SA
16. My child went to a mental health professional in the past but it did not help (leave blank, if not applicable).	SD	D	A	SA
17. The therapist could not possibly understand my child's experience.	SD	D	A	SA
18. The therapist will not be the same race as my child, so cannot be trusted.	SD	D	A	SA
19. I do not trust mental health professionals to help my child.	SD	D	A	SA
20. The therapist would not really care about my child, he/she is only in it for the money.	SD	D	A	SA
21. The therapist would probably not be trustworthy and would let others know my child's business.	SD	D	A	SA
22. I would think my child's problem would get better by itself.	SD	D	A	SA
23. I would be concerned about what others might think of my child.	SD	D	A	SA
24. I would want to solve my child's problem on my own.	SD	D	A	SA
25. I would be scared about my child being put into a hospital against my will.	SD	D	A	SA
26. The therapist would treat my child badly because of my race.	SD	D	A	SA

Other Barriers

Please list other reasons (not listed above) that prevent you from seeking mental health services for your children.

Appendix H

Brief Symptom Inventory (BSI)

Instructions: Below is a list of problems people sometimes have. Please read each one carefully, and circle the number to the right that best describes **HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY**. Circle only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully.

0 = NOT AT ALL
1 = A LITTLE BIT
2 = MODERATELY
3 = QUITE A BIT
4 = EXTREMELY

HOW MUCH WERE YOU DISTRESSED BY:

1. Nervousness or shakiness inside	0	1	2	3	4
2. Faintness or dizziness	0	1	2	3	4
3. The idea that someone else can control your thoughts	0	1	2	3	4
4. Feeling others are to blame for most of your troubles	0	1	2	3	4
5. Trouble remembering things	0	1	2	3	4
6. Feeling easily annoyed or irritated	0	1	2	3	4
7. Pains in heart or chest	0	1	2	3	4
8. Feeling afraid in open spaces	0	1	2	3	4
9. Thoughts of ending your life	0	1	2	3	4
10. Feeling that most people cannot be trusted	0	1	2	3	4
11. Poor appetite	0	1	2	3	4
12. Suddenly scared for no reason	0	1	2	3	4
13. Temper outbursts that you could not control	0	1	2	3	4
14. Feeling lonely even when you are with people	0	1	2	3	4
15. Feeling blocked in getting things done	0	1	2	3	4
16. Feeling lonely	0	1	2	3	4
17. Feeling blue	0	1	2	3	4
18. Feeling no interest in things	0	1	2	3	4
19. Feeling fearful	0	1	2	3	4

Appendix H (Continued)

20. Your feeling being easily hurt	0	1	2	3	4
21. Feeling that people are unfriendly or dislike you	0	1	2	3	4
22. Feeling inferior to others	0	1	2	3	4
23. Nausea or upset stomach	0	1	2	3	4
24. Feeling that you are watched or talked about by others	0	1	2	3	4
25. Trouble falling asleep	0	1	2	3	4
26. Having to check and double check what you do	0	1	2	3	4
27. Difficulty making decisions	0	1	2	3	4
28. Feeling afraid to travel on buses, subways, or trains	0	1	2	3	4
29. Trouble getting your breath	0	1	2	3	4
30. Hot or cold spells	0	1	2	3	4
31. Having to avoid certain things, places, or activities because they frighten you	0	1	2	3	4
32. Your mind going blank	0	1	2	3	4
33. Numbness or tingling in parts of your body	0	1	2	3	4
34. The idea that you should be punished for your sins	0	1	2	3	4
35. Feeling hopeless about the future	0	1	2	3	4
36. Trouble concentrating	0	1	2	3	4
37. Feeling weak in parts of your body	0	1	2	3	4
38. Feeling tense or keyed up	0	1	2	3	4
39. Thoughts of death or dying	0	1	2	3	4
40. Having urges to beat, injure, or harm someone	0	1	2	3	4
41. Having urges to break or smash things	0	1	2	3	4
42. Feeling very self-conscious with others	0	1	2	3	4
43. Feeling uneasy in crowds	0	1	2	3	4
44. Never feeling close to another person	0	1	2	3	4
45. Spells of terror or panic	0	1	2	3	4
46. Getting into frequent arguments	0	1	2	3	4
47. Feeling nervous when you are left alone	0	1	2	3	4
48. Others not giving you proper credit for your achievements	0	1	2	3	4
49. Feeling so restless you couldn't sit still	0	1	2	3	4
50. Feelings of worthlessness	0	1	2	3	4
51. Feeling that people will take advantage of you if you let them	0	1	2	3	4
52. Feeling of guilt	0	1	2	3	4
53. The idea that something is wrong with your mind	0	1	2	3	4

Appendix I

Dear Sir/Madam,

Thank you for participating in this research study. As you recall, this study was about understanding how typical parents and their children use mental health services and the reasons why they use mental health services. Since some people wonder about where to receive services, this letter is being sent out to all participants regardless of their answers to the survey.

In case you are interested in seeking mental health services, we wanted you to know that most health insurance companies cover some type of mental health service. Therefore, you should first check with your insurance company to see what type of mental health services are covered, if any. Many insurance companies have a list of “preferred providers” from whom you should seek treatment. Sometimes they have certain rules that you need to follow (for example: they will pay for 70% of services from a licensed psychologist but not pay for a licensed mental health worker). Please get this information clarified with your insurance company if you are concerned about payment for mental health services.

If you do not have health insurance or if your health insurance does not cover mental health services, you may want to consider one of the following facilities in the Tampa Bay area (all of which have either low-fees or fees on a sliding scale):

Mental Health Care Near Hillsborough and 22 nd	(813) 272-2244
Northside Mental Health Center On Bruce B. Downs, near USF	(813) 977-8700
USF Psychological Services Center At USF in the Psychology Department	(813) 974-2496
Child and Family Counseling Hillsborough County	(813) 744-5953

If you do not live in the Tampa Bay area, consider using the “Find a Psychologist” referral service that is run through the American Psychological Association. This service can be accessed on-line (<http://locator.apahelpcenter.org>) or through a toll-free phone call (1-800-964-2000). In addition, most communities throughout the United States and Canada have a Community Mental Health Center, so a quick call to the local information center might help you gain access to the services in your community, if you are interested.

If you have any questions about this research study, please contact Idia Binitie, Department of Psychology, University of South Florida, 4202 E. Fowler Avenue., PCD 4118G, Tampa, FL 33620, 813-974-9222, ibinitie@mail.usf.edu. Thank you.

Sincerely,
Idia Binitie
Graduate Student