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Parental Mental Health Help-Seeking: Addressing Service Utilization
Disparities Across Ethnic Minorities

by

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Undergraduate honors thesis under the direction of

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Abstract

For youths, service use is dependent on the parent or caregiver's decision to seek mental health services. Due to this, there are significant disparities between the number of youths who display mental health concerns and the number of youths actually being treated (called the service gap). Likewise, ethnic minority youths exhibit higher rates of the service gap. Parental help-seeking behavior plays the largest role in whether a child receives mental health treatment, so this study contributes to the existing literature by investigating three questions: (1) differences in parent's help-seeking intentions based on race/ethnicity; (2) the association between religiosity and help-seeking intentions; and (3) the potential relationship between religiosity and stigma and its variance based on race/ethnicity. A sample of 289 parents of children between ages 4-17 participated in this study by taking a series of questionnaires and scales. Findings suggest that no differences exist between race/ethnicity on help-seeking intentions or stigma. Conversely, religious fundamentalism plays a role in determining help-seeking intentions, and there is a relationship between religious fundamentalism and stigma. As parents are the gateway in which children obtain mental health services, understanding what factors contribute to parents' willingness to seek help is essential in promoting service utilization and decreasing barriers to mental health services in order to reduce the service gap. Additional research is necessitated to better understand parental help-seeking behavior and how to best improve mental health equity.

Keywords: barriers, help seeking, mental health, service use, parent, youth

Parental Mental Health Help-Seeking: Addressing Service Utilization
Disparities Across Ethnic Minorities

In the United States, prevalence rates of mental illness in children and adolescents are on the rise and signify an important public health concern. For instance, rates of diagnosed depression among youth aged 6 to 17 increased from 5.4% in 2003 to 8.4% in 2012 (Bitsko et al., 2018). Approximately 1 in 5 adolescents aged 13 to 18 experiences a mental health disorder at some point during this developmental period; the estimate is 13% for children aged 8 to 15 (Merikangas et al., 2011). Depression and anxiety become more common as children age, with half of all chronic mental health disorders beginning by the age of 14 (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005). According to a recent study conducted by Whitney and Peterson (2019), they found that of the 46.6 million children included in their analysis, 16.5% had at least one mental health disorder. Of that number, 49.4% of children did not receive treatment.

Early intervention and treatment of mental health concerns are key to preventing the development of more severe, pervasive or intractable problems, such as poor academic performance or underachievement, disruption in social functioning and family relationships, substance use and abuse, and more (Costello, Copeland, & Angold, 2011; Turner & Liew, 2010). Service utilization for youths is largely dependent on the parent or caregiver, as they are the gateway through which children obtain health services. Because of this, there are disparities between the number of youths who display clinically significant mental health concerns and the number of youths actually being treated. This discrepancy between displayed mental health needs and service use is even bigger for racial/ethnic minority populations (hereafter ethnic minorities). Ethnic minority youths have the highest rates of unmet mental health needs (Hough

et al., 2002; Kataoka, Zhang, & Wells, 2002; Yeh, McCabe, Hough, Dupuis, & Hazen, 2003; Institute of Medicine, 2009). Since parents play a critical role in seeking professional help for their children, it is important to understand parental mental health help-seeking (MHHS) behavior, including factors that prevent or facilitate help-seeking, to develop methods to reduce disparities in mental health service utilization.

The Help-Seeking Pathway

General models of parental help-seeking have identified three important stages: (1) problem recognition; (2) decision to seek help; and (3) choosing the source of help (Cauce et al., 2002). Sometimes the act of accessing care is an additional fourth step in the help-seeking pathway (developed in a model by Srebnik, Cauce, & Baydar, 1996). A model of service access developed by Costello et al. (2011) defines two components of the problem recognition step: parent perception of the child's problems and parent perception of the intensity and suffering the child's psychopathology causes others, which they termed problem perception and family impact respectively. Cauce et al. (2002) notes that problem recognition can be assessed with two types of need: an epidemiologically defined need (e.g., mental health screening, clinical assessments, DSM diagnosis) or as perceived need (i.e., personal belief that someone has a mental health problem). Additionally, stage two, decision to seek help, can occur in two ways: coercive (e.g., referrals from schools or courts) or voluntary (influenced by personal perceptions and attitudes; Cauce et al., 2002).

Goldberg and Huxley's (1980, 1992) Pathways to Care model provides a framework for understanding how individuals navigate through the healthcare system, with five levels, each separated by a filter. According to Goldberg and Huxley's approach, problem recognition and referral are essential in accessing specialized care. Rogler and Cortes (1993) conceptualized a

help-seeking pathway as a sequence of events where individuals, prompted by their distress and their significant others' concerns, contact multiple organizations and service providers. They proposed that pathways occur in a linear direction and have specific durations (time lapses between help-seeking efforts). However, recent studies have found that the stages do not always occur in a linear pathway (Boulter & Rickwood, 2013; Farmer, Burns, Phillips, Angold, & Costello, 2003; Ford, Hamilton, Goodman, & Meltzer, 2005; Godfrey 1995; Logan & King, 2001; Pavuluri, Luk, & McGee, 1996; Reid et al., 2011; Shanley, Reid, & Evans, 2008; Zwaanswijk, Verhaak, Bensing, Van der Ende, & Verhulst, 2005). Parents tend to go through multiple pathways to access mental health services, most often through teachers and the primary care physician (Shanley et al., 2008).

Despite inconsistencies in research, there is evidence that the problem recognition stage is the most important, as it is strongly and positively correlated with willingness to seek help (Godoy, Mian, Eisenhower, & Carter, 2014; Oh and Bayer, 2015; Teagle, 2002; Thurston, Phares, Coates, & Bogart, 2015; Thurston et al., 2018). Zwaanswijk et al. (2003) found that problem recognition was greater for boys, older children, children of single parents, severity of the child's problems, a history of mental disorders, life events, and academic problems. Problem recognition has also been found to be correlated with the number of symptoms, parent's history of psychopathology, and parent income. Additionally, parents were more likely to recognize a problem if the child self-perceives a problem and ethnic minority parents were less likely than White parents to recognize a problem (Villatoro, 2018).

Predicting Help-Seeking

Theory of planned behavior. Once a parent believes that his/her child has a problem, the Theory of Planned Behavior (TPB; Ajzen, 1985, 1991) is a useful theory for understanding

and predicting a parent's intention to seek help. The theory posits that an intention to do something is a direct antecedent to engaging in the behavior. The development of a behavioral intention is determined by three factors: attitudes toward the behavior, subjective norms regarding the behavior, and perceived behavioral control to carry out the behavior (Armitage & Conner, 2000; Ajzen, 1985, 1991; Fishbein, Hennessy, Yzer, & Douglas, 2003). The first construct, attitudes, is the positive or negative beliefs the individual holds about performing the intended behavior. The second construct, subjective norms, is the approval or disapproval from important others of the individual regarding engagement in the behavior. The third construct, perceived behavioral control, refers to the individual's perception of how difficult the intended behavior is and whether they are capable of performing the behavior.

TPB is widely researched and has been applied across multiple disciplines. For example, research using the TPB in public health has predicted a variety of health behaviors, including but not limited to, help-seeking, healthy eating habits, and smoking cessation (Bohon, Cotter, Kravitz, Cello, & Garcia, 2016). TPB has also been used to examine how attitudes and subjective norms influence mental health help-seeking behavior in adults (Hobbs, Dixon, Johnston, & Howie, 2013; Turner, 2012). TPB can be used to help explore parents' intentions to seek mental health services for their children. In a recent study by Oh and Bayer (2017), they found that attitudes and subjective norms were significantly correlated to behavioral intention for help-seeking in parents. Results highlighted that parents' personal attitudes on seeking professional help highly predicted their help-seeking intentions. Specifically, parents who believed that seeking help was beneficial or necessary, were more likely to indicate an intention to seek mental health services.

Turner and colleagues (Turner, Jensen-Doss, & Heffer, 2015) also utilized the TPB in a study of parental attitudes and stigma on help-seeking intentions. Results showed that positive attitudes were correlated with an increased likelihood of help-seeking intentions for White parents, but not for Black or Hispanic parents. Generally, evidence seems to suggest a significant correlation between positive attitudes and help-seeking intention. Although the TPB explains a significant portion of the variance in help-seeking, across a large body of research it has been shown to account for only about 40 to 45% of the variance in behavioral intentions and 20 to 25% of the variance in behavior (see Long & Maynard, 2014). Therefore, it is important to consider other factors that may be contributors to parent help-seeking behavior.

Parent factors. Since parents' role in service use for their children is important, multiple characteristics of the parent have been found to be associated with help-seeking for their children. For instance, sociodemographic characteristics, family burden, parental attitudes and perceptions, perceived barriers, and social support have all been found to have an association with service utilization (Connor et al., 2010; Sayal et al., 2010; Teagle, 2002; Thurston et al., 2018; Turner et al., 2015; Zwaanswijk et al., 2003). Predisposing characteristics, such as sociodemographic factors (e.g., income, educational attainment, rurality, race/ethnicity) play an important role in determining willingness to seek help and these characteristics interact with other significant factors that influence help-seeking. In a study by Dempster and colleagues (Dempster, Davis, Jones, Keating, & Wildman, 2015), researchers used the likelihood of enrolling in a parenting class as a proxy for seeking mental health treatment. Results found that parents who had higher levels of educational attainment were more likely to enroll in parenting classes. Thurston et al. (2018) found similar results in that parents with higher levels of

socioeconomic status (SES), were more likely to seek mental health treatment than parents of low SES.

A history of mental illness in the family or the parent has also been found to be associated with likelihood of help-seeking on behalf of children. For example, Zimmerman (2005) found that children whose mothers have depression were more likely to receive treatment. Additionally, researchers found that the more adults in the household, the more likely the child will receive treatment, but the presence of a father decreased the probability of receiving treatment for depression. Similarly, in a study by Godoy et al. (2014), results highlighted that higher levels of parent depression and stress were correlated with help-seeking behavior for their children. Teagle (2002) and Villatoro et al. (2018) showed that family and parental history of psychopathology predicted problem perception, which in turn, determined help-seeking intention.

Parental attitudes and perceptions can have a large influence on help-seeking intentions (e.g., Alegría et al., 2004; Teagle, 2002; Turner et al., 2015; Villatoro et al., 2018). Oh and Bayer (2017) found that parent's belief that the problem will eventually go away by itself and that the child is capable of dealing with the problem by themselves are barriers to help-seeking. Other parent characteristics associated with help-seeking behavior include parent trust in professionals (Reardon et al., 2017), family resources (Reardon et al., 2017; Thurston et al., 2018), the nature or quality of the parent-child relationship (Flink, Beirens, Butte, & Raat, 2013; Teagle, 2002), and parental burden experienced as a result of their child's mental health issues (Alegría et al., 2004). The parent's culture also seems to have an influence on help-seeking behavior, as different cultures have varying beliefs about mental illness and how to address it (Lawton, Kapke, & Gerdes, 2016; Yeh et al., 2003).

Mental health stigma is one of the most researched parent contributors to help-seeking intentions. Evidence from multiple studies has revealed that stigma is one of the largest predictors of parental MHHS, with less parental stigma consistently found to be associated with greater MHHS (e.g., Gronholm et al., 2015; Raviv, Raviv, Propper, & Fink, 2003; Sayal et al., 2010; Thurston et al., 2018; Villatoro et al., 2018; Zwaanswijk et al., 2003). In two systematic reviews of barriers and facilitators that parents perceive to affect MHHS for their children, stigma was the most commonly reported barrier (Clement et al., 2015; Reardon et al., 2017). Studies have suggested that mental health stigma is more prevalent in racial and ethnic minorities than in White communities (Pham, Goforth, Castro-Olivo, & Costa, 2017).

Research has identified different types of mental health stigma as well as different associations between these types and MHHS. For example, in a study by Dempster et al. (2015), researchers examined three types of stigma—perceived public stigma, personal impact of stigma, and self-stigma—in a sample of urban, low-income African American parents. Perceived public stigma refers to a parent's perception about how people in the general public would react to the parent's child receiving mental health treatment. Personal impact of stigma refers to the degree to which the parent believes they or their child would be stigmatized by important others in their life, such as family and friends. Lastly, self-stigma refers to how the individual thinks of themselves negatively because of the need to seek treatment. Researchers used likelihood of enrolling in a parenting class as a proxy of seeking mental health treatment. Results showed that lower levels of self-stigma were correlated with a higher likelihood of enrollment and public stigma and impact of stigma were found to not be significantly correlated with likelihood of enrollment.

Turner et al. (2015) conducted a study on differences in stigma across White Americans, African Americans, and Hispanic Americans. Using the TPB, they assessed parental attitudes, mental health stigma, and ethnicity on parent's intentions to seek mental health treatment. Results showed that there was a significant relationship between ethnicity and help-seeking attitudes. African Americans reported fewer positive attitudes and more stigma than White Americans and Hispanic Americans, while no other group differences were significant. Furthermore, Hispanic Americans with higher reported stigma were less likely to seek help; this effect was not found to be significant in White and African American parents. The aforementioned studies emphasize the importance of assessing the attitudes and stigma and the impact they have on parental MHHS in ethnically diverse samples.

Overall, parent factors that have been consistently found in past research to be related to parental MHHS include: SES, educational attainment, history of psychopathology, attitudes and perceptions, stigma, and race/ethnicity. Consistent across the literature is ethnic minority parents' higher or differing threshold for recognizing something as a mental health problem and underutilization of mental health services for their children. Many studies have suggested that race/ethnicity alone does not significantly influence MHHS behavior, but it is a collection of interacting variables that does so. Taken together, this reveals a need for further exploration of sociocultural variables that may influence parents' MHHS behavior.

Child factors. The characteristics of the child influence parental recognition of psychopathology and thus, help-seeking intention. Zimmerman (2005) found evidence for several variables that contribute to the likelihood of treatment. Children who attend a private school were more likely than public school children to receive treatment. African American

children were less likely to receive treatment compared to White children. The middle child was less likely to receive treatment and girls were also less likely to receive treatment.

In a sample of Latino caregivers, caregivers were more likely to seek mental health care for male children and if their children presented problems in school, such as poor academic performance, not completing homework on time, and conduct problems (being suspended or expelled; Alegria et al., 2004; also see Zwaanswijk et al., 2003). Furthermore, parents were more likely to recognize and consequently seek help if the child displayed externalizing problems compared to internalizing problems (Alegria et al., 2004; Brannan, Heflinger, & Foster, 2003; Dempster, 2013; Godoy et al., 2014; Thurston et al., 2015). Contrary to these findings, Raviv et al. (2003) did not find any differences between help-seeking for internalizing and externalizing problems. Other characteristics found to be central to parental help-seeking include illness profile factors, such as type of problem, problem severity or persistency (Boulter & Rickwood, 2013; Dempster et al., 2015; Dempster, Wildman, & Keating, 2013; Godoy et al., 2014; Pham et al., 2017; Teagle, 2002; Zwaanswijk et al., 2003).

External barriers and facilitators. There are structural (or practical) barriers that can prevent parents from seeking mental health services. Evidence has indicated that the following structural barriers can be particularly problematic for parents: limited time, lack of transportation, lack of insurance, expensive costs of services, and lack of accessibility (for rural communities; e.g., Clement et al., 2015; Girio-Herrea, Owens, & Langberg, 2013; Gulliver, Griffiths, & Christensen, 2010; Reardon et al., 2017; Thurston et al., 2018). Additionally, a poor service provider environment, feelings of not being listened to, feelings of being blamed, lack of knowledge about available mental health services, belief that treatment is unhelpful and unnecessary, and perceived lack of confidentiality are all barriers of parental help-seeking

(Clement et al., 2015; Gulliver et al., 2010; Reardon et al., 2017). Furthermore, minority populations have revealed that language or cultural barriers serve to prevent MHHS (Reardon et al., 2017). In a systematic review by Gulliver et al. (2010) and Reardon et al. (2017), facilitators identified to help-seeking include: positive past experiences with help-seeking, social support, having a trusting and positive relationship with healthcare professionals, and assurances regarding confidentiality.

Summary. As past research has shown, there are many components that play a crucial role in determining parental MHHS behavior. Significant predictors of parent's willingness to seek help from the literature include parents' race/ethnicity, history of psychopathology or symptom severity, attitudes and perceptions, stigma, perceived structural barriers, child's age and gender, SES, and educational attainment. These factors all interact with one another, inhibiting parents from seeking mental health services for their child. Conclusively, research demonstrates that White parents, residents of urban areas, and families of high SES seek mental health services from professionals most often (Logan & King, 2001; Zwaanswijk et al., 2003). In addition, negative attitudes and stigma about seeking mental health services have been shown to be the most influential factor of parental help-seeking (Oh & Bayer, 2017; Reardon et al., 2017; Thurston et al., 2018). Furthermore, TPB is useful in helping researchers predict help-seeking intention, and many important factors that have been shown to display a consistent impact throughout the literature are reflected in the TPB. For instance, attitudes, subjective norms via public stigma, and perceived behavioral control via parent's perceived barriers to treatment. Thus, it is necessary to build upon the current literature to reveal the unique and potentially significant ways sociocultural variables contribute to parental MHHS. Revealing these contributions may help more fully illuminate MHHS and related factors across all parents.

Formal and Informal Sources of Help

While parental recognition of their child's mental health problems is an important contributing factor to help-seeking behavior, so are where and whom they seek help from, as these sources are crucial in determining initial engagement and whether care is continued. In a study from Boulter and Rickwood (2013), it is found that parents often seek informal help after they receive a formal diagnosis for their child. Thurston et al. (2018) examined variables that contributed to White and African American parents' intentions to seek formal and informal help for children's internalizing and externalizing symptoms. Formal resources of help included: pediatricians, family doctor, psychologists, and teachers. Informal resources of help included: religious leaders, family members, friends, co-workers, and self-help books/internet guides. Results from this study suggest that high SES parents have an increased likelihood of seeking formal help for their children compared to low SES parents. In addition, African American parents were more likely to seek help from religious leaders, while White parents were more likely to seek help from self-help resources. Moreover, parents with high levels of religiosity were more likely to seek help from religious leaders as opposed to seeking help from mental health professionals (Thurston et al., 2018).

In a sample of parents in rural communities with kindergarten aged children, Girio-Herrera et al. (2013) found that parents sought informal help more often than professional help; but amongst professionals, parents were more likely to seek help from medical doctors and school staff, while spouses and relatives provided the most common informal help. Evidence from Zwaanswijk et al. (2003) suggested that in ethnic minority groups and cultures, informal sources of help were most often relied upon. Flink et al. (2013) interviewed mothers of Dutch, Moroccan and Turkish ethnic backgrounds in the Netherlands on their help-seeking behavior for

their adolescent girls with internalizing problems. Consistent with Zwaanswijk et al., researchers found that the mothers from ethnic minority backgrounds preferred using informal care to support their daughters and were hesitant of using formal resources. Further research finds that parents do not seek help from mental health professionals due to expensive costs of treatment (Raviv et al., 2003).

Current Study

Much insight has been gained through previous research on factors that contribute to parents' MHHS for their children. However, these studies are not without limitations. For instance, there is a dearth of research examining the influence of sociocultural variables, such as religiosity, and their relationship to MHHS. In relation, investigations between sociocultural variables and parents' mental health stigma have largely been ignored. Most notably, there is a need for more diverse ethnic minority samples in the literature in order to examine help-seeking behavior across ethnicities and identify additional contributing factors that may be unique to ethnic minority parents. Thus, more research is necessary to gain a full understanding of factors influencing parents' MHHS, especially to shed light on why ethnic differences exist and why ethnic minorities tend to underutilize mental health services. Research has well established the primary role parental help-seeking has on whether a child receives treatment, so this study contributes to the existing literature in three critical ways. First, this study examines whether there were differences in parents' MHHS based on race/ethnicity. Second, this study examines whether religiosity is correlated with parents' MHHS. Finally, this study investigates the association between religiosity and parents' perceived stigma related to MHHS and, if present, determines if this relationship varies based on race/ethnicity.

Previous research has demonstrated that differences exist between parents' MHHS behavior across race/ethnicity (Lawton et al., 2016; Pham et al., 2017; Turner et al., 2015), so it was hypothesized for research question one that ethnic minority parents will exhibit lower levels of help-seeking intent compared to White parents. For research question two, it was hypothesized that parents who display higher levels of religiosity (religious fundamentalism and religious commitment) will be less likely to seek help for their child's mental health problems from a relevant professional. Lastly, for the final research question, it was hypothesized that higher religiosity will be associated with higher perceived MHHS stigma. This is hypothesized because past studies have indicated that adults who have higher levels of religiosity had more negative attitudes towards MHHS and were less likely to seek help from mental health professionals (Abe-Kim, Gong, & Takeuchi, 2004; Darroch, 2011; Hathaway, 2005).

Method

Participants

Prior to conducting the study, a power analysis was used to determine the approximate sample size needed to detect a small (effect size input $f^2 = .10$) or moderate (effect size input $f^2 = .15$) effect in maximum likelihood at the .05 level of significance (80% chance). Based on this power analysis, a minimum range of 100 to 150 biological or adoptive parents were needed. Eligibility criteria for this study included being proficient in English, having at least one child between the ages of 4-17, and living with one's child or children for 50 percent of the time or greater. Also, no more than one parent from the same family could participate to avoid the nesting of data. No additional eligibility criteria were used for this study.

Participants were comprised of 289 parents (mothers: 77.9%, $N = 225$; fathers: 19.7%, $N = 59$; neither, guardian/primary caregiver: 2.4%, $N = 7$) aged 21-63 years old ($M = 39.48$, $SD =$

7.80). The majority of participants were married or in a committed domestic partnership, 82.4%; 10.4% were single, never married; 6.2% were divorced/separated; and 1% were widowed. Over forty percent (44.6%) of parents identified as White ($N = 129$), and 55.4% identified as a member of an ethnic minority group ($N = 160$). In regard to generational status, the majority of participants were third generation or higher, 57.3%; 15.7% were second generation, and 26.9% were first generation. Parents had an average of 4.10 ($SD = 1.27$) members living in their household, with an average of 1.88 children living in the home ($SD = .89$), and an average of 2.21 ($SD = .82$) adults. Participants' educational background included 0.7% who had completed less than high school, 7.3% who had completed high school/GED, 16.8% who had some college but no degree, 9.4% who had an associate's degree, 36.7% who had a bachelor's degree, 16.4% who had a master's/specialist degree, and 12.6% who had a doctorate/professional degree. One hundred and seventy-three parents (59.86%) reported that someone in their immediate family has sought out or received mental health services in the past and that it was helpful (to some degree). For an overview of the sample demographic information, including a breakdown of ethnic minority groups, see Table 1.

Design

The research design of this study is non-experimental and a correlational study. Given that the main predictor variables of interest are sociocultural variables (e.g., race/ethnicity, religiosity), no variable manipulation was possible. The main study variables included: willingness to seek mental health help, stigma related to mental health help seeking, religiosity, and race/ethnicity.

Procedures

Data were gathered as part of a larger project on ethnic minority treatment seeking. A community sample of parents was solicited through three methods of recruitment: in-person, email/social media, and Prolific. In-person recruitment was community-based and included solicitation at parent-focused community events, community organizations or stores (e.g., religious organizations, public libraries, the mall, grocery marts), and researchers' contacts. Social media recruitment included online parent forums, social media platforms (e.g., Facebook), and direct invitation via email (including the snowball method, in which parents who participated invite other parents to participate). Lastly, an online crowdsourcing platform, Prolific, was used due to the diversity of its survey sample panels. Prolific enables fast, reliable, and high-quality data collection from various parties based on the exclusion and inclusion parameters set.

Participants who were recruited in-person completed the paper and pencil version of the survey, while those recruited through email/social media and Prolific were directed to a parallel online version through Qualtrics. To incentivize participation, parents who completed the survey in-person were given \$5. Participants invited through email or social media had the option to be entered into a raffle to win a \$5-\$10 gift card. Lastly, participants recruited through Prolific received approximately the minimum wage hourly rate for their time. All parents recruited in-person were provided a brief overview of the study's purpose and the consent form that described the study's purpose and procedures in more detail. Parents completing the surveys online also reviewed the same consent form and were made aware that beginning the study is confirmation of their consent. The study was completely anonymous and took an estimated time of fifteen minutes. Although, the completion time varied by the participant.

Measures were questionnaires and scales that gathered necessary information concerning parent background, child emotional and behavioral problems, parental attitudes towards MHHS,

barriers preventing treatment-seeking, and degree of parent religious commitment and fundamentalism. The survey was compiled into three sections: (1) Participant background information; (2) Mental health and help-seeking; and (3) Cultural and religious engagement and beliefs. Section one included the demographics questionnaire. Section two included a question about previous mental health services, the Strengths and Difficulties Questionnaire (SDQ), Parental Attitudes Toward Psychological Services Inventory (PATSPI), and Barriers to Treatment Participation Scale (BTPS). The last section included a question on participants' religious affiliation, the Religious Commitment Inventory (RCI-10), and the Religious Fundamentalism Scale (RFS-12). To ensure that no other measure would influence how parents rated their own child's behavior, the SDQ was administered immediately after gathering demographics. After parents thought about their child's behavior, they could begin thinking about treatment-seeking that could be related to their child's behavior, hence the order of PATSPI and BTPS following SDQ, respectively. The last measures were the cultural items (RCI-10, and RFS-12 in this order) to avoid priming participants to race or related cultural factors that would then impact how they would think about treatment-seeking. This was the standard order across all platforms of data collection for consistency.

Measures

Section One: Participant Background Information.

Demographics. A demographics questionnaire was developed for this study and gathered information on the following characteristics of the participant: age, gender, marital status, relationship to their child/children, educational attainment, partner/spouse's educational attainment (if applicable), race/ethnicity, generational status, number of household members, and what languages are spoken at home.

Section Two: Mental Health and Help-Seeking. Consistent with previous related research, to account for familial history of past mental health help-seeking, a question at the beginning of this section asked the participant: Has anyone in your immediate family (including yourself, spouse/partner, or children) ever sought out or received mental health services in the past? (i.e., contacted a medical or mental health professional for help regarding a behavioral concern or emotional distress). Response choices included: no; yes, but not at all helpful; yes, somewhat helpful; yes, very helpful. At the end of section two, before beginning onto the next section, participants were asked if they had any other comments about seeking help for their child/children.

Strengths and Difficulties Questionnaire. The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) is a brief 25-item measure of emotional and behavioral problems of children 4 to 17 years old. Parents were asked to think about their most difficult child and rate items on a scale of 1 to 3 (i.e., not true, somewhat true, and certainly true). Five items were reverse coded. The measure consists of five subscales: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behavior. The total score of the first four subscales is used to identify the presence and severity of emotional and behavioral problems. The measure has demonstrated adequate test-retest reliability and internal consistency, with a mean Cronbach's alpha score of .73 (Goodman, 2001). Additionally, the SDQ has been used successfully across several different cultures. The SDQ also has an impact supplement (Goodman, 1999), which asks whether the parent thinks their child has a problem and if so, rate the chronicity, distress, social impairment, and burden to others. The items on distress and impairment are totaled for the impact score, ranging from 0 to 10. The questions on chronicity and burden to others are not included in the impact score. If the participant answered 'no' on the

first question of the impact supplement (“Overall, do you think that your child has difficulties in one or more of the following areas...”), they do not perceive their child has having any emotional or behavioral difficulties and were asked to not complete the following questions on subsequent distress and impairment. The internal consistency for this measure in this study has a Cronbach’s alpha of .73.

Parental Attitudes Toward Psychological Services Inventory. The Parental Attitudes Toward Psychological Services Inventory (PATSPI; Turner, 2012) consists of 21 items scored on a Likert scale from 0 (*strongly disagree*) to 5 (*strongly agree*). The measure has three subscales which correspond with three key variables of interest for this study: help-seeking intentions (extent to which the parent is willing and able to seek professional help), help-seeking attitudes (beliefs the parent has about seeking professional psychological help), and stigmatization (extent to which the parent is concerned about how others perceive them for seeking mental health services). Internal consistency for the total scale and subscales (help-seeking intentions, help-seeking attitudes, and stigmatization) has been shown in previous research to be adequate at .90, .70, .88, and .89, respectively. The measure has also shown good internal consistency across ethnic groups. High scores on each subscale means (a) higher probability of seeking mental health services, (b) more negative attitudes about help-seeking, and (c) more stigma towards help-seeking. Cronbach’s alpha for the total scale and subscales (help-seeking intentions, help-seeking attitudes, and stigmatization) for this study demonstrated scores of .75, .77, .77, and .81, respectively.

Structural Barriers. To account for structural barriers that may prevent parents from seeking professional help, Subscale I, Stressors and Obstacles that Compete with Treatment, was taken and used from the Barriers to Treatment Participation Scale (BTPS; Kazdin et al., 1997).

Subscale I comprises of 20-items that are related to events that interfere with parent's mental health service utilization for their child, such as conflict with significant other, conflict with the parent's job, personal or family illness, and other stressors that frequently interfere in families' abilities and desire to seek treatment. This 20-item subscale is scored on a 5-point Likert scale that ranges from 1 (*totally disagree*) to 5 (*totally agree*). The alpha coefficient for the total scale is .94. Higher scores indicate higher perceived barriers to mental health service use. The Cronbach's alpha of this scale for this study is .91, demonstrating excellent internal consistency.

Section Three: Cultural and Religious Engagement and Beliefs. Before beginning the first measure of this section, participants were asked to identify their religious affiliation or identify as nonaffiliated. If participants indicated that they were atheist or unaffiliated with a religion, then they were asked to omit the Religious Commitment Inventory and move on to the Religious Fundamentalism Scale.

Religiosity. To measure parents' religiosity, the Religious Commitment Inventory (RCI-10; Worthington et al., 2003) and the Religious Fundamentalism Scale (RFS-12; Altemeyer & Hunsberger, 2004) were used. Religious commitment is defined as the degree to which an individual follows their religious values, beliefs and practices and integrates them into their daily activities. The RCI-10 is a measure consisting of 10 items on a Likert scale, ranging from 1 (*not at all true of me*) and 5 (*totally true of me*). Higher scores indicate higher levels of religious commitment and involvement. The measure has also shown good internal consistency and test-retest reliability in previous research, with a Cronbach's alpha of .93. The internal consistency for this particular study has a Cronbach's alpha score of .96.

Religious fundamentalism refers to the belief that one religion or set of ideologies contains the essential truth and that this truth must be followed (or strictly adhered to). The RFS-

12 consists of 12 self-reported items, half of which are reverse coded to control for response bias. Ratings are on a 9-point Likert scale, starting from -4 (*very strongly disagree*) to +4 (*very strongly agree*). Lower scores indicate low fundamentalism, while higher scores indicate high fundamentalism. This measure was revised from the original 20 item RFS and demonstrates a high internal consistency with an alpha coefficient of .91. The Cronbach's alpha for this study demonstrates excellent internal consistency, with a score of .95.

Data Analysis

To examine research question one (Are there differences in parents' willingness to seek help based on race/ethnicity?), an independent sample t-test was used to compare differences in mean levels of help-seeking intent across racial/ethnic groups. The t-test was nondirectional, with an alpha level set at .05. Assumptions of normality and homogeneity of variance were assessed. Normality assumes that the scores are normally distributed, and homogeneity of variance assumes that the variances of the groups are equal. The grouping variable was race/ethnicity (i.e., White or ethnic minority group, given that research suggests all U.S. racial/ethnic minority groups underutilize services in comparison to White Americans) and the test variable was parent help-seeking intentions (as measured by the help-seeking intentions subscale of the PATSPI; Turner, 2012).

In order to assess research question two (Is religiosity associated with willingness to seek help?), we looked at the correlation between the variables religiosity and willingness to seek help. A multiple linear regression was used for this purpose to control for other variables that might account for any association. First, covariates were identified for inclusion in the regression model based on previous research and the use of a correlation matrix. Second, the standard method—the simultaneous forced entry method—was used in the regression analysis. This

method enters all predictor variables (i.e., religiosity and other relevant covariates) simultaneously into the regression model. Assumptions of linearity, homoscedasticity, and multicollinearity were assessed. Linearity assumes that there is a linear relationship between the outcome variable and predictor variables and homoscedasticity is the assumption that there is an equal variance of scores along the regression line. No multicollinearity assumes that predictor variables are not highly correlated with each other. Multicollinearity was assessed using the correlation matrix, as well as through the data output of the regression analysis. The F-test of overall significance was used to assess whether the predictor variables contribute significantly to the variance observed in the outcome variable (i.e., willingness to seek help). R-squared, the coefficient of determination, was used to determine how much variance in the outcome variable is explained by the predictor variables. Additionally, results from the multiple regression were explored to determine whether religiosity makes a significant independent contribution to the variance observed in parent willingness to seek help.

Lastly, a hierarchical regression analysis was conducted for the final research question (Is there a relationship between religiosity and perceived stigma? If so, does this relationship vary based on race/ethnicity?). A hierarchical regression allowed us to examine the relationship between religiosity and perceived stigma while controlling for potential confounding variables, permitting a test of our moderational hypothesis. First, a correlation matrix was performed to determine the specific covariates that should to be added into the regression analysis. Second, the hierarchical regression was conducted. The dependent (outcome) variable in this analysis is stigma (as measured by the stigmatization subscale of the PATSPI; Turner, 2012). The predictor variables were entered in three Steps: (1) covariates that research suggest are significantly and meaningfully associated with stigma, such as relevant study and demographic variables from the

correlation matrix; (2) the main effects of religiosity on perceived stigma; and (3) the interaction of religiosity and race/ethnicity on perceived stigma. This strategy ensured that effects at Step 3 cannot be attributed to the variance shared with variables in Steps 1 and 2 (Cohen & Cohen, 1983). The nature of a significant interaction was to be probed by following guidelines outlined in Cohen & Cohen (1983). Assumptions of regression—linearity, homoscedasticity and multicollinearity—were assessed.

Results

An independent sample t-test revealed that there were no statistical differences between White parents' ($M = 20.89$, $SE = 0.38$) and ethnic minority parents' ($M = 20.12$, $SE = 0.38$) help-seeking intentions, $t(256) = 1.43$, $p = 0.16$, $d = 0.18$ (95% CI [-0.29, 1.82]). Levene's test indicated unequal variances ($F = 4.05$, $p = 0.045$), so degrees of freedom were adjusted from 260 to 256. A further analysis included only those parents who perceived their child as having a problem (as measured by the SDQ Impact Supplement question, "Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get along with other people?"). An independent sample t-test compared White ($N = 81$, $M = 20.93$, $SE = 0.44$) and ethnic minority ($N = 89$, $M = 19.93$, $SE = 0.51$) parents who indicated that they perceived their child as having a problem and again revealed no statistically significant difference in help-seeking intentions, $t(166) = 1.47$, $p = 0.14$, $d = 0.22$, 95% CI [-0.34, 2.33]. Degrees of freedom were adjusted from 168 to 166, since Levene's test indicated unequal variances ($F = 4.74$, $p = 0.031$). A final independent sample t-test included of parents who not only perceived their child as having a problem, but also their SDQ Impact Supplement scores indicated that their child has high distress and social impairment (SDQ Impact score of 2-10). Analyses compared White parents ($N = 58$, $M = 20.91$, $SE = 0.49$) and ethnic minority parents

($N = 47$, $M = 19.70$, $SE = 0.74$), again revealing no statistical significance between help-seeking intentions, $t(83) = 1.36$, $p = 0.18$, $d = 0.2$, 95% CI [-0.56, 2.98]. Levene's test indicated unequal variances, so degrees of freedom were adjusted from 103 to 83, ($F = 5.99$, $p = 0.016$).

A multiple linear regression was conducted to investigate whether religiosity and other relevant covariates could predict help-seeking intentions. A correlation matrix was conducted to identify covariates to be included in the regression. Predictor variables included: gender, race, generation status, structural barriers, help-seeking attitudes, stigmatization, religious commitment, religious fundamentalism, and past MHHS. The results of the regression indicate that the model explains 26% of the variance, and the overall model is a significant predictor of help-seeking intentions, $F(9, 186) = 7.25$, $p < 0.01$. Help-seeking attitudes ($B = -.147$, $p = .009$, 95% CI [-.257, -.038]), structural barriers ($B = -.078$, $p = .001$, 95% CI [-.123, -.034]), and religious fundamentalism ($B = -.028$, $p = .046$, 95% CI [-.055, -.001]) significantly contributes to the model; while religious commitment ($B = .058$, $p = .053$, 95% CI [-.001, .118]) contributes a marginally significant amount. The results of the regression analysis can be found in Table 2.

Lastly, a hierarchal regression was conducted to examine the relationship between religiosity and perceived stigma, and whether there is an interaction based on race/ethnicity. Based on the correlation matrix used previously, predictor variables were entered in three steps: (1) gender, race, generation status, past MHHS, structural barriers, help-seeking intentions, help-seeking attitudes; (2) all variables in step one, including religious fundamentalism; (3) all variables in step two, including the interaction of religiosity (RFS-12) and race/ethnicity on stigma (PATSPI stigmatization subscale). The results of the first step of the model was revealed to be statistically significant, $F(7, 239) = 21.31$, $p < 0.01$. Furthermore, the R^2 value of .384 associated with this model suggests that the predictor variables account for 38.4% of the variance

in stigmatization. In this step, help-seeking attitudes ($B = .521, p < .001, 95\% \text{ CI } [.393, .649]$), and structural barriers ($B = .108, p = .001, 95\% \text{ CI } [.046, .171]$) contributes significantly to the model. For the second step, religious fundamentalism was added to the analysis, and results also were revealed to be statistically significant, $F(8, 238) = 20.66, p = .001$. The R^2 value explains 41% of the variance for the overall model, with the inclusion of religious fundamentalism accounting for an additional 2.6% of the variance. In this step, help-seeking attitudes ($B = .502, p < .001, 95\% \text{ CI } [.376, .628]$), structural barriers ($B = .113, p < .001, 95\% \text{ CI } [.051, .174]$), and religious fundamentalism ($B = .038, p = .001, 95\% \text{ CI } [.015, .061]$) contributes significantly to the model. In the last step, the interaction of religiosity and race was added to the model. The overall model revealed to be statistically significant, $F(9, 237) = 18.32, p < 0.01$. However, the interaction was not significant, $B = .009, p = .702, 95\% \text{ CI } [-.038, .057]$. See Table 3 for further details.

Discussion

This study aimed to understand further factors that contribute to parents' MHHS intentions by investigating help-seeking attitudes, stigma, and religiosity in a sample of diverse parents in the United States. Whether a child receives mental health treatment for their emotional or behavioral difficulties is largely dependent on the parents' decision; however, there exists a variety of barriers that hinders parents from seeking mental health services. This study investigated several factors that have been deemed as relevant contributors to parents' help-seeking behavior, such as stigma, attitudes, ethnicity, gender, and lastly, religiosity, a variable that presents little research in the literature. The current study utilized the Theory of Planned Behavior (Ajzen, 1985, 1991), including three constructs pertaining to the theory: attitudes toward the behavior (measured by the PATPSI subscale, help-seeking attitudes), subjective

norms (measured by the PATPSI subscale, stigmatization) and perceived behavioral control (measured by BTPS) to investigate MHHS intentions and religiosity in parents.

The results of this study support previous research that people with higher levels of religiosity tend to have fewer positive attitudes towards help-seeking and were less likely to obtain mental health services (Abe-Kim et al., 2004; Darroch, 2011; Hathaway, 2005). Furthermore, it is consistent with previous findings that stigma is a crucial MHHS determinant (Gronholm et al., 2015; Thurston et al., 2018; Villatoro et al., 2018). In the current sample, higher levels of religious fundamentalism were positively correlated with more negative attitudes and stigma towards MHHS. Likewise, in the regression analyses, religious fundamentalism explains a significant variance in help-seeking intentions and stigma ($p = .046$ and $p = .001$, respectively). As religious fundamentalism decreases, help-seeking intentions increases. Moreover, though religious commitment contributes only a marginal amount of variance ($p = .053$), regression analysis suggests that as religious commitment increases, so does help-seeking intentions. In contrast, as religious fundamentalism increases, so does stigma towards MHHS. Religious commitment is the degree to which an individual actively participates in their religious values, beliefs, and practices in their daily lives, while religious fundamentalism is the degree to which an individual strictly conforms to one set of religious teachings or ideologies that they believe holds the sole fundamental truth. To an extent, religious commitment can have a positive impact on psychological adjustment, though there is evidence suggesting nonsignificant or negative effects as well (Chen & Koenig, 2006). Moreover, individuals who are more involved in their faith may have additional social networks, hence the benefits of more social support (Ellison, Hummer, Burdette & Benjamins, 2010; Musick, Blazer, & Hays, 2000). The benefits of social support have been widely studied and there is evidence indicating that

social support can serve as a protective factor by enhancing resilience, and maintaining physical and psychological health (Ozbay, Johnson, Dimoulas, Morgan, Charney, & Southwick, 2007). Likewise, social support has a positive association with parental service utilization for their children, as it gives parents encouragement and assistance to actively seek mental health services (Gulliver et al., 2010; Oh & Bayer, 2017; Zwaanswijk et al., 2003). Due to these differences in religious commitment and fundamentalism, this may explain the divergent findings between the two measures of religiosity and their relationship with parental MHHS.

In addition, structural barriers play a large role in not only predicting help-seeking intentions, but also stigmatization, and MHHS attitudes. Correlational results indicate that the more perceived structural barriers an individual reports, the more negative help-seeking attitudes, and stigmatization. Even more noteworthy is that more structural barriers are also significantly correlated with higher SDQ scores. For the SDQ questionnaire, parents were asked to refer to their most difficult child when responding. The SDQ measures behavioral and emotional difficulties and the extent to which the child presents a problem and the severity of it (higher scores indicate more problem severity). So, in other words, parents with more perceived structural barriers (e.g., lack of time or transportation) tend to report that their child has a higher severity of behavioral and emotional problems. As analyses have revealed, more structural barriers suggest more negative attitudes and stigma, thus fewer help-seeking intentions. This is consistent with previous research that indicated that structural barriers prevent parents from seeking mental health services (Clement et al., 2015; Gulliver et al., 2010; Reardon et al., 2017). However, this is discrepant from previous research that suggests a positive association between symptom severity and help-seeking, such that a higher endorsement of symptoms is associated with a stronger intent to seek professional help (Boulter & Rickwood, 2013; Dempster et al.,

2015; Godoy et al., 2014; Teagle, 2002; Zwaanswijk et al., 2003). Although, the relationship between structural barriers and the child's problem severity is merely correlational, thus other contributing variables were not accounted for.

With regard to race/ethnicity differences, results were not as hypothesized. Despite disparities in mental health service utilization by ethnic minority parents for their children, there were no group differences between MHHS. In fact, White parents and ethnic minority parents displayed near identical levels of help-seeking intentions. Likewise, when comparing racial/ethnic majority versus minority parent differences in MHHS for only those parents who perceived their child as having a problem, scores between the two groups were equally similar, suggesting that White parents and ethnic minority parents are comparable in help-seeking intentions. Furthermore, when analyzing whether an interaction of race/ethnicity exists on religiosity and stigma, race/ethnicity did not appear to make a difference. These results contradict previous studies, in which researchers discovered that ethnic minority parents tended to have more stigma toward MHHS, and lower help-seeking intentions compared to their White counterparts (Pham et al., 2017; Turner et al., 2015). However, these results may be due to an unquantifiable degree of selection bias for ethnic minorities in which those included in the present sample may be less representative of the target population than was the case for White parents in the sample. Although ethnic minorities are less likely to participate in research in general, it is possible that the sample in this study was more biased towards those who would seek support given that they were aware of the nature of the study. Additionally, there were differences in the numbers of parents who were recruited through each of the recruitment source (in-person, email/social media, Prolific). A majority of ethnic minority parents were recruited through Prolific (43.75%), followed by email/social media (33.75%), and then in-person

(22.5%). For White parents, most were recruited through email/social media (54.26%), followed by in-person (40.31%), then Prolific (5.43%). Thus, the sample might have been more diverse if it was less reliant on online recruitment through social media or Prolific.

Strengths and Limitations

This study enriches the literature by exploring mental health help-seeking disparities in ethnic minority groups, specifically evaluating the effects of help-seeking attitudes, stigma, and religiosity. By investigating the various combined influences (stigma, attitudes, religiosity, gender, generation status, structural barriers, etc.) in ethnic minority groups, the current study provides evidence of the intricacy that is involved in examining mental health disparities and help-seeking behaviors. Likewise, given the limited amount of studies on the impacts of religiosity in help-seeking behavior, this study adds onto the existing literature by providing additional data on the effects of religious fundamentalism. Given the important findings of this study relating to religiosity in parents, future studies should further explore sources of help and its variance on help-seeking intentions and religious factors. Most specifically, help-seeking from religious leaders, as the literature has suggested that African American parents often seek help from religious leaders and that parents of high levels of religiosity are more likely to seek help from religious leaders versus professionals (Thurston et al., 2018).

Although this study has important contributions to the literature, there are some limitations that merit consideration. The current study was limited to using the U.S. Census' broad racial categories for gathering data on ethnic minorities. So, differentiations between subcultures were not accounted for, if any. Likewise, the current study contains a larger sample of Asians and Asian Americans compared to other ethnic minority groups (e.g., Hispanic/Latinos). Thusly, future studies comparing data of more representative samples of

subcultures would be informative in further exploring MHHS across various ethnic minority groups. Despite this, notably, a post hoc exploratory investigation of MHHS differences between the broad pan-ethnic groups represented in this study's sample did not reveal differences.

Although, it is possible that ethnicity may interact with other relevant contributors that were not examined in the present study. For instance, formal and informal sources of help, parent's history of psychopathology, trust in professionals, and parent-child relationship, to name a few. Future research should consider assessing those factors, particularly formal and informal help, and trust in professionals. Past research has indicated that ethnic minorities are more likely to use informal help and have more medical mistrust (Girio-Herrera et al., 2013; Reardon et al., 2017; Zwaanswijk et al., 2003). Moreover, majority of parents in our sample held a bachelor's degree or higher (71.3%), thus issues related to socioeconomic disparities may have been inadequately accounted for.

Implications

The results of the current study suggest that religious fundamentalism is key to understanding mental health help-seeking intentions and stigma. In addition, religious fundamentalism appears to significantly influence help-seeking intentions in all parents, regardless of race/ethnicity. High religious commitment indicates more help-seeking intentions, possibly due to the beneficial value of social support; however, high fundamentalism can negate the positive effects of social support by exerting rigid values, which suppresses help-seeking intentions. In other words, religion can provide social support for families, but high fundamentalism can inhibit help-seeking by contributing to more negative attitudes and stigma towards MHHS. Social support has protective effects against poor health outcomes (e.g., stress and depression), and it also influences parental MHHS. Due to the findings suggesting the

importance of religious fundamentalism, leaders of religious organizations may be key in encouraging parents to seek mental health services for their children who are experiencing difficulties.

Empirically based public education on mental health and anti-stigma programs may be beneficial in decreasing stigma around mental health service utilization. However, targeting stigma alone may not be sufficient enough in improving help-seeking intent. Future research should identify how to increase help-seeking intentions and mental health service use engagement in parents, particularly those who display high religious fundamentalism. Additionally, structural barriers continue to need to be addressed. Treatment can be costly and time-consuming, especially for those with low SES. To promote mental health equity, there should be a focus on broader scale policy efforts to further decrease structural barriers and reduce the service gap to some extent. Although this study was important in highlighting the roles of parental factors in mental health help-seeking intentions, intent does not fully predict actual use, and there may be additional factors to understand parental help-seeking behavior that were not assessed. Hence, as youth mental health concerns continue to serve as an increasing public health concern, the need for future examination of sociocultural variables on help-seeking intent—specifically how religious fundamentalism hinders parents from seeking mental health services for their children—is necessary for promoting service use, and preventing long-term negative effects of mental health difficulties in underserved youth.

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Table 1***Sample Demographics***

Race	White				Ethnic Minority ^a			
	N	Percent	M	SD	N	Percent	M	SD
Age	127		38.84	7.41	159		39.99	8.08
Household Number	129		3.97	1.05	160		4.21	1.42
Adults	129		2.05	.57	160		2.34	.95
Children	129		1.91	.86	160		1.86	.92
Gender	129				160			
Male		17.1%				23.1%		
Female		82.2%				76.3%		
Neither		.8%				.6%		
Relationship Child	129				160			
Father		17.1%				21.9%		
Mother		80.6%				75.6%		
Neither of the above, guardian/primary caregiver		2.3%				2.5%		
Marital Status	129				160			
Single, never married		7.8%				12.5%		
Married or committed domestic partnership		82.9%				81.9%		
Widowed		.8%				1.3%		
Divorced/ Separated		8.5%				4.4%		
Education	127				159			
Less than high school						1.3%		
High school/GED		5.5%				8.8%		
Some college but no degree		15.0%				18.2%		
Associate's degree		12.6%				6.9%		
Bachelor's degree		33.9%				39.0%		
Master's/ Specialist Degree		21.3%				12.6%		
Doctorate/ Professional Degree		11.8%				13.2%		
Generation Status	128				158			
First generation		4.7%				44.9%		
Second generation		6.3%				23.4%		
Third generation or higher		89.1%				31.6%		
Religious Affiliation	108				145			
Unaffiliated/ Atheist		23.1%				17.2%		
Agnostic		7.4%				3.4%		
Buddhist		.9%				3.4%		

Christian	60.2%	62.8%
Hindu	.9%	1.4%
Jewish		.7%
Muslim		3.4%
Native American Religion/Indigenous Spiritual practice		.7%
Other	7.4%	6.9%
Past MHHS	127	158
No	22.0%	52.3%
Yes	78.0%	46.8%

a. American Indian/Alaskan Native 1.4%; Native Hawaiian/Pacific Islander .3%; Asian/Asian American 26.3%; Asian Indian/Indian American 1%; African American/Black/Caribbean Black 13.5%; White/Caucasian/European American 44.6%; Hispanic/Latino(a) 9%; Multiracial/ethnic 2.8%; Other 1%.

Table 2.***Regression Analysis Summary for Predicting Help-seeking Intentions***

Variable	B	SE	β	t	p
Constant ^a	19.559	2.586		7.563	.000
Gender	1.196	.642	.122	1.862	.064
Race	.307	.670	.035	.458	.648
Generation status	-.214	.374	-.044	-.574	.567
Religious commitment	.058	.030	.177	1.945	.053
Religious fundamentalism	-.028	.014	-.187	-2.012	.046**
Stigma	-.024	.049	-.041	-.495	.621
Help-seeking attitudes	-.147	.055	-.219	-2.656	.009**
Past MHHS	.854	.621	.097	1.375	.171
Structural barriers	-.078	.023	-.250	-3.456	.001**

Note. SE = standard error. MHHS = mental health help-seeking. Structural barriers measured with BTPS scale. Stigma and help-seeking attitudes measured by PATPSI stigmatization and attitudes subscale scores, respectively. Religious commitment measured with RCI-10. Religious fundamentalism measured with RFS-12. $R^2 = .26$. Adjusted $R^2 = .224$. R^2 change = .26.

** indicates significant contributors at the level of $p < .05$.

a. Outcome variable: Help-seeking intentions, measured by PATPSI intentions subscale score.

Table 3.*Hierarchical Regression Model for Religiosity and Stigma*

	Variable	B	SE	β	t	p
Step 1 ^b	(Constant) ^a	2.420	3.950		.613	.541
	Gender	.113	.859	.007	.131	.896
	Race	.353	.887	.025	.398	.691
	Past MHHS	-.473	.807	-.032	-.586	.559
	Generation status	-.486	.503	-.059	-.967	.335
	Structural barriers	.108	.032	.201	3.403	.001**
	Help-seeking attitudes	.521	.065	.473	8.016	.000**
	Help-seeking intentions	-.041	.094	-.025	-.438	.662
	Step 2 ^c	(Constant)	2.262	3.876		.584
Gender		.026	.843	.002	.031	.975
Race		.163	.872	.011	.186	.852
Past MHHS		-.198	.797	-.014	-.249	.804
Generation status		-.433	.494	-.053	-.876	.382
Structural barriers		.113	.031	.209	3.610	.000**
Help-seeking attitudes		.502	.064	.456	7.845	.000**
Help-seeking intentions		-.032	.092	-.020	-.345	.730
Religious fundamentalism		.038	.012	.164	3.215	.001**
Step 3 ^d	(Constant)	2.346	3.889		.603	.547
	Gender	-.013	.851	-.001	-.015	.988
	Race	.218	.886	.015	.246	.806
	Past MHHS	-.175	.800	-.012	-.219	.827
	Generation status	-.422	.495	-.051	-.851	.396
	Structural barriers	.111	.031	.207	3.552	.000**

Help-seeking attitudes	.500	.064	.454	7.753	.000**
Help-seeking intentions	-.037	.093	-.023	-.402	.688
Religious fundamentalism	.024	.038	.105	.644	.520
Religious fundamentalism, race interaction	.009	.024	.062	.383	.702

Note. SE = standard error. MHHS = mental health help-seeking. Structural barriers measured with BTPS scale. Help-seeking attitudes and intentions measured by PATPSI attitudes and intentions subscale scores, respectively. Religious fundamentalism measures with RFS-12.

** indicates significant contributors at the level of $p < .05$.

a. Outcome variable: Stigma, measured by PATPSI stigmatization subscale score.

b. $R^2 = .384$. Adjusted $R^2 = .366$. R^2 change = .384

c. $R^2 = .41$. Adjusted $R^2 = .39$. R^2 change = .026

d. $R^2 = .41$. Adjusted $R^2 = .388$. R^2 change = .000